

POLICY AND PROCEDURE MANUAL

Section:	PFS
Subject:	Charity Care
Policy #:	PFS.Charity Care
Related Policy #:	
Related Policy #:	

Prepared by:	Leslie Rawson
Approved by:	
Revised Date:	3-12-19
Supersede Date:	
Original Date:	
Reviewed Date:	

Purpose: To establish a policy to provide a financial assistance option for qualified patients.

Scope: Any staff involved in the Charity Care determination process

Policy: It is the policy of Tippah County Hospital to provide financial assistance to patients that meet specified financial criteria and request such assistance. The criteria used will be reflective of the current years Poverty Guidelines for the 48 Contiguous States and the District of Columbia.

A patient can qualify for financial assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Patient Accounts Manager will review and analyze the application and make a recommendation to the Patient Financial Services Department for final determination of eligibility.

Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet presumptive financial assistance eligibility criteria.

Once a patient is approved for Financial Assistance, Financial Assistance Converge shall be effective for the month of determination and the following six (6) calendar months.

Once a patient is approved for partial Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to TCH. It is recommended that the patient make a good faith payment at the beginning of the financial assistance period.

Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for assistance, but there is no financial assistance form. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support patients eligibility for financial assistance, TCH may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstance, the only financial assistance that can be granted is a 100% write-off of the account balance. The write-off will be done by performing a truncation code adjustment. These cases will not be updated to the various financial assistance plan codes. Presumptive eligibility may be

determined based on individual life circumstances that may include:

- Homelessness
- Food Stamp Eligibility
- Patient is deceased with no known estate

Catastrophic Financial Assistance Guidelines: These guidelines are to be provided a separate, supplemental determination of financial assistance for patients who are not eligible for financial assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a Catastrophic Assistance Application. Under these circumstances, the term “catastrophic” is defined as a situation in which the self-pay portion of the affiliate medical bill is greater than the patient/guarantor’s ability to repay with current income and liquid assets in 18 months or less. General Conditions for Catastrophic Assistance Application include:

- Patient has exhausted all insurance coverage.
- Patient is not eligible for any of the following:
 - Medicaid
 - The Financial Assistance Program
 - Other forms of Assistance
- The patient cannot repay the self-responsible portion of the affiliate account in 18 months or less.
- The affiliate has the right to request patient to provide documentation of proof.

Responsibilities:

- Patient Accounts Manager:
 - Understand current criteria for Assistance qualifications.
 - Identify prospective candidates or follow-up with referred patients; initiate application process when required.
 - Review preliminary application and make probable eligibility determination within two business days of receipt of preliminary application. Notate patient account comments.
 - Review and ensure completion of final application. If financial assistance application is not required, to patient meeting specific criteria, notate patient account comments and forward to Director for Review.
 - Scan completed applications to file and notify PFS Director and/or CFO of applications that have passed preliminary screening.
 - Document all transactions in the patient account’s comments.
 - Mail letter of final determination to patient.
 - Identify retroactive candidates, initiate final application process.
 - Review and ensure completion of final application; Monitor applications for final determination status.
- PFS Director
 - Review Applications
 - Approve/disapprove application

- Notify Patient Accounts Manager of Rejections and Approvals so response letters can be mailed to patients.
- Forwards approved Charity Care Applications to Accounts Receivable so that an adjustment can be made on the account.

Procedure:

1. The evaluation for financial assistance is started in at least one of the following methods:
 - a. A patient/guarantor with a self-pay balance due notifies the Patient Account Manager that he/she cannot afford to pay the bill and requests assistance.
 - b. Identified as uninsured at point of service by the by Registration staff
 - c. Referral from Physician's Office for financial screening
2. Registration Staff will notify the Patient Accounts Manager (In the absence of the Patient Accounts Manager, Registration will perform service) so that a Charity Care Application ("Exhibit A") and Instructions can be provided to the patient. Should the patient require assistance in completing the application, it will be provided.
3. Once the application is completed, the information is forwarded to the Patient Accounts Manager for Review.
4. The Patient Accounts Manager will request prior verification of income. This could include:
 - a. W-2 withholding form
 - b. Pay stubs
 - c. Income tax return
 - d. Written verification of wage from employer or other public assistance agencies
 - e. Proof of disability Income (if applicable)
5. Once all information has been obtained, the Patient Account Manager will review and a preliminary determination made if the patient meets the charity guidelines set forth by this policy.
6. If the patient's application or financial assistance is based on excessive medical expense or if there are extenuating circumstances as identified by the Patient Accounts Manager or designated person, the Patient Accounts Manager will forward the application and the attachments to the Patient Financial Services Director (PFS) and /or the Chief Financial Officer (CFO). The PFS Director and/or CFO will have decision-making authority to approve or reject applications for charity care. It is expected that an application for financial assistance, which is reviewed by the PFS Director and/or CFO, will have a final determination made no later than thirty (30) days from the date it was considered complete.
7. After a final determination has been made, the patient/guarantor will be notified with either an approval ("Exhibit B") or a denial letter ("Exhibit C") with further instructions.
8. Approved Charity Accounts will be sent to Accounts Receivable to be adjusted appropriately.

