PATIENT CARE AMERICA

3890 Park Central Blvd N.
Pompano Beach, FL 33064
P: 866-348-0441 F: 888-503-6982

Patient Assistance Program

Patient Care America may provide patient assistance based on an individualized determination of patient need. A Patient Assistance evaluation process applies equally to all patients and will be initiated for patients who have expressed financial hardship and/or need. The patient must complete the Application for Patient Assistance and may also be required to submit proof of income: W-2, bank statement, current pay stubs or any other substantial proof or signed patient statement explaining financial hardship.

1. Determination for Patient Assistance will be based on the information provided within the Application for Patient Assistance (APA).
2. Determination for awarding patient assistance is based on individual and/or household financial status.
3. The patient will be provided with notification of eligibility status within no more than five (5) business days from the date of submission of the APA.
4. If approved:
    a. The payment arrangements and valid approval dates will be provided.
    b. The patient will be required to review, sign and date the agreement and send back to Patient Care America for scanning into the patient's billing account record.
    c. An approval is valid for the remainder of the calendar year or fiscal year (depending on the patient's plan), unless stated otherwise.
    d. All Patient Assistance Evaluation information and related documentation will be maintained in the patient's billing account record and will need to be resubmitted and reassessed upon expiration of the agreement.
5. Patient Assistance Evaluations are reviewed at least annually. If there is a change in insurance plan, financial status, household size, etc., Patient Care America will re-evaluate the patient for assistance and determine eligibility for the program.

This policy is not applicable when superseded by state and federal law. No Application for Patient Assistance will be considered complete unless reviewed, signed, and dated by the patient.

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APPLICATION FOR PATIENT ASSISTANCE PROGRAM (PAP)

Patient Name (Last Name, First Name, M.I.)	SSN	DOB
Address	**City**	**State**
Telephone	**Marital Status**	**# of dependents**

MONTHLY Household Income	MONTHLY Household Expenses
Number of household members ____________	Mortgage / Rent $ ____________________
Gross Pay $_________________	Utilities (Inc. Phone & Cable) $ ____________________
Pension $_________________	Transportation $____________________
Disability $_________________	Child Care $ ____________________
Social Security $_________________	Food $ ____________________
Other $_________________	Medical Expenses $ ____________________
	Other $ ____________________
Total Monthly Income $_________________	Total Monthly Expenses $ ____________________

PLEASE NOTE: INCOMPLETE APPLICATIONS WILL BE RETURNED
(Signatures are required by patient/legal representative)

PATIENT CERTIFICATION
By signing this application, the patient certifies that the financial information provided is true and accurate for Patient Care America to consider patient assistance. The patient agrees to notify PCA of any changes to their financial status and that the information provided on this application may be verified.

_________________________________ _____________________________ ________________
Patient Signature/or Legal Representative   Patient Name/Legal Representative (Print)   Date

For Internal Use Only: __________ **Approved** _________ **Denied**

_________________________________ _____________________________ ________________
Patient Care America Approval Signature   Patient Care America (Print name)   Date

Patient Assistance Program

Patient Assistance Program %__________   From:____________ To:_____________

Payment Plan Agreement

Amount Approved Per Week: _____________   From: ____________ To:_____________

Revised May 2020