



HEALTH & WORK

Hospital Financial Assistance Application Workbook

Prepare, submit and verify a hospital financial-assistance application after accident bills disrupt household finances.

WHAT THIS WORKBOOK HELPS YOU DO

- 01 ————— • Complete your policy extraction
- 02 ————— • Complete your provider coverage map
- 03 ————— • Complete your requirement-to-evidence matrix

For people handling accident-related paperwork and preparing clear, evidence-backed questions.

Use it on screen or on paper. Save a personal copy before entering information. Blank response areas are fillable; printed copies work just as well. Keep completed copies private.

Scope. Educational organization tools, not legal, medical, tax or financial advice. No claim result, coverage decision or payment is promised. Verify policy language, current local rules and all deadlines with the appropriate professional or official source.



START HERE

Start with a clear working file

Work on one claim, account or issue at a time. Keep originals unchanged and label working copies with a short evidence ID. Complete the guidance in order, then use the worksheets to turn questions into an organized next step.

A practical order

- 01 Read the four guidance pages before filling the worksheets. Mark facts you can support and questions that still need an answer.

GUIDANCE / PAGES 03-06

- 02 Use the fictional examples to check your method. Their facts and dollar amounts do not describe your claim or predict an outcome.

EXAMPLES / PAGE 07

- 03 Complete the four working sheets, then use the readiness check and next-step page. Duplicate a worksheet when you need another record.

WORKSHEETS / PAGES 08-11

Protect your information

Store completed copies somewhere private. Use a claim or account suffix when a full identifier is unnecessary. Share only relevant copies through a verified recipient and appropriate channel. A saved PDF can contain personal information even when it is not open on screen.

Before a deadline. Do not wait to finish this workbook when a notice, release, court paper or policy deadline needs attention. Verify the actual requirement and seek qualified help promptly.



GUIDANCE 1

01

Identify the assistance route

Begin with the facility that issued the bill and ask for its financial-assistance policy (FAP), application and plain-language summary. A payment plan and a financial-assistance award are different arrangements, so record which one is being discussed. The federal charitable-hospital framework applies to qualifying tax-exempt hospitals; it is not a universal promise that every clinician must waive charges. Other hospitals may offer assistance under their own policies or state rules. Save the policy version that applies to your care and verify the department authorized to decide your request.

Read the actual eligibility policy

Extract the policy's definitions before collecting financial papers. Household size, counted income, documentation periods and accepted alternatives may be defined differently from the terms you use at home. Copy the relevant page reference rather than substituting a rule from another hospital. Ask how changed income after an injury is handled and whether the policy uses current income, prior-year information or both. Report the facts accurately even when the form feels poorly suited to your situation. A missing document should become a question about accepted alternatives, not a fabricated entry.

RELATED WORKING SHEETS

- Policy extraction
- Requirement-to-evidence matrix

Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 2

02

Separate covered provider accounts

A hospital visit can produce facility, physician, imaging and other bills. List each account and compare the biller with the policy's provider list. An award for one account does not establish an award for every professional who treated you. Mark covered, excluded and uncertain providers, with the source for each entry. Ask uncertain providers directly about their own assistance policies. This prevents a successful hospital application from creating false confidence that an unrelated bill is also resolved.

Build a complete evidence packet

Create a requirement-to-document map. For each policy requirement, identify the exact supporting page, date range and file label. Explain a recent drop in earnings with truthful current records and the application's approved process. Include only information required or relevant to the application, especially when bank statements contain unrelated people or transactions. Keep a full private source copy and use the hospital's verified submission channel. Do not assume that uploading a large stack of papers is equivalent to satisfying each requested field.

RELATED WORKING SHEETS

- [Provider coverage map](#)
- [Requirement-to-evidence matrix](#)

Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 3

03

Control notices and submission dates

Keep the first post-discharge statement, later collection notices and application correspondence together. The federal charitable-hospital rules contain notification and application periods, but their application depends on the facility and circumstances; a date printed on a worksheet is not a substitute for checking the actual policy and notice. Submit promptly and retain delivery evidence. Ask what happens to billing and collection activity while the application is reviewed, then record any confirmed terms. Do not ignore a lawsuit or other separate deadline because an assistance request is pending.

Repair an incomplete application

If the hospital says information is missing, ask for a specific written list rather than guessing what went wrong. Identify each missing item, who can supply it and the response date stated by the hospital. If an item cannot be obtained, explain why and ask whether an alternative is accepted. Send a cover sheet tying the new documents to the original application reference. Keep a copy of every supplement. An unanswered request for more information can stall review even when the original application was submitted on time.

RELATED WORKING SHEETS

- Requirement-to-evidence matrix
- Decision and adjustment audit

Sources for this page: [1], [2]. See the linked source guide.



GUIDANCE 4

04

Audit the written decision

Read the award or denial against the requested accounts and service dates. An approval may cover only a defined period, facility or balance. If a percentage discount is stated, compare the resulting account statement with that instruction rather than estimating the result from memory. Record any remaining amount separately. If the decision seems to overlook evidence or misapply the policy, use the stated reconsideration process and identify the precise issue. Do not label a denial unlawful without qualified review of the applicable facts and rules.

