JASPER HEALTH SERVICES, INC.

POLICY AND PROCEDURE **JASPER MEMORIAL HOSPITAL**

SUBJECT: Indigent and Charity **POLICY: BO-PFS-031**

Applies To: Patient Financial Services **Approved by: Controller**
Revision Date: August 2017 **Department: Business Office**

PURPOSE:

To establish guidelines for recognizing and processing accounts for patients that qualify for indigent care, charity care, or government assistance programs.

POLICY:

In order to provide community benefit, Jasper Memorial Hospital (JMH) offers several payment options and financial assistance programs for our patients. JMH supports the provision of medical services to medically indigent persons so that they may receive care without charge or at a reduced rate. This program applies to emergent and medically necessary care provided by the hospital.

PROCEDURE:

I. Eligibility Criteria:

A. The hospital shall apply standard eligibility criteria for each person requesting free or reduced charge care that enables the hospital to:

1. Provide free services to persons with incomes below 125 percent of the federal poverty level.

2. Provide services for no charge or reduced charge based on a sliding fee scale for persons with incomes between 125 and 250 percent of the federal poverty level.

3. Provide services to persons where income and family size cannot be verified, otherwise referred to as presumptive eligibility (see section below).

II. Income Qualifications:

A. Income is the family's gross income. Use either the average monthly income for the previous three months or for the previous year, whichever is more favorable to the applicant.

B. For self-employed individuals, the amount of income to be counted is gross income minus work expenses directly related to producing the goods or services and without which the goods or services could not be produced. A W-2 form may be required.

C. For money that may be considered as a non-recurring lump sum (insurance settlements, accumulated back RSDI payments, etc.), consider the gross amount received in the month received.

D. Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family member should be excluded.

E. Do not count income from any person who is not financially responsible for the patient. For example, do not count income from one sibling as available to another sibling for the purposes of paying medical bills. Likewise, do not count income from any child (minor or adult) in considering eligibility for free or reduced level of care.

III. Processing Indigent/Charity Care Accounts

A. Apply the following guidelines when processing indigent/charity care applications:

1. Have the patient complete a financial statement, whenever possible, for all self-pay and underinsured patients to determine if criteria are met. Provide assistance to the patient in completion of the form if needed.

2. Financial applications must be accepted even if collection effort has been initiated.

3. Outline the supporting documents needed from the applicant in order to evaluate the application. This may include bank statements, pay stubs, copies of last tax return, employer statements, award letters, or support statements from others. The hospital reserves the right to verify all submitted documentation.

4. Make indigent/charity care determination prior to discharge whenever possible following the screening for other programs such as Medicaid.

5. Perform a financial analysis identifying eligibility resources for Medicaid, Vocational Rehabilitative Services, State funding, disability, etc. on all self-pay and underinsured patient accounts.

6. Applications are good for twelve months and can be used to include bad debt accounts

which are no older than one year from the date of service.

7. Assist the applicant in the completion of the necessary forms for Medicaid and other community and state programs.

8. Applications will be submitted to the Patient Financial Services Director for approval.

9. The approved or denied determinations must be made within five (5) business days from the date of application.

10. Issue written notice to the applicant informing them of the results of the determinations. If an applicant is determined ineligible, include the reasons and the information you relied upon to make the determination.

11. Include in the notice information on how to be reconsidered if the patient disagrees with the initial decision. Someone different from the person who made the initial determination of eligibility will be appointed to reconsider the application.

12. Include information in the notice on how to be reconsidered if the patient disagrees with the initial decision. Someone different from the person who made the initial determination of eligibility will be appointed to reconsider the application.

13. You must then issue a written final determination of eligibility. Include the information for Indigent Care Trust Fund, Division of Medical Assistance's toll-free telephone number 1-877-261-3117 or local 404-463-5827 to call if the applicant still disagrees with the determination you have made.

14. Applications are available to print from the Financial Assistance Program section at www.jaspermemorial.com.

IV. Family Unit/Size:

A. The family unit consists of individuals living alone, with spouses, and parents and their children under age 21 living in the same household.

