MEDICAL FINANCIAL ASSISTANCE POLICY SUMMARY

Medequip has a Medical Financial Assistance (MFA) program to help patients pay for care. It may cover all or part of your costs for necessary durable medical equipment provided by Medequip. Getting help depends on financial need as described below.

Who is eligible?

You may be eligible if you are low-income, uninsured or underinsured. In general you're eligible for financial help:

- If your household income is at or below 350% of the federal poverty guidelines
- Or if you have very high medical costs compared to your income

What will the program pay for?

The MFA program may help you pay for necessary care provided by Medequip. The program may cover the complete bill or part of it.

The program will not pay for:

- Health care premiums
- Care that your insurance provider decides was not medically necessary

How do I apply?

You can apply by mail, fax, phone, or in person.

You can also get a blank application at medequiportho.com/patients/forms/

You can apply at any point in the intake or billing process. You don't have to wait for a bill to ask for help.

What information will I need to apply?

You'll be asked for the following information when you apply:

- Household size and income information for all adults in the household
- Household annual expenses
- Account balances

Providing this income and expenses helps us determine if you qualify.

When will I know if my application has been approved?

If your application is complete, we will send you a letter with your decision within 30 business days.

If your application is incomplete or lacks sufficient info, we'll contact you. We'll give you a date by which you need to provide the missing information. If your application stays incomplete, you may not receive financial help.

Ways to apply

Fax it in
Fax your completed application to 800-685-5678

Mail it in
Mail your completed application to:
Medequip MFA Program
27 Brookline
Aliso Viejo, CA 92656

By phone
Call 1-800-944-3422, Monday through Friday, 8 a.m. to 5 p.m. Pacific time.

Medequip

FINANCIAL HARDSHIP PATIENT CERTIFICATION

Date:

Patient:

RE: Certification of Financial Hardship

Dear Patient:
We are required to bill you for the cost of your equipment and supplies. The portion we will bill you includes charges that would not be covered under an insurance plan such as co-payment and deductible.
You have indicated to us, however, that payment by you of this amount will result in financial hardship to you. In addition, you have requested that we evaluate your financial situation for purposes of our Financial Hardship Program. If we determine that payment by you would, in fact, result in financial hardship to you, we may elect to waive all or a portion of this payment amount.

In order to assist us in determining if payment of the amount would result in financial hardship to you, please provide us with the following information: Please enter amounts for entire year.

1	**How many family members (including yourself) live with you in your household?**	
2	**What is the gross (total) annual income of all family members living with you from :**	
	Your employment	
	Unemployment benefits	
	Social Security (do not include SSI - supplemental SS)	
	Retirement	
	Interest, Rents	
	Alimony, Child Support	
	Other	
	TOTAL	
3	**What are your total annual expenses for all family members living with you for:**	
	Rent/House Payment	
	Car Payment/ Transportation Costs	
	Food	
	Utilities	
	Education	
	Medical/Prescriptions	
	Other	
	TOTAL	
4	**Please specify balances in any of the following types of accounts you have:**	
	Checking Account(s)	
	Savings Account(s)	
	Money Market or CD	
	Other	
	TOTAL	

By signing below, you are certifying to us that the above information is complete and accurate, and that you will provide us with updated information as soon as it becomes available should any of the information set forth above change.

Patient Signature: _____ Date: _____

Office Use Only Date ___/___/___ Waiver Approved ____ Denied ____