

Financial Assistance Policy and Procedure

POLICY: Easterseals Southern California (ESSC) provides financial assistance for families who meet certain requirements and who are unable to meet their financial obligations for services received at ESSC. This policy is not intended for those with third party insurance. This policy requires written denial by other potential payers such as the regional center.

ELIGIBILITY: Eligible families are those who:

- A. Receive medically necessary services from ESSC.
- B. Are underinsured and otherwise financially qualified.
- C. Have a household income (see attached schedule) less than 300% of the Federal Poverty level.
- D. Have been denied support by potential third party payers such as the regional center.

Individuals who elect not to apply for other sources of payment such as regional center or other third party insurance, may be excluded from receiving financial assistance.

APPLICABLE TIME PERIOD: The determination of this benefit is not retrospective; therefore, it cannot be applied to charges from a previous period. Your household income will be reviewed each year in April, to determine if you are still eligible for benefits. Any determination of benefit will apply prospectively to the current services.

PROCEDURE: Financial assistance is determined based on the financially responsible party's income in comparison to Federal Poverty rates/guidelines. See attached schedule.

This percentage may change from time to time as deemed appropriate by the Chief Operating Officer, Chief Financial Officer and/or the Board of Directors of ESSC. Before financial assistance is approved, families must apply for all other sources of payment, including regional center, Medicaid or other third party insurance.

The process for Financial Assistance is as follows:

1. Complete the application and submit with supporting documents.
2. Submit the completed application and all applicable documents in a sealed envelope or online to:

Medical Specialties Managers, Inc. (MSM)
PO Box 4206
Orange, CA 92863-4206
Email: billing@msmnet.com
Phone: 714-245-8872

3. MSM will review the documentation for completeness and evaluate the financial need to make a determination of eligibility.
4. Approval will be determined based upon the income on the tax return as compared to the Federal Poverty Scale as provided with this policy.
5. If financial assistance is approved, approval status will be noted in the account.
6. If financial assistance is not approved, an appeal may be made to the Chief Operating Officer for final and binding determination of eligibility.

Attachment – Federal Poverty Guidelines with Discount Scale and Financial Assistance Application



Financial Assistance Application

Demographic Information

Name of person served: _____

MRN of person served: _____

Name of applicant(s): _____

Relationship to child/person served: parent or guardian self spouse other

Applicant address: _____

City / State / Zip: _____

Telephone numbers (home): _____ (mobile): _____

Email: _____

Income Information

Number of dependents living in the family household: _____

Annual Gross Income: Applicant \$ _____ Spouse \$ _____ Other \$ _____

Total Annual Household Gross Income: \$ _____ (income before taxes and other deductions)

Document Information

Please attach copies of the following documents:

Copy of written denial letter from regional center. **(Required)***

Copy of Federal Income Tax Returns for the prior year (IRS 1040, 1040A, 1040EZ). **(Required)***

Proof of other sources on income (Social Security, unemployment benefits, child support). (If applicable)

***Applications not containing required documents will be returned to the applicant as incomplete.**

I HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND REFLECTS FINANCIAL INFORMATION AS OF THE DATE OF THE APPLICATION.

Signature of Applicant: _____ Date: _____

For Internal Use: Received on: _____ Received by: _____ Decision: _____

Expires on: _____ Max Annual Value: _____



2022 HHS Poverty Guidelines (48 Contiguous States and D.C.)

	Category Cost Income Level Reduction to Charges	A 15% Income at 100% 85% Reduction	B 25% Income at 200% 75% Reduction	C 50% Income at 250% 50% Reduction	D 75% Income at or below 300% 25% Reduction
Persons in Family or Household	Federal Poverty Guidelines				
1	13,590	13,590	27,180	33,975	40,770
2	18,310	18,310	36,620	45,775	54,930
3	23,030	23,030	46,060	57,575	69,090
4	27,750	27,750	55,500	69,375	83,250
5	32,470	32,470	64,940	81,175	97,410
6	27,190	27,190	54,380	67,975	81,570
7	41,910	41,910	83,820	104,775	125,730
8	46,630	46,630	93,260	116,575	139,890
For each additional person added:	4,720	4,720	9,440	11,800	14,160

If your family income is less than or equal to the amount in Categories A, B, C and D you are eligible for reduced cost health care services.

Source: Federal Register, January, 2022