



Policy and Procedure No: BUS-03	Revised Date: 10/01/2018
Title: Department Financial Assistance / Indigent and Charity Policy	Effective Date: 10/01/2018
Department: Business Office/Registration	
Approved by: Department Manager	References:

**PURPOSE**

The Financial Assistance Policy of Jefferson Hospital serves to provide financial assistance to uninsured or underinsured patients based on the Federal Poverty Guidelines. This policy also administers the distribution of ICTF (Indigent Care Trust Fund) per state regulations. Jefferson Hospital is committed to providing quality health care services to the community. In order to provide necessary medical services, the Health System must maintain a viable financial foundation by seeking reasonable reimbursement for its services to the extent available while at the same time recognizing its obligations to provide free or discounted services to uninsured and underinsured patients who are eligible for financial assistance under this Policy. Jefferson Hospital is committed to providing emergency and medically necessary services to all patients without discrimination, regardless of their ability to pay.

Each request for financial assistance will be reviewed independently and allowances may be made for extenuating circumstances on a case by case basis.

**ELIGIBILITY**

Jefferson Hospital uses the Federal Poverty Guidelines (FPG) in effect at the time an application is completed and submitted to determine eligibility for financial assistance. If the family's income falls below the 200% of the guidelines, the patient is eligible for some level of financial assistance. The Federal Poverty Guidelines can be found on the government website, [www.aspe.hhs.gov/poverty](http://www.aspe.hhs.gov/poverty). Criteria are set as follows:

Household incomes that are at or below 125% of the FPG are eligible to receive free care. This is classified as indigent care.

Household incomes that exceed 126% of the FPG but are at or below 200% of the FPG qualify for a discounted payment based on a sliding scale as shown below. This is classified as charity care. The patient may also be approved for a payment plan.

## 2018 FEDERAL POVERTY LEVEL GUIDELINES

SLIDING SCALE							
DISCOUNT	100%	100%	90%	80%	75%	70%	60%
FAMILY SIZE	100%	125%	140%	150%	175%	185%	200%
1	\$12,140	\$15,175	\$16,996	\$18,210	\$21,245	\$22,459	\$24,280
2	\$16,460	\$20,575	\$23,044	\$24,690	\$28,805	\$30,451	\$32,920
3	\$20,780	\$25,975	\$29,092	\$31,170	\$36,365	\$38,443	\$41,560
4	\$25,100	\$31,375	\$35,140	\$37,650	\$43,925	\$46,435	\$50,200
5	\$29,420	\$36,775	\$41,188	\$44,130	\$51,485	\$54,427	\$58,840
6	\$33,740	\$42,175	\$47,236	\$50,610	\$59,045	\$62,419	\$67,480
7	\$38,060	\$47,575	\$53,284	\$57,090	\$66,605	\$70,411	\$76,120
8	\$42,380	\$52,975	\$59,332	\$63,570	\$74,165	\$78,403	\$84,760
*	\$4,320	\$5,400	\$6,048	\$6,480	\$7,560	\$7,992	\$8,640

Household incomes that exceed 200% of the FPG, where the patient is medically indigent, or has unusual financial circumstances, such as catastrophic illness or accident, are evaluated based on their financial situation. Some examples include: (1) The size of the patient's medical bills based on a catastrophic illness or otherwise have resulted in patient liabilities for which payment is impossible based on current financial status of a household; or (2) The patient's subsistence is threatened resulting in an ability to meet patient liabilities. This is classified as medically indigent or charity hardship care. Self-pay patients may be eligible for a prompt pay discount of up to 30%. The patient may be approved for a payment plan.

### **INCOME VERIFICATION**

Income verification for **all working adults** in the household is to include their IRS tax return for the most recent calendar year and the following:

- One month's current pay stubs
- Copies of pension check or Social Security check
- Child support
- Social Security Statement/Verification
- VA statement
- Unemployment earnings
- Self-employment earnings

**Food stamps do not count as income.**

Additional Documentation Required

- 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

If patient/guarantor is unable to provide the documentation to verify income, an original letter from his/her employer on company letterhead should be sent showing part-time or full-time status, length of employment and monthly income. Should the patient not be able to provide any documentation of income verification, the patient must supply a letter from person providing support containing all facts supporting the need for financial assistance. Approval with this documentation will be on a case by case basis.