B. A family unit may include minor children living with a legal guardian. The child, legal guardian, and the legal guardian's family unit living in the same household may comprise a family unit.

V. Other Program Requirements:

A. Signs must be posted in all registration areas and the business office informing the patient of the availability of financial assistance.

B. Provide individual written notices to each patient potential eligible for free or reduced care. These written notices may also be included with letters and other billing forms. Include the information for Indigent Care Trust Fund, Division of Medical Assistance's toll-free telephone number 1-877-261-3117 or local 404-463-5827.

C. All notices and signs must be made available in both English and Spanish or any other language that might become necessary.

D. Staff is to communicate the notice information for those patients who might be unable to read.

All forms and notices are included at the end of the policy and should be used according to policy. Exceptions should be rare and approved by management before using.

VI. Other Indigent/Charity Care Eligibility–Presumptive Eligibility

A. Patients/guarantors may qualify for free or reduced care even when we are unable to obtain the completed application. The following will service as a guideline in determining presumptive eligibility:

1. Other medical financial obligations.
2. The amount and frequency of healthcare services.
3. Types of services provided (e.g., elective vs. emergency).
4. The patients are usually unemployed and have a high probability that they are unemployable; homeless; do not meet eligibility requirements of other programs; or have a history of inability to pay.
5. Patient/guarantor demographics and credit reports may also assist in determining presumptive eligibility.
6. Accounts returned from Collection Agencies as uncollectible based on specific written criteria. At this time these accounts would be reclassified to Indigent.
7. Deceased patients without an estate or third party coverage to fully cover his/her medical care costs.
8. Patient's address (lives in a zip code known to have a per capita income below the FPG).

9. Terminal Illness.

B. There must be complete documentation of why the decision was made and criteria used to determine the level of financial assistance provided.

C. In cases such as these, you would follow the same steps listed above along with your recommendation as to the disposition of a bill supported by documentation.

D. This process always requires the approval of management.

VII. Indigent/Charity–Catastrophic Illness/Medical Bills

A. There may be circumstances which present where a patient's medical expenses are such that they are unable to pay them within a reasonable length of time or without extreme financial hardship. Cases such as this are classified as "catastrophic." The hospital performs an Income Test to determine if the patient may be eligible for free or reduce care using the following guidelines:

1. The Hospital will multiply the family income by 30 percent.
2. The Hospital will determine that patient's allowable medical expenses.
3. The Hospital will compare 30 percent of the family income to the total of the patient's allowable medical expenses.
4. If the total of the allowable medical expenses is greater than 30 percent of the family income, then the patient meets the catastrophic charity care qualifications.
   a. The Hospital will limit patient liability for medical expenses to 30 percent of the family's income.
   b. Amounts that exceed this limit will be eligible for charity care.
5. Example: A family's income is $70,000.00 per year and they have medical expenses of $45,000.00. Thirty (30) percent of the family's annual income is $21,000.00; the family's medical expenses of $45,000.00 exceed this amount. The Family should then be eligible for a charity write off of $24,000.00.

VIII. Miscellaneous processes–Monitoring of Assigned Accounts.

A. Run reports monthly.
   1. In-house.
   2. FA.
B. Combine accounts and set up payment plans.
C. Respond to referrals from doctors/clinics.
D. Refer patients to community clinics.

REVIEW RESPONSIBILITIES:
Controller
Patient Financial Services Director

FORMS:
Attachment A thru N

REFERENCES:

None

APPROVAL SIGNATURES:

Stuart Abney
Controller

Amy Sofala
Patient Financial Services Director

Jan Gaston
Policy and Procedure Review Committee

Revision Date: March 2007
May 2009
August 2010 (Policy Name Changed from Financial Counseling)
March 2013
August 2014
August 2017

Attachment A

Charity Approval Letter

Dear

Thank you for your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are pleased to inform you that you are eligible for assistance through Oconee Regional Medical Center's Financial Assistance Program.

We have determined that your income $ per for your family size of , qualifies you to pay only % of our usual charge.