Close with account-level proof

Obtain an updated statement for each covered account and verify that the assistance adjustment was actually posted. Keep excluded accounts on a separate next-action list. If someone offers a payment arrangement for a remaining balance, review its terms before committing; this workbook does not choose financing for you. Archive the policy, application, supplements, delivery proof, decision and corrected statements together. A finished file should show both what was approved and what remains unresolved, so another household member or adviser does not assume all accident bills disappeared.

Verify the award on each covered account; keep excluded accounts visible.



Sources for this page: [1], [2]. See the linked source guide.



FICTIONAL EXAMPLES

Work through the examples

These invented cases demonstrate the method. They are not case results, estimates of what you will receive or statements of universal rights.

01 Fictional: split hospital and clinician bills

A hospital policy covers the facility bill but lists an independent emergency-physician group as excluded. The patient receives a 75% adjustment on an eligible \$4,000 facility balance, leaving \$1,000 on that account under the fictional award. The separate \$600 physician bill is unchanged. The next step is a separate assistance inquiry. Do not assume the \$600 physician bill was forgiven.

02 Fictional: changed income

Last year's tax return does not reflect the patient's current unpaid recovery period. The packet includes the return because the policy requests it, plus truthful current wage evidence and a question asking how the facility evaluates changed circumstances. It does not omit the return or substitute a guessed annual income.



WORKSHEET 1

01

Policy extraction

Use the policy for the actual facility and date of care; do not copy a universal income threshold.

Hospital/facility

Policy version/date

Tax-exempt status source if checked

Eligibility definition/page

Household definition

Income period

Required evidence

Application route

Policy-specific deadline

Questions

Related guidance: [Identify the assistance route](#)



WORKSHEET 2

02

Provider coverage map

Audit every biller separately.

Biller

Account suffix

Service dates

Original balance

Listed in FAP

Covered/excluded/uncertain

Policy page

Separate application needed

Contact/date

[Related guidance: Separate covered provider accounts](#)



WORKSHEET 3

03

Requirement-to-evidence matrix

Match each requirement to one or more identified pages.

Requirement

Requested date range

Document source

Page/file label

Obtained date

Missing item

Accepted alternative confirmed by

Supplement due date

Submitted proof

Related guidance: [Control notices and submission dates](#)



WORKSHEET 4

04

Decision and adjustment audit

Do not close on an approval letter alone; verify the account entries.

Application reference

Submitted/received dates

Decision date

Accounts covered

Award terms

Adjustment posted

New statement balance

Unresolved excluded account

Reconsideration route/deadline

Closure evidence

Related guidance: [Audit the written decision](#)



READINESS REVIEW

Check the file before using it

REVIEW EACH ITEM BEFORE MOVING ON

- ☐ Each working figure or statement is linked to an identifiable document.
- ☐ Missing information is marked as unverified rather than estimated as fact.
- ☐ The exact question and the person or organization able to answer it are identified.
- ☐ The current document version and any conflicting version are preserved.
- ☐ Independent deadlines and the source of each deadline have been checked.
- ☐ The final written response has been compared with the original question.

What still needs attention

Open fact or decision, who can resolve it, and the source needed

Completion standard. The working file is complete when the important facts are supported, the next action is assigned and any unresolved issues remain clearly visible. A completed checklist does not establish coverage, entitlement or legal compliance.



ACTION PLAN

Write down the next step

Choose the smallest useful next step. Make the request specific enough that the recipient can locate the record and explain or address the exact issue. Keep proof of what you sent and what came back.

The exact issue or request

Evidence IDs and document versions that support the request

Verified recipient and channel

Date sent and follow-up date

What response will resolve the issue, and what still needs professional review

Separate decisions. A courtesy follow-up date is not a legal deadline. A document request does not automatically pause another requirement. Do not sign, settle, move property or disclose sensitive records merely because a box on this page is complete.



REFERENCE GUIDE

Sources and scope

The linked official sources support the educational background. The forms and examples are original organization tools. Sources were checked on October 1, 2026; policies, procedures and law may change. Recheck the current source before relying on a rule.

[1] irs.gov

Qualifying tax-exempt hospitals must maintain a written financial-assistance policy stating eligibility, how to apply and which other providers are covered. The federal framework does not establish one national income cutoff for all hospitals.

<https://www.irs.gov/charities-non-profits/financial-assistance-policies-faps>

[2] irs.gov

Section 501(r)(6) addresses reasonable efforts before extraordinary collection actions. The rules describe a 120-day notification period and a 240-day application period measured from the first post-discharge billing statement, with important conditions and possible extensions; the 240-day period is not every hospital's universal final deadline.

<https://www.irs.gov/charities-non-profits/billing-and-collections-section-501r6>

Keep the scope clear

Assistance is policy- and facility-specific; approval and debt cancellation are not guaranteed

State charity-care protections may differ or add rights; verify current local sources

Insurance status alone does not establish eligibility or ineligibility

Do not ignore collection notices, court papers or requests for evidence.