POLICY TITLE: FINANCIAL ASSISTANCE/ CHARITY CARE POLICY	**EFFECTIVE DATE**: August 23, 2017 **SUPERSEDES**: 1/14, 1/15
POLICY NUMBER: **BO.8266.1001** DEPARTMENT: HOSPITAL-WIDE CATEGORY: Patient Accounting	**REVIEW DATE**: August 2018
APPROVED BY: NMH Board of Directors Chief Executive Officer	Page: 1 OF 22

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PURPOSE

To provide consumers with options to pay for health care services provided by Newman Memorial Hospital, (NMH). This policy outlines NMH's Financial Assistance/Charity Care Policy.

POLICY STATEMENT

Financial Assistance/Charity Care applications will be reviewed and assessed based on income, assets, and family size. Financial Assistance/Charity Care is not available for any cosmetic, elective (non-medically necessary), or non-urgent services as determined by a physician. NMH's policy incorporates the requirements of Title 63, section 1-723.2 of the Oklahoma State Statutes. It is the responsibility of the patient to establish their eligibility for the program discount. The eligibility for participation is based on the criteria below:

Evaluation Criteria:

- The only financial portion of a patient bill considered for financial assistance/charity care will be the patient responsibility amount. All insurance must be filed and resolved prior to any charity determination.
- A sliding scale (see table on last page) is used with documented proof of household income and assets to make the financial assistance/charity care determination. Total income for the household is calculated for the most current twelve (12) month period.
- For retired persons, Pension benefits are included in the income determination. However, Social Security benefits are excluded from the calculation.
- Patients can apply for financial assistance/charity care as long as the accounts are within 240 days of discharge or date of service. Patients will not be allowed to apply for financial assistance/charity on accounts with discharge or date of service greater than 240 days.

PROCEDURE

Application:

Application for eligibility determination for financial assistance may be obtained from the NMH Website, www.newmanmemorialhospital.org or directly from the NMH Patient Business Services Department's Financial Counselor (located at the first floor Registration desk), or by calling the Business office at (580) 938-2551. Consumers will have the ability to download the organization's Financial Assistance/Charity Care Policy on the hospital website. If the consumer chooses to obtain a copy of the organization's Financial Assistance/Charity Care Application from the Patient Business Services Department, the Financial Counselor will provide the consumer with a copy of the *Financial Assistance/Charity Care* policy. The Patient Financial Counselor will obtain a signature from the consumer acknowledging the acceptance of the application and the initiation of a consumer file to be retained within the Financial Counseling division of the Patient Business Services Department.

Required Consumer Documentation:

Consumers are required to return the following documentation with the completed financial assistance/charity care application (if applicable):

- DHS Eligibility Letter showing dates of coverage
- Social Security Eligibility Letter
- Signed copy of the most current year's federal income tax return and copies of the most recent W-2's for each household wage earner.
  Key Point: For students, a copy of their Financial Aid Award Letter (student loans do not count as income)
- Verifiable income statements, pay stubs, from the last three (3) months. Other income includes: financial assistance from parents or other relatives, child support, alimony, interest income, tips, unemployment, etc.
- Self-employed consumers will be required to produce a quarterly tax return if they contend that current income differs from their prior year income

  Key Point: Consumers with no visible means of support will not be approved.
  - Consumers who are homeless and living in a shelter will be required to obtain a letter of verification from the director of the shelter to submit with their application.
  - Consumers who reside in a household of which they are not a legal dependent of the head of household will not be required to provide proof of income for every member of the household. They will only be required to provide their own proof of income. The other members of the household will not be listed on the application and household expenses will not be included.
  - Family members are defined as persons occupying the same household and who are identified as dependents for tax purposes.
- The consumer will be required to complete a credit application. Application must be made prior to the account being placed with a collection agency

- Patient Business Services will obtain a current credit report as needed for verification of documentation enclosed in the application
- Proof of Food Stamps

Exceptions:

- Consumers who qualify for the following aid programs will automatically be awarded Financial Assistance/Charity Care:
  - SSI/Disability
  - Food Stamps
  - Consumers who qualify for Special Low Income Medicare Beneficiary (SLMB) will have any consumer responsibility adjusted to charity.
  - Consumers who have Medicare and Medicaid (dual eligible) and Medicare denies the claim or a portion of the claim, i.e. ambulance determined not medically necessary, non-covered self-administered drugs, Medicare Local Coverage Determinations (when an ABN is signed), those charges will be adjusted to charity once Medicare and Medicaid have been billed and have assigned an amount to patient responsibility.