Patient Name	Acct. Number	Date of Service	Balance	Patient Responsibility

Please contact our office to make arrangements to pay the above remaining balances. If you disagree with this decision and believe that you should qualify for a further reduction in your payment, you may ask for another review of your application. Please contact Carole Marchman at (478) 454-3698.

If you receive additional services from the hospital, please contact our office regarding eligibility. If you have received bills from any physicians for treatment they provided, please contact their office to make payment arrangements.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone #

Attachment B

Reconsideration Denial Letter

Date

Name of applicant
Address
Patient Acct number

Dear

We have reconsidered our original decision on your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are sorry to inform you that you still are not eligible for services under Oconee Regional Medical Center's Financial Assistance Program based on your income.

We have determined that your income of $ per for your family size of is more than the limit of (insert federal poverty guidelines for this family size).

If you still disagree with this decision and believe that you should qualify for free services or a reduction in your payment, you may contact the Department of Community Health by writing to the address below or calling 404-463-5827 or toll-free 1-877-261-3117.

Indigent Care Trust Fund
Hospital Policy Section
Division of Medical Assistance
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

You may be eligible for free legal assistance. You may contact your local office of Georgia Legal Services or Atlanta Legal Aid.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone

Attachment C

Reconsideration Approval Letter

Name of applicant
Address
Patient Acct number

Dear

We have reconsidered our original decision on your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are pleased to inform you that are eligible for services under Oconee Regional Medical Center's Financial Assistance Program based on your income.

We have determined that your income and family size qualifies you for 100% assistance on the following accounts:

Patient Name	Acct. Number	Date of Service	Balance	Patient Responsibility

If you receive additional services from the hospital, please contact our office regarding eligibility. If you have any questions, please contact my office at 706-468-6411. If you have received bills from any physicians for treatment they provided, please contact their office to make payment arrangements.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone

Attachment D

Reconsideration Charity Approval Letter

Dear

We have reconsidered our original decision on your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are pleased to inform you that you are eligible for assistance through Jasper Memorial Hospital's Financial Assistance Program.

We have determined that your income $ per for your family size of , qualifies you to pay only % of our usual charge.

Patient Name	Acct. Number	Date of Service	Balance	Patient Responsibility

Please contact our office to make arrangements to pay the above remaining balances. If you disagree with this decision and believe that you should qualify for a further reduction in your payment, you may contact the Department of Community Health by writing to the address below or by calling 404-463-5827 or toll free 1-877-261-3117.

Indigent Care Trust Fund
Hospital Policy Section
Division of Medical Assistance
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

You may be eligible for free legal assistance. You may contact your local office of Georgia Legal Services or Atlanta Legal Aid. If you receive additional services from the hospital, please contact our office regarding eligibility. If you have received bills from any physicians for treatment they provided, please contact their office to make payment arrangements.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone #

Attachment E
Indigent Approval Letter

Dear

Thank you for your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are pleased to inform you that you are eligible for assistance through Jasper Memorial Hospital's Financial Assistance Program.

We have determined that your income and family size qualifies you for 100% assistance on the following accounts:

Patient Name	Acct. Number	Date of Service	Balance	Patient Responsibility

If you receive additional services from the hospital, please contact our office regarding eligibility. If you have any questions, please contact my office at 478-457-2121. If you have received bills from any physicians for treatment they provided, please contact their office to make payment arrangements.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone

Attachment F
Denial Letter

Date

Dear

Thank you for your application for assistance with your hospital bill(s) under the Georgia Indigent Care Trust Fund. We are sorry to inform you that we have determined that you are not eligible for services under Jasper Memorial Hospital's Financial Assistance Program based on your income.

We have determined that your income of $ per for your family size of is more than the limit of (insert federal poverty guidelines for this family size).

If you disagree with this decision and believe that you should qualify for free services or a reduction in your payment, you may ask for another review of your application. Please contact the Patient Financial Services Director at 706-468-6411.

Sincerely,

Name
Title
Jasper Memorial Hospital
Telephone

Attachment G
Financial Assistance Letter

Dear Patient:

In keeping with the mission commitment of service to the community, Jasper Memorial Hospital offers financial assistance programs for the patients and the community according to recognized need and available resources.

