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DEPARTMENT: BUSINESS OFFICE	REVISED/Approved:

CHARITY AND UNCOMPENSATED CARE

Purpose

To provide definition of health care assistance to eligible beneficiaries and define the administrative processes and procedures for participant eligibility, application procedures and program administration.

Policy

Harmon Memorial Hospital (HMH) may provide charity care to patients who meet the criteria of this policy and do not have the financial means to pay for services provided. Charity care should be provided to patients who present themselves for care at HMH without regard to age, sex, race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the terms of this policy. HMH reserves the rights to limit charity care on a monthly and annual basis consistent with Oklahoma state law and the hospital's financial resources. HMH reserves the right to refuse charity care for elective services. A discount from the facility's retail charges may be made available to uninsured patients who do not qualify for charity care, under the terms of this policy.

Charity Care Eligibility Criteria

- A: Based on Eligibility First
- A financially indigent person could be a person uninsured or underinsured and whose bill will result in no obligation or a discounted obligation to pay for the services rendered based on the eligibility criteria set forth in this policy.
 - To be eligible for charity care as a financially indigent patient, a person's income shall be at or below the percentage of the federal poverty guidelines noted in Exhibit A. The system may consider other financial means of the applicant when determining eligibility.
 - The system should use the most current poverty income guidelines issued by the U. S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient.
 - HMH may adjust the eligibility criteria from time to time based on financial resources and as necessary to meet the charity care needs of each community. HMH may limit charity care to only those patients requiring emergent or urgent care.
- B: Medically Indigent
- A medically indigent patient is a person whose unpaid medical charges exceed their ability to pay and whose remaining bill will result in no obligation or a

discounted obligation to pay for the services rendered, based on eligibility criteria set forth in this policy.

- To be eligible for charity care as a medically indigent patient, the amount owed by the patient on a hospital bill after payment by third-party payers, if applicable, should exceed the percentage of the applicant's annual gross income noted in Exhibit B, and the patient must be unable to pay the remaining bill. The hospital may consider other financial means of the applicant when ability to pay.
- Charity care for the medically indigent may be provided in an amount less than the patient liability.
- HMM may adjust the eligibility criteria from time to time based on financial resources and as necessary to meet the charity care needs of each community. HMM may limit charity care to only those patients requiring emergent or urgent care.

C: Uninsured Patient Discount Eligibility

- An uninsured patient who does not qualify as financially or medically indigent could receive a discount.
- The discounts made available to uninsured patients are permitted under terms of Senate Bill 500 passed by the 79th Legislature of the State of Oklahoma, Regular Session.

Procedure

A Identification of Charity Cases

- HMM may inform each patient of the charity care program and how to apply. This may be done by posting notices in each patient registration area and providing a written notice to each potentially eligible patient.
- Patient Registration should attempt to identify any cases that may qualify as charity at the time of admission and offer the patient an application.
- Patients who desire to apply for charity care should complete a Financial Assistance application form and return it to the specified address.
- Patient Registration should refer patients who may qualify for financial assistance from a government program to the appropriate program, such as Medicaid.
- As soon as sufficient information is available concerning the patient's financial resources and eligibility for government assistance, a determination should be made concerning the patient's eligibility. The determination decision should be made within 30 days of receipt of complete application. A written notice should be mailed to the patient informing them of the determination decision. No collection efforts should be pursued on a charity account after such determination is made.

B Factors to be considered for Charity Determination

- The following factors should be considered in determining the eligibility of a patient for charity care:
 1. Gross income
 2. Family size
 3. Employment status
 4. Other financial resources
 5. Other financial obligations
 6. The amount and frequency of hospital/medical bills

C Failure to Provide Appropriate Information

- Failure to provide information necessary to complete a financial assessment may result in a negative determination, but the account may be reconsidered upon receipt of the required information. A determination of eligibility for charity may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstance. Example: person residing in a shelter.

D Documentation of Eligibility Determination

- Once an eligibility determination has been made, the results of the determination should be noted in the comments section of the patient's financial record.

E Recordkeeping and Reporting of Charity Care

- Charity care applications should be retained and kept on file for five (5) years. A copy of the patient's application and all correspondence with the patient regarding the application, approval, denial and/or appeal should be maintained in the patient's file.
- Information regarding the amount of charity care provided by the System in its fiscal year shall be aggregated and included in an annual report.

F Uninsured Patient Discount

- An uninsured patient discount may be applied to uninsured patients who do not apply for, or do not meet the criteria of the requirements for, charity care. The uninsured discount could be applied at the time service is rendered for outpatient or non-urgent care (imaging services, elective procedures) using an estimated total charge amount for services known at that time. If the service is for an emergent or acute need (i.e. emergency services or inpatient care) the discount could be applied at the time of discharge or at time of billing, resulting in a reflection of the net charges on the patient statement. The discount should not be extended for elective or cosmetic services. The amount of the discount noted may be changed by HMMH from time to time.