    Key Point:
    Copayments as required under Medicaid will be collected from patients and not considered part of the charity adjustment.

Additional Financial Assistance Determinations:

- NMH may consider granting, "Medical Indigence Allowance", if the patient's adjusted gross monthly income is less than monthly living expenses (to include only house payment or rent, food, utilities, and insurance) when applicant is the head of household (e.g., homeowner, rental lessor, etc.). Full financial assistance/charity may be granted in these cases.
- For those consumers who exceed Federal Poverty Guidelines (FPG), NMH will reduce the patient responsibility portion of the bill to no more than twenty percent (20%) of the patient's gross annual income per account, with this reduction requiring written approval
- In the event the consumer is deceased, the consumer's Attorney or Personal Representative should provide an official determination if the deceased has an estate. If there is no estate, the patient's family may complete a Financial Assistance application. If the family has no assets or funds to pay the patient's bill, the account maybe adjusted as uncollectible Bad Debt or if the patient has Medicare as Medicare Bad Debt. Full financial assistance/ charity care may be granted if the deceased has no surviving family members.

Deadline for Application Completion and Records Submission:

NMH's official **Financial Assistance/Charitable Care Application** must be completed, in its entirety, and submitted, in person unless otherwise approved by NMH Financial Counselor, to the Patient Business Services Department's Financial Counselor within fifteen (15) business days of the consumer making their official request for consideration to receive Financial Assistance/Charitable Care.

Key Point:
Deadline extensions may be granted, but the new application deadline must be documented within the consumer's file. Extension for Financial Assistance/Charitable Care will not be considered beyond the 240-day consideration period without written prior approval from an approved member of the organization's Administrative Team.

Management of Financial Assistance/Charity Care Determinations:

- Approved Assistance: Partial or full financial assistance/charity care will be determined through this policy.
  Key Point:
  If partial assistance is approved and payment arrangements are not kept in compliance, the organization at its sole discretion may rescind the charity agreement and balance is due in full. Documentation used to support the charity application will be kept on file for a maximum twenty-four (24) period and maintained with strict confidentiality.
- The application will apply to patient liabilities within six (6) months of the date of the application unless there is reason to believe that the circumstances have changed.
- The criteria for granting charity care are gross income, prior to the deduction of business expenses, taxes and other expenses, and the size of the family unit in accordance with Department of Health and Human Services (DHS) poverty guidelines:

Gross Wages Exceeding The DHS Poverty Guideline by:		Percentage of Patient Liability Allowable as Charity Care
Less than or equal to 180%		100%
181 - 200%		90%
201 - 220%		80%
220 - 300%		The cost of services as determined by the NMH cost to charge ratio by the billed charges

Identifying Consumers Eligible for Financial Assistance/Charitable Care:

- In accordance with this policy, NMH shall consider providing financial assistance/charitable care assistance to patients for medically necessary or physician determined medically necessary services including, but not limited to: emergency services, surgery, diagnostic testing, inpatient services, patient's receiving home care, hospice and educational programs.
- Any patient seeking urgent or emergent care through the Emergency Room at Newman Memorial Hospital will be treated without regard to the patient's ability to pay until the completion of a Medical Screening Examination is performed and the patient is deemed stable outlined by the EMTALA guidelines.

- Persons applying for financial assistance/charitable care from NMH will not be discriminated against because of race, religion, sex, color, national origin, age, or disability.
- All information provided to NMH for eligibility determination will be maintain in the strictest of confidentially and maintained in a secure location within the Patient Business Services Department.
- All eligibility determinations will be managed by the Patient Financial Counselor (PFC) the approval signatures of the PFC and the Director of Patient Business Services on every determination letter of approval or denial.
- Limitation for approval of Financial Assistance/Chartable Care are as follows:
  - Patient Financial Counselor $0 - 500
  - Patient Business Services Director $501 – 2,500
  - NMH Chief Financial Officer $2,501 – 5,000
  - NMH Chief Executive Officer $5,001 – 10,000
  - NMH Board of Directors > $10,000
- Federal Poverty Level (FPL) Guidelines are established annually and subject to update/change.
- Applicants for Financial Assistance/Chartable Care are to be notified, in writing, as to their eligibility Financial Assistance/Chartable Care within thirty (30) business days of receipt of a completed application that includes all required documents to support the consumer's financial status.