Enclosed you will find a financial information form, please complete and return the form with a copy of the following (the form cannot be considered without this information):

- Income Tax Return for year _____
- 3 current Pay Stubs or other sources of Income for all household members
- 3 months current bank statements
- Other _____
- College students must supply the following:
    1. Copies of grants &/or loans
    2. Living expense allotments granted by scholarships
    3. Documentation from parents if they assist with living expenses
    4. Proof of student status

The completion of this application will allow us to evaluate your need for assistance with your outstanding balance at Jasper Memorial Hospital. There are guidelines that we have to follow through the State of Georgia to be able to consider you/your family eligible for the hospital assistance.

If you have any questions or concerns in completing this information, please contact my office at 706-468-6411 Monday through Friday 8:00 am-4:30 pm.

Sincerely,

Patient Financial Services Director
Jasper Memorial Hospital
706-468-6411

Attachment H

Indigent Approval Letter (Spanish)

Estimado(a)

Gracias por presentar su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Nos complace informarle que usted reúne los requisitos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos y el tamaño de su familia le califican para recibir una asistencia del 100% en las siguientes cuentas:

Nombre del paciente	Número de cuenta	Fecha del servicio	Saldo	Obligación del paciente

Si usted recibe servicios adicionales del hospital, comuníquese con nuestra oficina para averiguar su elegibilidad. Si tiene alguna pregunta, llame a mi oficina al 706-468-6411. Si ha recibido facturas de cualquier médico por el tratamiento que le administraron, comuníquese con el consultorio de esos doctores para tramitar los pagos correspondientes.

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment I

Charity Approval Letter (Spanish)

Estimado(a)

Gracias por presentar su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Nos complace informarle que usted reúne los requisitos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos de $ por para el tamaño de su familia de le califican para pagar sólo el % de nuestros cargos acostumbrados.

Nombre del paciente	**Número de cuenta**	**Fecha del servicio**	**Saldo**	**Obligación del paciente**

Comuníquese con nuestra oficina para tramitar el pago de los saldos restantes indicados arriba. Si no está de acuerdo con esta decisión y piensa que sí califica para recibir un descuento adicional en su pago, puede pedir que se vuelva a revisar su solicitud. En ese caso, llame a Patient Financial Services Director al (706) 468-6411.

Si usted recibe servicios adicionales del hospital, comuníquese con nuestra oficina para averiguar su elegibilidad. Si ha recibido facturas de cualquier médico por el tratamiento que le administraron, comuníquese con el consultorio de esos doctores para tramitar los pagos correspondientes.

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment J

Denial Letter (Spanish)

Fecha

Estimado(a)

Gracias por presentar su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Lamentamos tener que informarle que hemos determinado que usted no reúne los requisitos de ingresos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos de $ por para el tamaño de su familia son superiores al límite de (insertar aquí las guías federales de pobreza para este tamaño de familia).

Si usted no está de acuerdo con esta decisión y piensa que sí califica para recibir servicios gratuitos o un descuento en su pago, puede pedir que se vuelva a revisar su solicitud. En ese caso, llame a Patient Financial Services Director al (706) 468-6411.

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment K
Reconsideration Denial Letter (Spanish)

Fecha

Nombre del solicitante
Dirección
Número de cuenta del paciente

Estimado(a)

Hemos vuelto a considerar nuestra decisión original sobre su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Lamentamos informarle nuevamente que usted no reúne los requisitos de ingresos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos de $ por para el tamaño de su familia son superiores al límite de (insertar aquí las guías federales de pobreza para este tamaño de familia).

Si todavía no está de acuerdo con esta decisión y piensa que califica para recibir servicios gratuitos o un descuento adicional en su pago, puede comunicarse con el Departamento de Salud Comunitaria (*Department of Community Health*) escribiendo a la dirección siguiente o llamando al 404-463-5827 o, gratis, al 1-877-261-3117.

Indigent Care Trust Fund
Hospital Policy Section
Division of Medical Assistance
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

Quizás sea elegible para recibir asistencia legal gratuita. Puede ponerse en contacto con su oficina local de Servicios Legales de Georgia (*Georgia Legal Services*) o Asesoría Legal de Atlanta (*Atlanta Legal Aid*).