Definitions

Charity care: Inpatient and outpatient medical treatment and diagnostic services for uninsured or underinsured patients who cannot afford to pay for the care according to the guidelines of this policy. Charity care does not include bad debt, contractual allowances from government programs and insurance, uninsured Patient Discounts but may include insurance co-payments or deductibles, or both. The patient may have no obligation or a discounted obligation to pay for any services received which are deemed to be Charity care under this Policy.

Contractual Allowance: The difference between the level of payment established under a contractual agreement and the patient's billable charges.

Elective Care: The patient's condition permits time for medical services to be scheduled.

Emergency Care: The patient requires immediate medical intervention due to a severe, life-threatening, or potentially disabling condition. Generally, the patient is admitted through the Emergency Room.

Patient: The terms "patient" and "person" are used throughout this Policy for ease of understanding and drafting. This policy applies to the Guarantor of the patient's account. The term "guarantor" is

interchangeable with the terms patient and person throughout this policy, when the guarantor is different from the patient.

Retail Charges: The standard rates charged to all patients, which do not reflect any contractual allowances or discounts. These rates are commonly referred as “gross” charges in the healthcare industry.

Uninsured Patient: A person receiving healthcare services who does not have private healthcare insurance and is not qualified to participate in a governmental program which provides healthcare benefits to it eligible participants, such as Medicare and Medicaid, and for purposes of this policy, does not qualify for charity care.

Uninsured patient discount: The amount of discount applied to retail charges incurred by uninsured patients.

Urgent Care: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

A person without healthcare insurance, who does not qualify for charity care, could receive an uninsured patient discount.

Uninsured patients could receive a general discount as noted below. In addition, HMM may offer specific pricing to uninsured patients for certain common services.

The amount of the general discount could be up to 40%

**HARMON MEMORIAL HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE OR UNINSURED DISCOUNT
PROGRAM**

Applicant Information:

Last Name

First Name

Middle Initial

Address _____ City _____ State _____ Zip _____
 Mailing Address (if different) _____ City _____ State _____ Zip _____

Please list the name of the patient(s) and the relationship to the applicant for which you are applying. If more space is needed, please use the back of this page.

Patient: _____ Relationship: _____

Date of Birth: ____/____/____ SS# _____ Date of Service: ____/____/____

Patient: _____ Relationship: _____

Date of Birth: ____/____/____ SS# _____ Date of Service: ____/____/____

Please list Full name, birth date, social security number and relationship of all persons residing with you, the applicant. If more space is needed, please use the back of this page.

Name	Birth Date	Social security number	Relationship
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

Do you have health insurance? _____ Yes _____ No
If you have coverage, please provide most current insurance card.

Do you have current Medicaid coverage? _____ Yes _____ No
If you have coverage, please provide the most current Medicaid card.

Have you applied for Medicaid? _____ Yes Date applied: _____ No
If denied, date of denial _____. A copy of the Medicaid denial letter must be attached to the application.

REQUIRED DOCUMENTS:

The following documents are required for all household members in order to complete your application.

- Last three (3) pay stubs
- Previous year's tax return or W2
- Evidence of rent/mortgage payment or letter of financial management if living with someone else
- Current utility bills
- List of other medical bills
- Current checking/savings account(s) statement
- Any other documentation proving your financial situation

_____ I don't file income taxes. Reason: _____

INCOME:

	Patient	Spouse		Patient	Spouse
Gross Monthly Wages	\$ _____	\$ _____	Self Employment	\$ _____	\$ _____
Real Estate income	\$ _____	\$ _____	Unemployment Benefits	\$ _____	\$ _____
Social Security Benefits	\$ _____	\$ _____	Pension or Retirement	\$ _____	\$ _____
Workers Compensation	\$ _____	\$ _____	Child Support/Alimony	\$ _____	\$ _____
Tax Refund	\$ _____	\$ _____	Veterans Benefits	\$ _____	\$ _____
Rental income	\$ _____	\$ _____	Military Family Allotments	\$ _____	\$ _____

Public Aid (Including food stamps) \$ _____ \$ _____ Other income not listed above \$ _____ \$ _____

Total Gross Monthly Income: \$ _____

EXPENSES:

	Patient	Spouse		Patient	Spouse
Rent/Mortgage	\$ _____	\$ _____	Auto	\$ _____	\$ _____
Utilities	\$ _____	\$ _____	Phone	\$ _____	\$ _____
Cell Phone	\$ _____	\$ _____	Auto Insurance	\$ _____	\$ _____
Food	\$ _____	\$ _____	Health Insurance	\$ _____	\$ _____
Other Transportation	\$ _____	\$ _____	Credit Cards	\$ _____	\$ _____
Student Loans	\$ _____	\$ _____	Personal Loans	\$ _____	\$ _____
Other Medical Expenses	\$ _____	\$ _____	Other Expenses	\$ _____	\$ _____

Total Monthly Expenses: \$ _____

If no income listed, please explain how living expenses are being paid:

Explanation of reason that you require assistance:

I hereby request that Harmon Memorial Hospital make a determination as to my eligibility for Financial Assistance/Uninsured patient discount program. I affirm that the information provided on this application is true and correct to the best of my knowledge. I consent to any investigation or credit check made by The Physician's Hospital in Anadarko or their representing agencies, to verify the information I have provided. I also understand that if the information I have provided is found to be false, such findings will result in an automatic denial for Financial Assistance/Uninsured patient discount program, and that I will be liable for charges for services provided.