Key Point:
Exceptions to this policy may only be made by written approval for the organization's Chief Financial Officer and/or the Chief Executive Officer, taking extenuating circumstances into consideration. These circumstances are required to be documented and retained within the consumers file and a part of the documentation justifying a decision to provide Financial Assistance/Charitable Care.

Overview of Service Line Determinations:

- URGENT VERSUS EMERGENT
  - Urgent Care – Care provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers of Medicare and Medicaid Services to occur within 12 hours, to avoid:
    - Placing the health of the patient in serious jeopardy or to avoid serious impairment or dysfunction; or
    - Likely onset of an illness or injury requiring emergent services, as defined in this document.

- Emergent care is that provided to a patient with an emergent medical condition, further defined as:
  - A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

- Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

- With respect to a pregnant woman who is having contractions, that there is in adequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

As outline within the organizations Point of Service/Pre-Service Cash Collection Policy, P&P #B8266.115 NMH requires consumer to provide a "Point of Collection Deposit" when requesting those services that are deemed elective, non-emergent or after a qualifying medical Screening Examination has been performed and the consumer has been deemed stable. The following is an excerpt of the Point of Service/Pre-Service Cash Collection Policy Statement:

It is the policy of Newman Memorial Hospital, Inc. to enforce the point of service collection (expected co-payment, deductibles, and/or coinsurance collection) for all NONEMERGENT services provided to consumers.

1. NMH requires patients to meet their financial obligations, as defined by the type of their financial sponsorship (i.e., third-party payor, Medicare, etc.) upon receiving services.

    a. Payors' required co-payments, deductibles, and/or co-insurances for patients with third party insurance coverage.

    b. Payment deposits for self-pay/uninsured patients or those patients receiving out-of-network or non-covered services.

2. Patients who are unable to meet their financial obligation to NMH will be referred to Financial Counseling for evaluation of the individual/family's financial status and assistance in identifying alternative sources of funding, **before service are rendered**.

3. A designated representative within each registration area will request payment at the time of patient pre-registration, sign-in, registration, or **prior to discharge in the case of in-patient and/or emergent services**. Payments will be posted in EPIC and a receipt will be provided to the patient, if requested.

4. **KEY POINT: Emergent cases will never be delayed based on a patient's inability to provide demographic or financial information or pay prior to discharge**.

5. Where past due balances are known, all representatives will attempt to collect and/or educate the patient on his or her past due liabilities. All payments received will be stored in a secure location by designated representatives at the point-of-service and reconciled with receipts at the end of day.

NOTICE:
In accordance with Federal law and U.S. Department of Agriculture policy, NMH is prohibited from discriminating on the bases of race, color, national origin, sex, age, or disability in the enforcement of the Point of Service/ Pre-service Cash Collections Policy.