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment L
Reconsideration Charity Approval (Spanish)

Fecha

Estimado(a)
Hemos vuelto a considerar nuestra decisión original sobre su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Nos complace informarle que usted sí reúne los requisitos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos de $ por para el tamaño de su familia de le califican para pagar sólo el % de nuestros cargos acostumbrados.

Nombre del paciente	**Número de cuenta**	**Fecha del servicio**	**Saldo**	**Obligación del paciente**

Comuníquese con nuestra oficina para tramitar el pago de los saldos restantes indicados arriba. Si no está de acuerdo con esta decisión y piensa que califica para recibir una reducción adicional de su pago, puede comunicarse con el Departamento de Salud Comunitaria (*Department of Community Health*) escribiendo a la dirección siguiente o llamando al 404-463-5827 o, gratis, al 1-877-261-3117.

Indigent Care Trust Fund
Hospital Policy Section
Division of Medical Assistance
2 Peachtree Street, NW, 37th Floor
Atlanta, Georgia 30303-3159

Quizás sea elegible para recibir asistencia legal gratuita. Puede ponerse en contacto con su oficina local de Servicios Legales de Georgia (*Georgia Legal Services*) o Asesoría Legal de Atlanta (*Atlanta Legal Aid*). Si usted recibe servicios adicionales del hospital, comuníquese con nuestra oficina para averiguar su elegibilidad. Si ha recibido facturas de cualquier médico por el tratamiento que le administraron, comuníquese con el consultorio de esos doctores para tramitar los pagos correspondientes.

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment M
Reconsideration Indigent Approval Letter (Spanish)

Fecha

Nombre del solicitante
Dirección
Número de cuenta del paciente

Estimado(a)

Hemos vuelto a considerar nuestra decisión original sobre su solicitud para recibir asistencia con sus facturas del hospital con el Fideicomiso para Atención de Indigentes de Georgia (*Georgia Indigent Care Trust Fund*). Nos complace informarle que usted sí reúne los requisitos de ingresos necesarios para recibir servicios según el Programa de Asistencia Financiera (*Financial Assistance Program*) de Jasper Memorial Hospital.

Hemos determinado que sus ingresos y el tamaño de su familia le califican para recibir una asistencia del 100% en las siguientes cuentas:

Nombre del paciente	Número de cuenta	Fecha del servicio	Saldo	Obligación del paciente

Si usted recibe servicios adicionales del hospital, comuníquese con nuestra oficina para averiguar su elegibilidad. Si tiene alguna pregunta, llame a mi oficina al 706-468-6411. Si ha recibido facturas de cualquier médico por el tratamiento que le administraron, comuníquese con el consultorio de esos doctores para tramitar los pagos correspondientes.

Atentamente,

Nombre
Cargo
Jasper Memorial Hospital
Teléfono

Attachment N

JASPER MEMORIAL HOSPITAL
APPLICATION FOR
FREE AND REDUCED-CHARGE SERVICES

Name of patient:_____

Account Nos.:_____ Balance: _____ Account Nos.:_____Balance:_____

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Name of Applicant:_____ Relationship to patient:_____
Address: _____
_____
Telephone/Cell: _____

List members of household, birth date, relationship to patient, and income form each source; state whether income if per week, per month, or year.

Name	Birthdate	Relationship Relationship	Income (wk/mo/yr)	Income (wk/mo/yr)	Income wk/mo/yr)	TOTAL INCOME

If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

(Note to applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

++

For Hospital Staff Use:

Name of Patient:_____

Number Counted In Household:_____ Total Countable Income:_____

(Average monthly income for the last year or 3 months, whichever is more favorable)

Verification of income supplied? Yes_____ No_____

Determination: Eligible for free services_____ Conditional_____ Pending:_____

Eligible for discount _____%

Ineligible _____Reason:_____

_____

Date notice mailed:_____ Staff Signature:_____ Date:_____

Original Approval Signature:_____ Date:_____

Reconsideration: _____Date:_____