

# Maui Health System Financial Assistance Program

If you can't pay for medical care, the Maui Health System (MHS) financial assistance program may be able to help. Our program offers financial help to those who qualify. If you meet the requirements listed below, you'll need to fill out and send this application to participate in the program. Please note: The financial assistance program is available to all MHS patients. Help is available for emergency or medically needed care only. If you qualify, certain expenses will be covered for medical services and prescriptions that are provided at an MHS facility, including Maui Memorial Medical Center, Kula Hospital or Lanai Community Hospital.

## Step 1

### QUALIFICATION REQUIREMENTS

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You must meet one of the following to qualify for financial assistance:

- Your gross household income must be no more than 250% of the Federal Poverty Guidelines. Visit [aspe.hhs.gov/poverty](http://aspe.hhs.gov/poverty) to find the poverty guideline for your state.
- Your out-of-pocket medical expenses are more than 15% of your annual gross household income.

**Qualifying based on High Out-of-Pocket Medical Expenses.** If you have unusually high medical costs, you may be eligible for the financial assistance program if your out-of-pocket costs over a 12-month period are equal to or more than 15% of your annual gross household income. Out-of-pocket medical expenses that qualify include copays, coinsurance, and deductible payments for emergency or medically needed services, as well as out-of-pocket costs for dental care and prescription medication. We may ask you to give proof of income or copies of your out-of-pocket medical, dental or medication expenses. **Not all medical expenses qualify.** For example, the following expenses do not qualify:

- Amounts you pay for health plan premiums
- Over-the-counter drugs or supplies
- Non-emergency elective or lifestyle services that aren't considered medically necessary
- Specifically excluded drugs, like fertility, cosmetic, or non-formulary medications

**For more information about qualifying for the financial assistance program, or to find out more about which services are covered, please see the MHS financial assistance policy at our website at [www.mauihealthsystem.org/fap](http://www.mauihealthsystem.org/fap).**

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## Step 2

### INSTRUCTIONS

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If you meet the eligibility requirements, please mail or fax your signed, completed application with all appropriate supporting documentation to Maui Health System - Lana'i Community Hospital, Attention: Financial Counseling Services, P.O. BOX 630650, Lanai City, HI 96763, FAX (808) 565-8474

**Questions?** If you have any questions or if you need help with this application, please call MHS at (808) 565-8456 from Monday through Friday, 8:30 am to 5:00 pm HST.

**Notification of our decision.** After we receive your completed application, we'll let you know our decision by mail or phone. This will include an explanation of your approval or denial. If approved, your award will depend on your income level and medical expenses. If you're denied, you'll have an opportunity to appeal the decision. In some cases, we may ask for corrected or additional information.

**You may also need to apply for public or private health coverage.** When you apply for financial assistance, you may also need to apply to any public or private health programs you're eligible for. These may include QUEST Integration or the Health Insurance Marketplace. For more information, visit [healthcare.gov](http://healthcare.gov) or call (800) 318-2596. We may ask you to show us proof you've applied to these programs or that you've been approved or denied. You may qualify for financial assistance while waiting for a decision from these programs.

**Please be sure to complete the application as completely as you can. Any missing information may delay any award you might get.**

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## Step 3

Please complete the information below.

### PATIENT

Name (first name, middle initial, last name)		Birth date (mm/dd/yyyy)
Street address		Apt. number
City, State, ZIP		
Home/cell phone	Medical record number	Social Security number
Spouse/guardian name (first name, middle initial, last name)		Birth date (mm/dd/yyyy)
Home/cell phone	Medical record number	Social Security number

### INFORMATION

Are you or a family member in your household currently employed?  Yes  No

Do you have any other medical insurance? If yes, with whom:  Yes  No Subscriber ID number: \_\_\_\_\_  
 Insurance company name: \_\_\_\_\_

Do you have Medicare?  Yes  No If yes, list your Subscriber ID number: \_\_\_\_\_

Are you enrolled in a Medicare savings program where the state pays for Medicare premiums?  Yes  No

Are you enrolled in a Medicare Part D?  Yes  No  
 If you're a Medicare Part D beneficiary with limited income and resources, you may qualify for extra help paying for your prescription drug costs through the Low Income Subsidy (LIS).

Have you already applied for Medicare LIS with Social Security Administration?  Yes  No  
 If yes and you have a recent approval, denial or pending letter, please submit a copy with your application.

Do you have or have you applied for QUEST Integration?  Yes  No  Unsure  
 If yes, list your Subscriber ID number: \_\_\_\_\_  
 If you've already applied for QUEST Integration and have a recent approval or denial or a pending letter, please send a copy with your completed application.