BILLING AND COLLECTIONS PROCEDURE

1. Patients shall be registered in the Hospital's Information System in a manner that ensures the capture of the information necessary to effectively provide medically necessary care and to professionally bill for services rendered.
2. After services are rendered the patients or guarantor's insurance (if any) shall be billed. If the patient has no insurance and was registered self-pay the bill for services will be adjusted in accordance with the Hospital's FAP.
3. The Hospital will make reasonable efforts to collect from an insurance carrier prior to billing the patient for services rendered. If after reasonable efforts are made to collect from the insurance carrier the hospital shall seek assistance from the patient to contact the insurance carrier and resolve the outstanding claim. If these efforts are not successful then the account may be changed to a self-pay account.
4. After the account, or any portion of such account, is deemed self-pay the Hospital, or it's designated agent, will bill the patient or guarantor for the remaining balance on the account.
5. Accounts that are deemed self-pay will receive up to four statements and/or notices asking that the account balance be paid.
6. After exhausting reasonable efforts over a period of up to 90 days to collect a self-pay balance, the Hospital may refer the account to a collection agency. Such referral shall not be deemed to be an Extraordinary Collection Action (ECA).
7. An account with a collection agency shall generally be pursued up to 180 days unless, after consulting with the Hospital, it is determined to maintain an account beyond that timeframe. If it is determined by the Hospital's Patient Financial Services department that the account requires an ECA, and such account meets the requirements of 501R, including but not limited to waiting a minimum of 120 days after the first post discharge bill to commence ECA activities, the agency shall notify the patient in writing a minimum of 30 days prior to commencing ECA. Such notification shall include a copy of the Hospitals plain language summary of the FAP along with a statement as to which ECA's the agency may be taking. If within the 30 day notice period the patient requests financial assistance, and the account is not older than 240 days from the first post discharge bill, then the patient shall be given 10 days to apply for financial assistance before ECA may be initiated. In the event ECA has been initiated and the account is not older than 240 days from the first post discharge billing date and the patient requests financial assistance then the ECA will be suspended for up to 10 days to allow for the patient to apply for financial assistance. (the first post discharge bill shall be the first bill a patient receives for services regardless if services are ongoing)
8. ECA's that the Hospital or its agents may take include:
    - Reporting adverse information to a credit reporting agency
    - Placing a lien on property

- Foreclosing on property
- Attaching or seizing a bank account or property
- Garnishing wages
- Deferring, denying or requiring payment for non-emergency medically necessary care when there is non-payment of previously provided care.

Categories of Consideration during the Evaluation of Eligibility for Financial Assistance/Charitable Care:

- **Medical Necessity -**
  - NMH offers the opportunity to receive financial assistance/charitable care to eligible consumers for all services provided to all patients if the service is deemed a medical necessity.
  - Medical necessity is defined as any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
  - Patients receiving emergency services shall be treated in compliance with EMTALA regulation. Initial registration processes shall only include asking the consumers first and last name, address, and/or social security number for registration purposes with no mention of the consumer's ability to pay until all requirements of EMTALA are met.

    Key Point:
    EMTALA Requirements:
    - Provide a medical screening examination to all patients that present upon its premises seeking medical attention: This provision requires hospitals to accept and evaluate any patient on its premises who presents for a non-scheduled visit and seeks care, regardless of ability to pay.
    - Hospital Premises: Any area, facilities or services contained in the hospital's operating certificate, such as hospital-owned clinics or physician practices owned by the hospital. Those units and departments under the legal definition of a dedicated emergency room and the grounds of the hospital, which is recognized as being within two hundred fifty (250) yards of the hospital.
    - Stabilization of an identified Emergency Medical Condition (EMC): Any condition that is a danger to the health and safety of the patient or unborn fetus, or may result in a risk of impairment or dysfunction to any bodily organ or part if not treated in the foreseeable future, and includes a specific range of itemized conditions.

  - Once all emergent requirements are met, the consumer will be required to meet with the registration clerk to complete the registration process and establish Point of Service Collection. Please refer to the Point of Service/Pre-Service Cash Collection Policy, P&P #B8266.115

- **Authorization and Methodology**
  - PATIENT ASSISTANCE

  Key Point:
  Review, consideration and approval of financial assistance/charitable care are managed by the Patient Business Services Department and the Patient Financial Counselor.

1. The methodology used considers income, family size, available resources and the likelihood of future earnings (net of living expenses) sufficient to pay for health care services provided. All available financial resources will be evaluated before determining financial assistance eligibility. NMH will consider financial resources for all members of the household and all other persons having legal responsibility to provide for the patient, such as the parent of a minor child or a patient's spouse. Patients are required to provide information and verification of ineligibility for benefits available from insurance, Medicare, Medicaid, workers' compensation, third-party liability and other programs.
2. NMH uses the Prospective Medicare Method to determine the amounts generally billed (AGB). NMH will not charge an FAP-eligible patient more than amounts generally billed (AGB).
3. Separate determinations of eligibility for charity care will be made for each date of service. Confirmation of continued eligibility should be updated every 90 days for patients who require ongoing health care services.
4. Patient/guarantors will be notified when the Hospital determines the amount of charity care eligibility related to services provided by the hospital. The patients/guarantors shall be advised that such eligibility does not include services provided by non-MBO employees or other independent contractor providers (e.g., emergency room physicians, private physicians, anesthesiologist, radiologists, pathologists, etc.) depending on the circumstances. The applicant will be informed that periodic verification of financial status is required in case of future services. Patient financial records shall be flagged to indicate future services shall be written off in accordance with the financial assistance determination. Guarantors will be notified in writing, if financial assistance is denied, with a brief explanation for the determination provided. A copy of the letter will be retained along with the application in the confidential central file.
5. A listing of all financial assistance/charity care discounts is maintained by the Patient Business Services Department with the following information:

- patient name,
- patient account number(s),
- date(s) of service,
- brief descriptions of services provided,
- total charges,
- amounts written-off to charity,
- date(s) of write-offs and the names of the authorizing individuals.
- Written denials of charity care discounts, including denial reasons, shall be retained in the confidential file(s)

- **Medical Indigence**

  The decision about a patient's medical indigence is fundamentally determined by the hospital without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients do not have appropriate insurance coverage that applies to services related to neonatal care, organ transplants, cancer, burn care, long and/or intensive care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets and the payment of their medical bills would be seriously detrimental to their basic financial well-being and survival.

  NMH's Financial Counselor shall make a subjective decision about a patient/guarantor's medically indigent status by reviewing formal documentation for any circumstance in which a patient is considered eligible for a charity care discount on the basis of medical indigence.

  The NMH Financial Counselor is responsible for obtaining and/or developing documentation that supports the medical indigence of the patient. Examples of such documentation to be reviewed are:

  - Copies of all patient/guarantor medical bills
  - Information related to patient/guarantor's drug costs
  - Multiple instances of high dollar patient/guarantor co-pays, deductibles, etc.
  - Other evidence of high dollar amounts related to healthcare costs, such as the existence of an HSA (Health Spending Account) that has been fully expended

  The NMH Financial Counselor shall consider granting financial assistance either through the use of Federal Poverty Level (FPL) Guidelines or up to 100% if the patient has the following:

  - No material applicable insurance
  - No material useable liquid assets
  - Significant and/or catastrophic medical bills

  In most cases, the patient will be expected to pay some amount of the medical bill, but the facility shall not determine the amount based solely on the income level of the patient. Recommendations to provide charity care can be accepted from sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel. For instances in which a patient does not complete an application for financial assistance, Newman Memorial Hospital may grant charity care without a formal request, based on presumptive circumstances.

- **Recording Charity Care**

NMH shall properly distinguish write-offs of patient accounts between charity care discounts and bad debt expenses. Such amounts shall be recorded in accordance with generally

accepted accounting principles and properly disclosed in financial statements and other reports.

Charity Care represents health care services provided but were never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.

NMH shall write off patient accounts in one of the following two categories:

Charity care discounts consisting of:

- Patients with no third-party payment source and for whom there is no expectation of payment

OR

- Medicare and Medicaid patients who are determined to be financially unable to pay applicable co-payment obligations, in which case the unpaid co-payment qualifies as a charity care discount for the facility and can be claimed on any filing for reimbursement as a Medicare or Medicaid bad debt.

Bad Debts – consisting of patients who have the ability to pay for health care services, where the patient or insurer does not pay the obligation.

A line item for charity care discounts does not appear in the Newman Memorial Hospital statements of operations because the amount is netted against gross revenues. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care discounts and prior-period charity care discounts. The cost of providing charity care discounts to all patients is recorded in the appropriate natural expense classifications in the Newman Memorial Hospital statements of operations when expenses are incurred through payroll records or accounts payable.

NMH shall include this information in the IRS Form 990 federal reporting and required state reporting.

NMH will use the approved journal entries required in accounting for reserves for charity care discounts.

- **Recording Community Benefit**

In accordance with its mission and philosophy, Newman Memorial Hospital sponsors a broad range of services to both the poor as well as to the broader community. Community benefit provided to the "poor" includes the cost of providing services to persons who cannot afford health care, due to inadequate resources and/or who are uninsured or underinsured. Community benefit for the poor includes: traditional charity care; unpaid costs of Medicaid and other indigent public programs; services such as free clinics and meal programs for which there is no charge or for which a nominal fee has been assessed; and cash and in-kind donations of equipment, supplies or staff time volunteered on behalf of the community.