Total family income, based on income verification for all working adults in the household who are responsible for the patient, is compared to current federal poverty guidelines. However, 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 purposes of paying medical bills. Likewise, do not count income from any child (minor or adult) in considering eligibility under the ICTF for the child's parent.

The family unit consists of individuals living alone; and any spouses, parents and their children under age 18 who are still in high school living in the same household.

### **PRESUMPTIVE ELIGIBILITY**

The patient may also qualify for Financial Assistance based on Presumptive Eligibility as discussed below.

Presumptive Eligibility- If there is adequate information provided by the patient or through other sources, the patient may be deemed presumptively eligible for financial assistance without a formal application. In the event there is little or no evidence to support a patient's eligibility for financial assistance Jefferson Hospital may use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility or potential discount amounts. Presumptive financial assistance will be determined prior to any outside collection activity. The following types of accounts may be considered eligible for financial assistance without documentation under the presumptive eligibility financial assistance program (1) Referrals from approved community agencies; (2) No estate (deceased and death certificate is presented); (3) Eligibility for Medicaid in states other than Georgia; (4) Eligibility for State/Federal Programs where program funding has been exhausted; (5) Food Stamp eligibility; (6) Low income or subsidized housing; (7) Participation in the Women, Infants and Children programs (WIC); (8) State funded prescription programs; or (9) Unemployed persons with no Third Party insurance coverage.

### **MEDICAID APPLICATION**

The patient/guarantor is to apply for Medicaid and comply with Medicaid requirements, as applicable.

## **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
- 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.

## **PROCEDURE TO IDENTIFY ELIGIBLE PATIENTS**

Individual notification of this policy will be given at registration to self-pay patients (or their representative) seeking services or having services Jefferson Hospital. A plain language summary of this policy, a copy of this policy, and application shall also be posted on the Jefferson Hospital website.

## **APPLICATION PROCESS**

- 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. The application must be signed by the patient/guarantor. Applications must be submitted by the 240<sup>th</sup> day from receipt of the first Jefferson Hospital statement for the care provided.
- Applications will be held until the account has final billed and necessary information has been obtained, and the service has been provided. If applicant is denied for one date of service and on another date of service financial circumstances have changed the applicant may re-apply but must provide require new proof of income. The Poverty Income Guidelines in effect the day of the application will be used. The guidelines are revised annually.
- If the income is more than the guidelines or the documentation required by this policy has not been submitted within 30 days of notification of an incomplete application, the application will be denied and referred to the appropriate department to set up payment arrangements. Each applicant will be given a copy of the Applicant's Financial Assistance Application Form and informed that a determination will be made based on policy guidelines. When a determination has been made, a letter indicating denial and/or amount approved for write off and patient balance, if any, will be forwarded to address on record.
- 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.
- Patients have the right to appeal if the decision is a denial. An appeal must be submitted in writing or in person to the financial counseling department within thirty (30) days after the determination date.

## **USE OF INDIGENT PATIENT DATA**

- The financial Assistant/Patient Accounting Staff may/will keep a record of all amounts written off to Indigent Care.
- Reports may be produced on request to identify patients receiving indigent care. Reports will identify patient name, account number, date of service, type of service received, total charges, co-payments, third party payments, amount of indigent care write off, patient's county of residence, and employer (if any) or any additional information the Hospital is required to provide to State or Federal agencies.
- Once patient has received Indigent Status and taken advantage of Jefferson Hospital's Indigent policy, patient cannot refuse consent for use of Health Information for reporting to state Jefferson Hospital's Indigent Care. If patient refuses consent or withdraws consent, then account will be reactivated, and full collection efforts will begin.

Reviewed/ Revised	Reviewed	Revised						
Date/ Initial	1/17/18 CSD	10/1/18 CSD						

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