

AOCOO-HNS Foundation PSG Program

AOCOO-HNS Foundation is committed to helping medically indigent patients of osteopathic ophthalmologists and otolaryngologists. With this in mind, the Foundation has created the PSG Program (patient services grant). This program provides access to monies to help offset the cost for medical treatment or medical appliances for families and individuals without adequate insurance coverage or personal income to compensate their hospital or clinic.

Instructions

The PSG Program is limited to ophthalmology and otolaryngology patients who meet certain insurance and financial criteria. No cash payments are involved. An osteopathic ophthalmologist or otolaryngologist may become a Sponsor and apply to the Program on behalf of their patients.

Sponsoring physician must complete PSG Form A and be prepared to provide the patient's name, social security number, annual family income, and insurance information. The physician will also need to obtain the patient's signed consent, PSG Form B, to disclose confidential patient-identifiable information (name, medical condition, social security number, address, zip code, insurance company and policy number or employer). Eligible patients will be contacted by letter once the completed forms are approved by the Foundation Board of Directors.

The AOCOO-HNS Foundation Board of Directors reserves the right to approve or deny any PSG Program application. The AOCOO-HNS Foundation Board of Directors reserves the right to make an independent determination of medical indigence in all cases.

Eligibility and Enrollment Information Requirements

Provider Information (Form A)

The following information will be requested of osteopathic ophthalmology or otolaryngology physicians who contact the PSG Program to establish patient eligibility:

- Physician's name
- Physician's address, telephone and fax numbers, and email address

Patient Information (Form B)

Before providing any patient-identifiable information (name, medical condition, social security number, address, zip code, insurance company and policy number or employer), you must have the patient's consent to disclose confidential information. The following information will be requested to establish a patient's eligibility:

- Patient name
- Social security number
- Medical condition and treatment or medical appliance
- Patient's family income
- Insurance information for all insurance plans in which the patient participates, including name of insurer, pending insurance and anticipated effective date, and any denied insurance
- Patient's current medical status

No patient is accepted into the PSG Program until the sponsoring physician's signature is received on the necessary forms.

Form A: Sponsor Form

Date: _____

1. Sponsor Information

Sponsor Name _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____

Email _____

PSG Program request

2. Patient Information

Patient name _____

Social security number _____

Medical condition and treatment or medical appliance _____

Patient's family income _____

Insurance information _____

Requested PSG Program amount: _____

3. Sponsor Certification and Consent

By submitting this application and agree to the following:

- o I understand that the AOCOO-HNS Foundation Board of Directors reserves the right to approve or deny any PSG Program application.
- o I understand that the AOCOO-HNS Foundation Board of Directors reserves the right to make an independent determination of medical indigence in all cases.
- o I understand that Insurance Verification may be required to determine a patient's eligibility for the PSG Program
- o If I become aware of any changes in the patients' circumstances which affect the PSG Program eligibility, I agree to notify the AOCOO-HNS Foundation Board of Directors immediately.
- o I agree to release or make available to any AOCOO-HNS Foundation representative the medical and financial records for the PSG Program patient at any time for the sole purpose of verifying patients' eligibility for the PSG Program, and I agree to obtain appropriate consent from each patient prior to releasing or making available to the AOCOO-HNS Foundation such records or information.

Sponsor Signature _____ Date _____

Print Name _____

Send completed forms to: AOCOO-HNS Foundation
Attn: PSG Program
4764 Fishburg Road, Suite F
Huber Heights, OH 45424
Fax: 937-233-5673

Form B: Patient Enrollment Form

Date: _____

1. Sponsor Information

Sponsor Name _____

Address _____

City _____ State _____ Zip _____

2. Patient Information

Patient Name _____

Social Security Number _____ Date of Birth _____

3. Financial/Insurance Information

Income: patients annual gross family income _____

Insurance: please check all insurers from which you receive benefits:

<i>Insurer</i>	<i>Status</i>	<i>Date</i>
___ Medicare ___ Yes ___ No	___ Pending ___ Denied	Effective _____
___ Medicaid ___ Yes ___ No	___ Pending ___ Denied	Effective _____
___ Commercial ___ Yes ___ No	___ Pending ___ Denied	Effective _____
Name _____		
___ Managed Care Plan		
___ Yes ___ No	___ Pending ___ Denied	Effective _____
___ Comments _____		

4. Patient Certification and Consent

My doctor has recommended me for the PSG Program and I would like to receive help through the AOCOO-HNS Foundation PSG Program. In order to participate, I hereby certify that the financial/insurance information listed above is accurate.

- I understand that, in order to determine my eligibility to participate in the PSG Program, the AOCOO-HNS Foundation needs information about my medical diagnosis and treatment, my family income, and my health insurance. I agree to permit information about me to be given to the AOCOO-HNS Foundation to support my application.
- I understand that this information identifying me will not be used for any purpose other than for the PSG Program unless:
 - I give written consent, or
 - It is required by the government, or
 - PSG Program first removes my name and any other identifying information

Type or print name

Date

Type or print name of patient's parent (if applicable)

Physician's signature

4. Sponsor Certification Agreement

I represent that the information contained in this application is complete and accurate to the best of my knowledge and agree to notify the AOCOO-HNS Foundation Board of Directors of any changes of which I become aware, which could affect the patient's eligibility status.

Sponsor Signature _____ Date _____

Print Name _____

Send completed forms to: AOCOO-HNS Foundation, Attn: PSG Program
4764 Fishburg Road, Suite F, Huber Heights, OH