Community benefit provided to the "broader community" includes the cost of providing services to other populations who may not qualify as poor but may need special services and support. This type of community benefit includes: unpaid costs of Medicare and other programs for seniors; services such as health promotion and education, health clinics and screenings, all of which are not billed or can be operated only on a deficit basis.

The following methods will assure that charity policies and procedures are being implemented consistently and fairly:

- We will utilize results to encourage discussion groups that allow staff to describe their perceptions of charity care discounts and to identify possible conflicting practices.
- We will monitor staff adherence to Newman Memorial Hospital charity care policy and procedures. Newman Memorial Hospital reviews actual experience for both charity care discounts and community benefit, in comparison to budgeted expectations quarterly.

Other Providers Covered by the FAP

Other than the hospital itself, the following providers delivering emergent or medically-necessary care in the hospital are identified as either following or not following this Financial Assistance/ Charity Care Policy:

Newman Healthcare Associates – Does not follow

NES Physician Group – Does Follow

Dr. Worthen, Urology – Does not follow

Dr. Cameron, Dermatology – Does Follow

Dr. Kassabian, Cardiology – Does not follow

Dr. Huenergardt, General Surgery – Does not follow

Financial Assistance/Charitable Care Determination

Dear Consumer,

Newman Memorial Hospital strives to be the best place to get care and receive care. The Hospital recognizes the financial cost associated with accessing such care. The Hospital offers the opportunity, for eligible consumers, to apply for financial assistance/charitable care determination. This service is designed to assist qualifying consumers who are in need of medical treatment the opportunity to reduce their financial obligation related to the medical services provided.

If you wish to apply for financial assistance/charitable care for those services provided to you, please complete the attached FA/CC Application and provide the required documentation needed to assess your eligibility for this program.

NMH requires the FA/CC Application and supporting documents to be returned to the Hospital's Financial Counselor, located within the Patient Business Services Department within fifteen (15) days of your official request to be considered to be eligible for this service. Eligibility is determined on an account by account basis and not eligible for those accounts that are greater than six (6) months old from the day services were originally provided.

If you have any questions or require assistance in the completion of the FC/CC Application, please call (580) 938-2551 Ext. 106.

Sincerely,

NMH Financial Counselor
Newman Memorial Hospital
Phone (580) 938-2551 Ext. 106
Fax (580) 938-2615

Financial Assistance/Charitable Care Application

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Social Security #	Date of Birth	Relationship to Patient
Guarantor's Address	City, State, Zip	Home Phone	Length of Residence
Previous Address	City, State, Zip	Marital Status	# of Dependents in Household

List names and Ages of Dependents in Household:

Employer (Guarantor/Patient) Previous Employer (Guarantor/Patient) Spouse Employer

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address	Address	Address
Job Title/Length of Employment	Job Title/Length of Employment	Job Title/Length of Employment
Business Telephone #	Business Telephone #	Business Telephone #
Hourly Rate	Hourly Rate	Hourly Rate
Monthly Income Gross	Monthly Income Gross	Monthly Income Gross
Monthly Income Net	Monthly Income Net	Monthly Income Net
Other Income Source/Amount	Total Family Monthly Income	Total Family Income Last 12 Months

Have you applied for Medicaid or any other State/County Assistance? (check one) Yes No (If denied, please attach a copy of the denial letter).

Application Date Caseworker Name/Telephone Number

Have you filed a bankruptcy? Yes No Chapter 7 Chapter 13 Date filed _____ Date of Discharge_____

Are you a Homeowner? Yes No Approximate $ Value _____

Approximate Balance on Loan _____ Yrs. Left on Loan _____

Bank Name	Checking Account #	Avg. Checking Balance

Savings Account #	Avg. Savings Balance

Automobiles:

1. Make:	Model:	Year:	Payment Amount:	Balance Due:
2. Make:	Model:	Year:	Payment Amount:	Balance Due:

Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	$			$	$
Charge Cards	$			$	$
	$			$	$
	$			$	$
Bank Loans	$			$	$
	$			$	$
School Loans	$			$	$

List Other Expenses Below

	Monthly Payment		Monthly Payment		Monthly Payment
Food	$	Medication	$	Auto Insurance	$
Utilities	$	Life Insurance	$	Other	$
Gas (Car)	$	Medical Bills	$	Other	$

Total $_____ Total $_____ Total $_____

TOTAL MONTHLY EXPENSES $_____

Note: Attach additional sheet if necessary.

