Jefferson Hospital Indigent Care Application Policy

It is the policy of Jefferson Hospital to establish a standard to determine the financial status of its patients for the purposes of identifying those in need of Indigent/Charity Care. This program will benefit all US citizens who are Jefferson County resident patients with income levels of 0% up to 200% of the Federal Poverty Guidelines with no other third party payor source. In order for a patient to be considered for the financial assistance program, the patient must have first applied for all other appropriate local, State or Federal programs**.**

No individual shall be denied a medically essential service based solely upon lack of ability to pay for services. All policies shall be implemented in accordance with all EMTALA and ICTF rules and regulations, as well as, any other federal or state law, rule or regulation as it relates to the delivery of health care services, as they currently exist and any future changes or amendments to these rules and regulations.

APPLICATION PROCESS

- Applications will be accepted during normal business hours at the Jefferson Hospital Registration Office or Business Office.
- Jefferson Hospital **does not** accept or process applications for patients who have not received nor are scheduled to receive services. Applications for this program are only to be taken when a patient accesses Jefferson Hospital services. Jefferson Hospital Indigent & Charity Program is not an insurance card that is applied for in the event that services are needed.
- All patients applying for financial assistance must complete a Financial Assistance Application Form and supply required documentation for income verification and proof of residency.
- Required Documentation
    - Most recent calendar year IRS tax return
    - One month's current pay stub
    - Copies of pension check or Social Security check
    - Child support
    - Social Security Statement/Verification
    - VA statement
    - Unemployment earnings
    - Self-employment earnings
    - Proof of residency (light or water bill or rent receipt, must be in applicant or spouses name)
    - Driver's license or State issued ID
    - Social Security Cards
    - Medicaid Denial Letter
    - W2/1099 or last paycheck stub
    - Bank statements
    - Bill from Clinic or Hospital

- Each application is on a case by case basis. The application will be approved for 6 months retroactively and 3 months prospectively from the date of approval.

NON-ALLOWABLE

The following are **NOT** covered by this policy:

- Patients who reside outside Jefferson County
- Amounts due to the hospital and collectable from third parties such as insurance, workers compensation medical benefits, etc.
- Patients who are Medicaid eligible and who have not applied for Medicaid.
- Amounts due to independent contractors, such as, radiologist fees, outside labs, and ambulance services
- Amounts due that are covered under liability, auto accident, or worker's compensation with no proof of denial of coverage
- Medicare co-pays and deductibles
- Elective or cosmetic procedures
- Physicals
- Preventive medicine or wellness visits
- Private rooms differences
- All services related to self-inflicted injuries
- Services required as a result from a criminal act, while incarcerated, or in the custody of law enforcement
- Non-emergent ER visits
- Drug Screens
- Jefferson Hospital employees who waive insurance coverage.

PATIENTS RESPONSIBILITY

- Clinic Visits - $35
- All Emergency Room Visits - $75
- Lab & Routine X-rays - $35
- All other Radiology procedures not listed below - $100
- CT - $250/ minimum $100 paid at time of service
- MRI - $500/ minimum $100 paid at time of service
- Surgery – $250
    - Surgeries are performed on a medical necessity basis and must be approved by administration. Most surgeries WILL NOT be covered by Indigent.
- Admission - $100 per day
    - The remaining balance will be eligible for a payment plan.

Failure to comply to the requirements of this program can and will lead to immediate suspension or termination from the Jefferson Hospital Indigent Care Trust Fund.

Charity/Indigent Care Application

Date: _____Social Security Number (SSN): _____ Date of Birth (DOB): _____

Patient Name: _____ Account Number: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Do you have any type of health insurance? Yes No Do you have a GA Medicaid Card? Yes No Date Issued: _____

Are you on Medicare? Yes No Are you on Social Security Disability with Medicare or Medicaid? Yes No

Are your children on health insurance, Peach Care or Medicaid? Yes No

Address: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ _____Cell Phone: _____ ____Work Phone: _____ _____

Parent or Guardian if patient is under 21: _____

Patient (or Guardian) Employer: _____ Phone: _____

Employer Address: _____

Are you self-employed? Yes No Type of Work: _____

Spouse's Employer: _____ Phone: _____

Employer Address: _____

Is your spouse self-employed? Yes No Type of Work: _____

Full Name of Spouse and/or Legal Dependents Living in Household under 21, SSN, DOB, and Relationship:

1. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

2. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

3. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

4. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

5. _____
(NAME) (SSN) (DOB) (RELATIONSHIP)

- I certify that this form has been examined by me and that the information given is true and correct to the best of my knowledge.
- My spouse and I agree to provide Jefferson Hospital with any information needed to verify statements given in this application and hereby give permission for their agents to obtain such information on our behalf.
- I understand that Jefferson Hospital may require additional documentation in order to process my application.
- I understand that if I give false information a charity care approval may be reversed, and Legal Action may be pursued. Further, I understand that the hospital may obtain any credit history of mine or my spouse.
- I understand that my application will be denied if it is incomplete or I fail to provide required documentation.

Signature of Patient or Guardian: _____ Date: _____Time: _____

Relationship to Patient: _____

Signature of Spouse (if applicable): _____ Date: _____Time: _____