Do you have a Health Savings Account with a current balance?  Yes  No

### FAMILY HOUSEHOLD/DEPENDENTS

Family Household Size: \_\_\_\_\_ (List the number of family members who live with you in your home, such as a spouse, a qualified domestic partner, children, non-parent caretaker relatives, etc.)

a. Dependent name: (only if applying for financial assistance)

Relationship	Medical record number	Birth date (mm/dd/yyyy)
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b. Dependent name: (only if applying for financial assistance)

Relationship	Medical record number	Birth date (mm/dd/yyyy)
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c. Dependent name: (only if applying for financial assistance)

Relationship	Medical record number	Birth date (mm/dd/yyyy)
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**Incomplete information will result in a delay in processing or denial of your application.**

<b>MONTHLY GROSS FAMILY INCOME (List ALL Income from family members in the household)</b>			
<b>Applicant/patient</b>		<b>Spouse/guardian</b>	
Gross Salary/Wages (before taxes)	\$	Gross Salary/Wages (before taxes)	\$
Alimony/Child support	\$	Alimony/Child support	\$
Self-employment or Business income*	\$	Self-employment or Business income*	\$
Pension or retirement/Annuities	\$	Pension or retirement/Annuities	\$
Unemployment benefits	\$	Unemployment benefits	\$
Social Security/state disability/temporary disability/supplemental security income/veterans benefits	\$	Social Security/state disability/temporary disability/supplemental security income/veterans benefits	\$
Rental property	\$	Rental property	\$
Other, including cash income (describe):	\$	Other, including cash income (describe):	\$
<b>Total monthly income</b>	<b>\$</b>	<b>Total monthly income</b>	<b>\$</b>

\*When reporting rental or self-employment income, include your most recent tax return, along with all supporting schedules.

### PROOF OF INCOME DOCUMENTATION

**Important:** You may need to provide us with *copies* of the following documents for all applicants.

- A copy of your most recent signed federal tax return or W-2, with electronic submission verification or your signature (including all pages and schedules)
- A copy of your 2 most recent pay stubs showing year-to-date (YTD) income
- Copies of other recent documents, income-generating statements or award letters to verify additional household income, such as:
  - Disability                      – Unemployment                      – Proof of alimony/child support payments                      – Rental or estate income
  - Social Security                      – Bank statements                      – Retirement or pension accounts

**Please do not send originals.** Only copies are needed.

**Please note:** If we're able to verify your financial status using external data sources or third-party vendors, then you do not need to send us the documentation listed above.

### OTHER INCOME DOCUMENTATION

If you don't have documentation to verify your income AND you meet any of the following criteria, please include a signed statement that explains your income situation.

- I do not receive a formal pay stub from my employer.
- I have no income. (If you check this box, you must provide a written explanation of your financial situation in the "Income" section of this application.)
- I was not required to file a federal or state tax return for the most recent tax year.

**If none of the above apply, you may need to submit copies of all required documents with this application.**

### MEDICAL EXPENSE INFORMATION

If your gross household income is greater than 250% of the Federal Poverty Guidelines or if you're applying under high medical expense criteria, you must complete this section. Please list your out-of-pocket medical expenses paid within the last 12 months and submit copies of your non-MHS receipts or itemized invoices with your completed application.

Hospital or office visits: \$ \_\_\_\_\_ Prescribed medications: \$ \_\_\_\_\_  
 Other medical expenses, such as ambulance services, medical equipment, or dental expenses: \$ \_\_\_\_\_  
 (please describe): \_\_\_\_\_

### FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION

I hereby declare under penalty of perjury that (a) all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents, or (b) I am unable to provide documents relating to proof of income or other evidence of my income. I also acknowledge and agree that I am liable to Maui Health System (MHS) for any and all amounts owing to MHS for medical goods and services that are not covered by the Program (the "Remaining Amounts").

- I agree to let Maui Health System obtain information from consumer credit reporting agencies and other third-party information sources to determine my eligibility for federal, state, and private medical programs.
- I do not agree to what's described in the previous sentence. (Please initial here if you checked this box.) \_\_\_\_\_

Applicant or account holder will be notified, by mail or phone, whether the application is approved or denied. Maui Health System reserves the right to amend or retract awards.

Signature of Applicant/Guardian X	Date (mm/dd/yyyy)
Signature of Spouse of Applicant/Guardian X	Date (mm/dd/yyyy)