Date: _____

Patient Name/Responsible Party (Print): _____

Patient/Responsible Party Signature: _____

Spouse Name (Print): _____

Spouse Signature: _____

HOSPITAL USE ONLY: DATE RECEIVED: _____ BY: _____

LETTER SENT: _____ BY: _____

HARMON MEMORIAL HOSPITAL

Patient name: _____ Account number: _____

Number of Dependents in Household: _____

Account Balance Gross Charges: _____

Annual Gross Household Income: _____ Account balance at % of Income: _____

Qualifying as Financially Indigent? _____ Yes _____ No

$$\frac{\text{Annual Income}}{\text{FPG Maximum Income (refer to Exhibit A, per family size)}} = \text{_____} \times \text{_____ \% of FPG}$$

- Is "X" calculated above less than 150%? If yes then:
- Charity discount amount is 100% of gross charges.
- Is "X" calculated above over 150% but below 200%? If yes then:
- Patient pays \$20/month for up to 24 months (\$480)
 - Charity discount amount is 100% of remaining balance (balance of charges less \$480)

Qualifying as Medically Indigent? _____ Yes _____ No

Account balance at least 10% of income? _____ Yes _____ No (then does not qualify under Medically Indigent)
(refer to Exhibit B, per family size)

$$\text{_____} / \text{_____} = \text{_____} \% \text{ of FPG}$$

Annual Income

FPG Maximum Income
(refer to Exhibit B, per family size)

x

Is "X" calculated above 200% but less than 250%? If yes then:

- Patient pays \$40/month for 24 months (\$960)
- Charity discount amount is 100% of remaining balance (balance of charges less \$960)

Is "X" calculated above over 250% but below 300%? If yes then:

- Patient pays \$50/month for up to 24 months (\$1,200)
- Charity discount amount is 100% of remaining balance (balance of charges less \$1,200)

Amount due from patient: \$ _____

Charity Discount: _____ % \$ _____
(PSI Code)

Submitted By: _____ Date: _____

Reviewed By: _____ Date: _____

Approval Levels:

PAS Supervisor: _____ Date: _____
Up to \$5000

VP Revenue Cycle: _____ Date: _____
\$5001 -\$10,000

CFO/EVP: _____ Date: _____
Over \$10,000

Notice of Financial Assistance and Patient Responsibility

Patient Name:

Account #:

HARMON MEMORIAL HOSPITAL thanks you for choosing our facility for your medical needs. In keeping with the values underlying our mission, we are committed to making a measurable difference in the health of the individuals in the communities that we serve. An important element of this commitment is helping, within the resources reasonably available to us, to meet the healthcare needs of uninsured and underinsured patients in a manner that treats patients and their families with dignity, respect and fairness. We hope that you have found our financial assistance program a positive experience and thus that you will share any suggestions on how we can improve this process in the future.

Based on information that you submitted on your confidential Application for Financial Assistance or Uninsured Discount Program, we have determined your eligibility to be as noted below:

Payments of \$ _____ per month for _____ months.

Followed be an adjustment of _____ % of estimated account balance gross charges.

Estimated gross charges are based on the services and charges we can reasonably expect you will require during your admission to our facility. This is only an estimate. The amount of final charges will depend on the actual services rendered during your stay and may be less or more than the estimate provided. If you have any questions regarding the estimate, please contact one of our Account Representatives.

The amount of final discount, if any, you have received was based on an assessment of your income and expenses compared to the Federal Poverty Guidelines issued by the United States Census Bureau and a discount scale we offer based on these guidelines. The amount of assistance offered for medical catastrophe, if any, you received was based on the assessment of your specific circumstance regarding medical costs and other related factors disclosed in your application in addition to the income and expenses guidelines as outlined above.

Please be aware that you are responsible for any payments due as noted above. Our ability and willingness to continue to grant discounts to patients, such as you, is dependent on patients, such as you, promptly paying amounts due. The facility may turn any unpaid amounts over to a collection agency, which could affect your credit status. We may also sell you unpaid bills to a company that could pursue collections from you, in which case we would no longer be able to provide you any financial assistance or payment options. We would like to work with you to avoid any such situations, so it is important that you let us know if you will have trouble making your monthly payment.

Should you have any questions regarding our determination of your financial assistance and patient responsibility, please contact an Account Representative at _____.

Thank you.