Important: income verification must be attached – W-2, pay stub, tax return, etc.

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Newman Memorial Hospital, information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Newman Memorial Hospital to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)_____ Date_____ Witness_____ Date_____

Signature (Spouse)_____ Date_____ Witness_____ Date_____

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1. Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.
2. Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.
3. Complete the guarantor's address, home telephone number and length of residence at this address.
4. Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-"in the dependent field.
5. List the names and ages of dependents.
6. Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.
7. Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A."
8. Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A."
9. Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.
10. Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.
11. Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No." Please verify that all questions have been completed. Attach additional paper if needed for any explanations.
12. Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No."

13. Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14. For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.

15. Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A."

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION

Rent/Mortgage: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

Charge Cards: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if needed to complete this field. If you have no charge cards, please note "N/A."

Bank Loans: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Use additional paper if needed to fully explain this field. If you have no bank loans, please mark "N/A."

School Loans: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A."

LIST OTHER MONTHLY EXPENSES:

Food: Please list the amount paid for food on a monthly basis.

Utilities: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Pleas add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" and explain. Use a separate sheet of paper if needed.

Gas (Car): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A."

Medication: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "N/A" in this section.

Life Insurance: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

Medical Bills: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

Auto Insurance: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by 3 and place the amount in this section. If you pay every 6 months, please divide the total amount you pay by 6 and place the amount in this section. If there is no monthly payment being made, please mark "N/A?"
Other: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section doesn't apply to you, mark "N/A."

Total Monthly Payments: Please total all the above payments and place the amount in this section.

DOCUMENTS NEEDED TO JUSTIFY INCOME

If social security income: copy of check or a copy of bank statement showing most recent social security check deposit.
If unemployed: verification of any compensation received. Example: unemployment compensation, workers compensation, etc.
If unemployed and receive no income: a letter of support written by the person or persons who are providing financial support.
If assistance from City Welfare: vouchers from each program that provides assistance to the individual. Example: food stamps, rental subsidy, fuel assistance, etc.
If child support and/or alimony are provided: copies of checks.

PLEASE READ THE FINE PRINT

Documentation: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing Newman Memorial Hospital to obtain credit information and perform a credit check.

FINANCIAL ASSISTANCE CHECKLIST

INFORMATION REQUIRED FOR COMPLETE APPLICATION (Check if yes)

- ☐ The demographic information is completed for patient and guarantor (i.e., address, etc.).
- ☐ The dependent information is completed (i.e., number in household, names, ages, etc.).
- ☐ The employment and income information is completed for the patient/guarantor and spouse.
- ☐ A copy of most recent year's IRS Tax Return is attached.
- ☐ A copy of most current pay stub is attached.
- ☐ If no income is documented, attach an explanation for how expenses are being met.
- ☐ If the patient/guarantor has filed bankruptcy, all questions are answered.
- ☐ If the patient/guarantor is a homeowner, all questions are answered.
- ☐ Information is completed for banking information (i.e., checking and savings accounts).
- ☐ Information is completed for automobile.
- ☐ Information is completed for other assets.
- ☐ Rent and utility receipts for the past 3 months.
- ☐ The expense/monthly payment information is completed.
- ☐ Does all information look reasonable?
- ☐ Are there any luxurious items listed that might prevent patient/guarantor from paying the bill (e.g., country club dues, maid or lawn service, boat, high cable bills, etc.)?
- ☐ Has the patient/guarantor and spouse signed and dated the form?
- ☐ Has the witness signed and dated the form?
- ☐ Compare the Total Family Monthly Income to the Total Monthly Expenses. Can the patient/guarantor afford to make monthly payments? If so, contact the patient/guarantor to establish payment arrangements. **STOP**.
- ☐ If the patient/guarantor cannot afford monthly payments, use the FPL Guidelines to determine if the patient/guarantor qualifies for Financial Assistance.
- ☐ If the patient qualifies for Financial Assistance, forward all information to Business Office Manager to review and approve.
- ☐ If the patient does not qualify for Financial Assistance, send denial for Financial Assistance letter to patient/guarantor.
- ☐ If the application is incomplete, return application and all supporting documentation to patient with a letter indicating what is required and that it needs to be returned.
- ☐ The Business Office Manager needs to approve and forward to the CFO all discounts over $5,000 for approval.
- ☐ The Business Office Manager will return all supporting documentation to the Financial Representative to send acceptance for a Financial Assistance letter to the patient and to enter information on the Charity Log.
- ☐ The Financial Account Representative will enter the percentage of charity eligibility on the account and send a reminder to the CFO.
- ☐ The Financial Representative will send an acceptance for Financial Assistance letter to the patient and file.
- ☐ The Business Office Manager selects this chart for Quality Review.

