PIONEER
Community Hospital of Stokes

DEPARTMENT: Business Office/ Patient Financial Services	**ORIGINATION DATE:** 8/01/2011
POLICY/PROCEDURE: Financial Assistance Guidelines	**REVISED DATE:**
APPROVED BY:	**REVIEWED: 9.10.12**

Purpose:
To establish guidelines and procedures for identifying patients who are under or uninsured by insurance or other third-party payers and who are unable to pay for some or all of their healthcare services due to genuine financial need.

Policy:
Patients who do not have sufficient third party payer coverage, are not eligible for Medicaid or any other funded program and who are unable to pay for services will be considered for indigent/ poverty care. Patients or the patient's guarantor are required to provide documentation to qualify for financial assistance. This designation requires that the patient/guarantor not have sufficient income or assets with which to pay for care. Patients or their guarantors are expected to assist with all such efforts to obtain third-party payments. *Verified dually eligible Medicare and Medicaid patients qualify for indigent care without completing a financial assistance application. These dually eligible accounts are also eligible for inclusion on the Medicare Bad-Debt cost report.*
Pioneer Community Hospital of Stokes will not discriminate against any patient because of race, creed, religion or national origin.

Procedure:
1. Before an application for Financial Assistance can be considered, the patient / guarantor may be asked to apply for Medicaid and present a denial letter with the application.
2. The patient / guarantor will authorize Pioneer Community Hospital of Stokes to obtain a consumer credit report.
3. Dually eligible Medicare and Medicaid patient accounts must include the Medicare and the Medicaid remittance advice as evidence the patient is dually eligible and automatically qualifies for an indigent care write off. This includes services that are non-covered by Medicaid. These patients are not required to complete a financial assistance application.
4. An application for financial assistance will be completed with all financial and social information and submitted to the Patient Accounts Collection Representative for review (Social Services may be requested to assist in obtaining emotional, social and psychological factors).
   Documents required:
   a. Medicaid Denial Letter if requested by facility or PFS.

b. Most recent prior years tax returns including W2s /1099s / Schedule C
c. Proof of income
* If working, paycheck stubs for the previous month
* If unemployed and receiving unemployment check, provide check stub or unemployment compensation determination letter
* If income is from a retirement fund, pension, rental property, etc. provide proof of the source and amount of income received.

d. If income has changed since last tax return, provide a written explanation.
e. Proof of disability / physicians work order restriction.
f. Outstanding medical bills other than bills at Pioneer Community Hospital of Stokes.
g. Rent or mortgage payment receipt for one month
h. Utility bills; gas, electric, water and sewage
i. Three months bank statements (checking and savings)

5. After review, the completed application will be approved or denied. Reduced payment arrangements will also determined.
6. The application must be complete including signatures, dates and all applicable documents attached before the PFS department will accept for processing. If an incomplete application is received, it will be returned to the patient / guarantor.
7. The Financial Application will be returned to Pioneer Community Hospital of Stokes or Pioneer PFS Department within 2 weeks.
8. Approval is based on a sliding scale methodology. The scale is as follows:
    a. If total income is 200% or less of Federal Poverty Guideline – the patient will qualify for 100% indigent care write-off.
    b. If total income is between 200% and 250% of Federal Poverty Guideline – the patient will qualify for 75% indigent care write-off.
    c. If total income is between 250% and 300% of Federal Poverty Guideline – the patient will qualify for 50% indigent care write-off.
    d. The Patient Account Collection Representative will also review any other liabilities the patient may have to assist in determining indigent care qualifications.
    e. The patient balance after a partial write off will be subject to the payment arrangements policy unless otherwise determined by the Director of Revenue Cycle Management**.**
9. The PFS Director and the Director of Revenue Cycle Management will review and approve accounts using the most recent annual HHS Poverty Guidelines prior to requesting an indigent write-off of accounts receivable.
10. The financial application is valid for **3 months** after review.
11. The hospital administrator, PHS CFO, or the PFS department reserves the right to grant approval for financial aid based on extraordinary circumstances on a case-by-case basis.
12. A letter will be sent to the guarantor by the PFS representative with a list of accounts and amounts approved / not approved within 15 days of review.
13. Any account that is proven to be indigent eligible should be placed into the Indigent Financial Class.

Reference:
CMS Manual Pub 15-1, Chapter 3, Bad Debts, Charity, and Courtesy Allowances.

Financial Aid Application

Patient and/or Guarantor information if patient is a minor:

Name:_____ Date of Birth:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone: (____) _____

Social Security #:_____ Marital Status:_____

Employer:_____ Position:_____

Annual Salary:_____ Length of Employment:_____

Health Insurance Company:_____ Policy #:_____

Spouse and/or Legal Guardian Information:

Name:_____ Date of Birth:_____

Employer:_____ Social Security #:_____

Annual Salary:_____ Position:_____

Dependent (s) Information:

Number of Dependents:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Use a separate sheet of paper if necessary:

Asset Information Please write yes or no:

Automobile:_____ Rental Property:_____ Farms:_____ Cattle:_____

Do you own a business:_____ Name of business?_____

Checking Account:_____ Bank Name:_____

Balance: $_____

Savings Account:_____ Bank Name:_____

Balance: $_____

Disclaimer and Authorization:
I authorize Pioneer Community Hospital of Stokes to obtain a consumer credit report on my behalf to process my application if necessary. This information will only be used for the purpose it was intended. I also understand that Pioneer Community Hospital of Stokes will not share or disclose the information with any third party vendor unless I give the proper authorization. Pioneer Community Hospital of Stokes will not give me a copy of my credit report; it will stay in the hospital financial record. I also authorize Pioneer Community Hospital of Stokes to verify all the information given by me in order to process my application.

Applicant's Name _____

Applicant's Signature _____ Date: _____