FINANCIAL ASSISTANCE/CHARITY CARE INFORMATION

POLICY STATEMENT:

In order to serve the health care needs of our community, **Sharon Regional Health System** will provide financial assistance/charity care to patients without financial means to pay *for Inpatient, Observation and Emergency Room hospital services.*

Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent according to the hospital's eligibility criteria.

If there are state specific laws that conflict with any portion of this policy, those sections have been identified and edited to comply with said law. In addition, attached to this policy are copies of each law as verification of requirements.

PURPOSE:

To properly identify those patients who are financially indigent, who do not qualify for state and/or government assistance, and to provide assistance with their Inpatient and Emergency Room medical expenses under the guidelines for Financial Assistance/Charity Care.

ELIGIBILITY FOR FINANCIAL ASSISTANCE/CHARITY CARE

1. **FINANCIALLY INDIGENT:**

   A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

   B. To be eligible for charity care as a financially indigent patient, the patient's total household income shall be at or below 320% of the current Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities for the person when determining eligibility.

   C. The hospital will use the most current Federal Poverty Income Guideline 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. The Federal Poverty Income Guidelines are published in the Federal Register in January or

February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 100% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

E. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for charity upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. No other documents will be required in order to approve the charity application. The patient will not be required to make a formal financial assistance/charity application. The hospital may submit the application and verification of Medicaid coverage as proof of qualification.

2. **MEDICALLY INDIGENT:**

A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.

B. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for charity care assistance. Payment of copayments and spend down amounts are a condition of coverage and should not be written off or discounted.

C. To be eligible for charity care as a medically indigent patient, the amount owed by the patient on medical bills for the prior 12 month period, after payment by third party payers, must exceed 50% of the patient's annual gross income and the patient must be unable to pay the remaining bill. The hospital may consider other financial assets and liabilities of the person when determining ability to pay.

D. A determination of the patient's ability to pay the remainder of the bill, or portion of the bill, will be based on whether the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.

E. The patient may be eligible for a charity discount for any amount beyond what the patient is expected to pay over a 3-year period.

F. If a determination is made that a patient had the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should there be a change in the patient's financial status.

1. **FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION**

A. The following factors are to be considered in determining the eligibility of the patient for charity care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for charity are attached on *Exhibit "B"*. The current Federal Poverty Guidelines are attached as *Exhibit "C"* and they include the definition of the following:

1. Family
2. Income

2. **FAILURE TO PROVIDE APPROPRIATE INFORMATION**

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.
B. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

3. **TIME FRAME FOR ELIGIBILITY DETERMINATION**

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

Exhibit A
Financial Assistance Form
Sharon Regional Health System
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION	PARENT/GUARANTOR/SPOUSE
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
SS#_____	SS#_____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit A (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Exhibit B
Income Guidelines For Determining % of Charity Care Discount
(For Financially Indigent Patients)

Based on Current Year's Federal Poverty Income Guidelines

% of Poverty Income	Discount from charges
Equal to or Below Poverty	100% - 320%

Exhibit C

Income Guidelines for Determining Percentage of Charity Care Discount (For Financially Indigent Patients)

Based on 2016 Federal Povery Income Guidelines

Federal Poverty Income Guidelines 2016

# of Person(s) in family	Poverty Guideline
1	$ 11,880.00
2	$ 16,020.00
3	$ 20,160.00
4	$ 24,300.00
5	$ 28,440.00
6	$ 32,580.00
7	$ 36,730.00
8	$ 40,890.00
9	$ 45,050.00
10	$ 49,210.00

Income Guidelines for determine % of Charity Care Discount

% of Poverty Income	Discount from Charges
Equal to or below	100%
100-200%	100%
201-220%	90%
221-240%	80%
241-260%	70%
261-280%	60%
281-300%	50%
301-320%	40%
321-340%	30%
341-360%	20%

# of Person(s) in family	Poverty Guideline	Equal to or below	200%	220%	240%	260%	280%	300%	320%	340%	360%
1	$ 11,880.00	$ 11,880.00	$23,760.00	$ 26,136.00	$ 28,512.00	$ 30,888.00	$ 33,264.00	$ 35,640.00	$ 38,016.00	$ 40,392.00	$ 42,768.00
2	$ 16,020.00	$ 16,020.00	$32,040.00	$ 35,244.00	$ 38,448.00	$ 41,652.00	$ 44,856.00	$ 48,060.00	$ 51,264.00	$ 54,468.00	$ 57,672.00
3	$ 20,160.00	$ 20,160.00	$40,320.00	$ 44,352.00	$ 48,384.00	$ 52,416.00	$ 56,448.00	$ 60,480.00	$ 64,512.00	$ 68,544.00	$ 72,576.00
4	$ 24,300.00	$ 24,300.00	$48,600.00	$ 53,460.00	$ 58,320.00	$ 63,180.00	$ 68,040.00	$ 72,900.00	$ 77,760.00	$ 82,620.00	$ 87,480.00
5	$ 28,440.00	$ 28,440.00	$56,880.00	$ 62,568.00	$ 68,256.00	$ 73,944.00	$ 79,632.00	$ 85,320.00	$ 91,008.00	$ 96,696.00	$ 102,384.00
6	$ 32,580.00	$ 32,580.00	$65,160.00	$ 71,676.00	$ 78,192.00	$ 84,708.00	$ 91,224.00	$ 97,740.00	$ 104,256.00	$ 110,772.00	$ 117,288.00
7	$ 36,730.00	$ 36,730.00	$73,460.00	$ 80,806.00	$ 88,152.00	$ 95,498.00	$ 102,844.00	$ 110,190.00	$ 117,536.00	$ 124,882.00	$ 132,228.00
8	$ 40,890.00	$ 40,890.00	$81,780.00	$ 89,958.00	$ 98,136.00	$ 106,314.00	$ 114,492.00	$ 122,670.00	$ 130,848.00	$ 139,026.00	$ 147,204.00
9	$ 45,050.00	$ 45,050.00	$90,100.00	$ 99,110.00	$ 108,120.00	$ 117,130.00	$ 126,140.00	$ 135,150.00	$ 144,160.00	$ 153,170.00	$ 162,180.00
10	$ 49,210.00	$ 49,210.00	$98,420.00	$ 108,262.00	$ 118,104.00	$ 127,946.00	$ 137,788.00	$ 147,630.00	$ 157,472.00	$ 167,314.00	$ 177,156.00