Signature – Financial Representative	Date
Signature – Financial Representative	Date

Application Form – Presumptive Eligibility

My name is (please print): _____ _____ ____
Last First M.I.

I am: The Patient The Patient's Guarantor

Neither (Please state your relationship to the Patient: _____)

Instructions:

1. ***Please indicate that the Patient is eligible for charity care discount because the Patient is in one or more of the following categories.***
2. ***More than one copy of this form may be required if it is to be completed by more than one individual (e.g., Patient, Guarantor, etc.).***

#	Is category applicable?		Is relevant document attached?		
1.	yes	no	yes	no	Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
2.	yes	no	yes	no	Patient is homeless and/or has received care from a homeless clinic.
3.	yes	no	yes	no	Patient is eligible for and is receiving food stamps.
4.	yes	no	yes	no	Patient's family is eligible for and is participating in subsidized school lunch programs.
5.	yes	no	yes	no	Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
6.	yes	no	yes	no	Family or friends of a patient have provided information establishing the patient's inability to pay.
7.	yes	no	yes	no	The patient's street address is in an affordable or subsidized housing development.
8.	yes	no	yes	no	Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
9.	yes	no	yes	no	Patient is deceased with no known estate.
10.					Other – ***Provide explanation*** _____

Signature _____ Date_____
Authorized by: _____ Title: _____ Date_____

Notification of Determination:
After determining the patient's eligibility for financial assistance/charity care, the patient will be notified, by the organization Financial Councilor, in writing of the determination. If possible, verbal notification will be provided as well.

Eligibility of Financial Assistance/ Charity Care:
Though Financial Assistance/Charitable Care is approved on a "per occurrence basis", NMH will maintain the application and records of consumers who apply for Financial Assistance/Charitable Care for a period of twenty-four (24) months. Individuals needing to apply for reoccurring assistance will only need to provide updated information concerning their financial status. NMH reserves the right to require consumers to complete the full application process each time the consumer is applying for Financial Assistance/Charitable Care.

THIS SECTION IS PURPOSFULLY LEFT BLANK

Financial Assistance Sliding Scale
Based on 2017 U.S. Federal Poverty Guidelines

	Poverty Guidelines			
Number In Household	**0-180%**	**181 - 200%**	**201 - 220%**	**221 - 300%**
1	$21,708	$24,120	$26,532	$36,180
2	$29,232	$32,480	$35,728	$48,720
3	$36,756	$40,840	$44,924	$61,260
4	$44,280	$49,200	$54,120	$73,800
5	$51,804	$57,560	$63,316	$86,340
6	$59,328	$65,920	$72,512	$98,880
7	$66,852	$74,280	$81,708	$111,420
8	$74,376	$82,640	$90,904	$123,960
Per Additional Person	$7,524	$8,360	$9,196	$12,540
Percentage of Charges Discounted	**100%**	**90%**	**80%**	**The cost of services as determined by multiplying the NMH cost to charge ratio by the billed charges.**

REFERENCES

Patient Protection and Affordable Care Act, Section 9007(a)
Internal Revenue Code, Section 501(r)
The Poverty Guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). Effective January 26, 2017.