“Exhibit A”

TIPPAH COUNTY HOSPITAL
FINANCIAL SCREENING FOR CHARITY CARE

Please return completed form
with proof of household income-
such as check stub, w-2 form.

Proof of income must be obtained
within 7 days or application is null
and void.

PATIENT/GUARDIAN INFORMATION

Patient Name: _____

DOB: _____

Address: _____

SS#: _____

Telephone #: _____

ARE YOU CURRENTLY EMPLOYED? (Circle One) YES NO

NAME OF EMPLOYER: _____

EMPLOYER TELEPHONE NUMBER: _____

GROSS INCOME: \$ _____ (Must show Proof of Income)

PAID: WEEKLY BI-WEEKLY MONTHLY DEPENDENTS: _____
(Circle One)

ADDITIONAL HOUSEHOLD CONTRIBUTORS INFORMATION

Name(s) of Contributor(s) to Household Income: _____

Relationship: _____ Income: \$ _____

(Must show Proof of Income)

Employer: _____ Emp. Telephone: _____

GOVERNMENT ASSISTANCE

Social Security Income: \$ _____ (must show proof)

Social Security Income Dependents: \$ _____ (must show proof)

Supplemental Social Security Income: \$ _____ (must show proof)

Food Stamps (Amount): \$ _____ (must show proof)

POVERTY REPORT

HOUSING: RENT OWN BUYING PAID Monthly Payment: _____
(Circle One)

AUTOMOBILE: (Type and Year) _____ Monthly Payment: _____

FINANCIAL REFERENCES

Bank(s): \$ _____ Checking Amt.:(s): \$ _____
Savings Amt.: \$ _____ Other: \$ _____

ATTESTATION STATEMENT

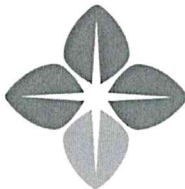
I ATTEST THAT THE FINANCIAL INFORMATION PROVIDED ABOVE IS CORRECT. I understand that this information must be true and accurate to the best of my knowledge and that the Tippah County Hospital may take any reasonable action to verify it. If it proves to be untrue, the Tippah County Hospital may review my case again and take whatever action becomes suitable.

Signature of Applicant

Date

Reviewed By:

Approval Letter



TIPPAH COUNTY HOSPITAL

1005 City Avenue North, Ripley, MS 38663
Phone: 662-837-9221

TRUSTEES:

Ray Crawford, Board President
Lana Richardson, Board Vice-President
Vickie Skinner, Board Secretary
Fred Permenter, Board Attorney

TRUSTEES:

Greg Ward
Roger Childs
Robert Cagle
David Hubbard

Dr. Patrick Chapman, Chief Executive Officer

April 11, 2019

John Doe
123 TCH Lane
Ripley, MS 38663

Patient: John Doe
Acct #: 11111111
DOS: 03/05/2019
Amt: \$50

Dear Mr. Doe,

We recently reviewed your application for financial assistance with Tippah County Hospital. We screen all applications using current poverty guidelines set forth by the Department of Human Services. In reviewing your application, we have come to the following decision:

We are pleased to inform you that you do qualify for financial assistance to help in satisfying your account(s) with the Tippah County Hospital. According to our charity guidelines, you currently qualify for a [] discount on your account. This leaves your current account balance for this admission at [\$]. Your application will be processed as quickly as possible and your accounts should reflect this decision at this time.

If you have further questions or concerns, please feel free to contact me at (662) 837-9221, extension 150. Thank you for your assistance.

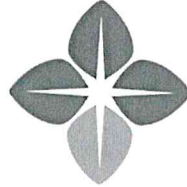
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Ripley, MS
PFS.Charity Care

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Sincerely,

Leslie Rawson
Charity Care Coordinator
Tippah County Hospital

“Exhibit C”
Denial Letter



TIPPAH COUNTY HOSPITAL

1005 City Avenue North, Ripley, MS 38663

Phone: 662-837-9221

TRUSTEES:

Ray Crawford, Board President
Lana Richardson, Board Vice-President
Vickie Skinner, Board Secretary
Fred Permenter, Board Attorney

TRUSTEES:

Greg Ward
Roger Childs
Robert Cagle
David Hubbard

Dr. Patrick Chapman, Chief Executive Officer

April 12, 2019

Jane Doe
123 TCH Lane
Ripley, MS 38663

Patient name: Jane Doe
Account #: 11111111
Service Date: 01/01/2019
Account Balance: \$5,694.23

Dear Ms. Ayers,

We recently reviewed your application for financial assistance with Tippah County Hospital. We screen all applications using current poverty guidelines set forth by the Department of Human Services. In reviewing your application, we have come to the following decision:

We regret to inform you that based on the submitted information; you do not meet the qualifications for financial assistance to help in satisfying your account with the Tippah County Hospital. Please contact us immediately to set up adequate payment arrangements.

If you have further questions or concerns, please feel free to contact me at (662) 837-9221 (ext. 150). Thank you for your assistance.

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Ripley, MS
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Sincerely,

Leslie Rawson
Charity Care Coordinator
Tippah County Hospital