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

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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: _____

Rev 4/8/25

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Financial Assistance Worksheet

2025 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	15,650	15,650	31,300	39,125	46,950
2	21,150	21,150	42,300	52,875	63,450
3	26,650	26,650	53,300	66,625	79,950
4	32,150	32,150	64,300	80,375	96,450
5	37,650	37,650	75,300	94,125	112,950
6	43,150	43,150	86,300	107,875	129,450
7	48,650	48,650	97,300	121,625	145,950
8	54,150	54,150	108,300	135,375	162,450
For each additional person added:	5,500	5,500	11,000	13,750	16,500

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, 2025