PATIENT FINANCIAL ASSISTANCE PROGRAM SUMMARY

Thank you for choosing Select Specialty Hospital - Tucson for your care.

To further the Select Specialty Hospital - Tucson mission to the communities it serves, Select Specialty Hospital - Tucson is pleased to provide financial assistance for medically necessary care in a fair, consistent, respectful and objective manner for low-income patients who do not have insurance coverage or are underinsured.

The term ***medically necessary*** refers to inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms that if left untreated would pose a threat to the patient's ongoing health. Services not considered medically necessary are services that are cosmetic, experimental or part of a clinical research program. Private fees for physicians, radiologists and anesthetist services remain the patient's responsibility.

APPLICATION PROCESS

A financial assistance application must be completed within 30 days after discharge or before any court judgment has been assigned to the account. Documentation necessary for income, asset, and monthly expense verification for the household includes, but is not limited to:

- Most current W-2s and tax forms

- Last (3) paycheck stubs from employment
- Social Security award letter for the current year
- Unemployment Compensation benefit letter
- Bank and/or credit union statements for the last three (3) months
- Rent receipt or lease/mortgage statement
- Room and board/support letter
- Utility bills
- Divorce decree
- Copy of death certificate

Incomplete applications will be denied until they are fully completed. A letter will be sent to the patient outlining the information needed with instructions on how to submit the necessary documents. Applications will remain on file for 240 days. If the required documents are not received or no payment arrangements have been made, the account will be submitted for bad debt review.

ELIGIBILITY DETERMINATION

The Select Specialty Hospital – Tucson's Central Business Office has 30 days from the date when the completed application is received to authorize financial assistance and to notify the patient. Final determination for financial assistance will be provided in writing. Assignment to a collection agency will not occur during the assistance-determination process.

Determining factors for approval include:

- No third party is responsible for payment
- Household income is below 350 percent of the Federal Poverty Level
  - Includes all pre-tax income for all those 18 years of age and over who reside in the household.
- A credit history report may be requested

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ELIGIBILITY DETERMINATION, continued

- Household assets
  - Checking accounts
  - Savings accounts
  - Stocks, bonds and annuities
  - Cash value of life insurance policies
  - Personal property
  - Vehicles other than primary transportation

PAYMENT PLANS

If a payment plan is needed, please contact the Central Business Office.

Patients who agree to make monthly payments will not be assigned to a collection agency and will not be charged interest. Failure to make a payment within two (2) months may result in the account being submitted to a collection agency.

Patients have the right to appeal the financial assistance determination by submitting an explanation of circumstances to the Select Specialty Hospital – Tucson's Central Business Office within 30 days of receiving the notification of determination.

A copy of the financial assistance application and the complete financial assistance policy is available from Select Specialty Hospital – Tucson's website at www.selectspecialtyhospitals.com/locations-and-tours/az/tucson/tucson/ or by calling the Select Specialty Hospital Central Business Office, (888) 868-1103. If you have any questions about the Financial Assistance Program, please contact the Select Specialty Hospital Central Business Office.

THE UNDERSIGNED VERIFIES RECEIPT OF THIS INFORMATION ABOUT THE SELECT SPECITALTY HOSPITAL - TUCSON PATIENT FINANCIAL ASSISTANCE PROGRAM

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE	DATE / TIME