Policy and Procedure No: BUS-04	Original Date: 10/01/2018
Title: Indigent Application Policy	Effective Date: 10/01/2018
Department: Business Office/ Registration	
Approved by: Department Manager	References:

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 250% 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.
- 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

*Additional documentation may be requested if the required documentation above is unable to be obtained.

*Each application is on a case by case basis. The application will be approved for 6 months retroactively and 6 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, ambulance services, specialty clinics and emergency department providers.
- 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.

INDIGENT HOUSEHOLD SIZE INCOME AMOUNT

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 250% 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. Criteria are set as follows:

- Household incomes that are at or below 150% of the FPG are eligible to receive discounted care. This is classified as indigent care.
- Household incomes that exceed 151% of the FPG, but are at or below 250% 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.

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.

PATIENTS RESPONSIBILITY*
***Patient Responsibility cannot be more than 25% of total charges.**

Payment Plan Schedule:

Amount Owed:	**Minimum Payment:**	**Maximum Months:**
< $26	Payment in Full	N/A
$26-$100	1/3rd of the total	3
$101-$300	1/6th of the total	6
$301 - $600	1/12th of the total	12
$601 - $1,000	1/18th of the total	18
$1,000 - $1,500	1/24th of the total	24
$1,501 - $3,000	1/30th of the total	30
$3,001 - $5,000	1/36th of the total	36
$5,001 - $7,500	1/42nd of the total	42
Over $7,501	To be determined	N/A

Reviewed/ Revised		Revised	Revised	Revised	Revised	Revised	Revised	Revised	Revised		
Date/ Initial	10/1/18 CSD	5/2019 CFO	7/2020 JH	8/2020 JH	11/2020 JH	01/2021 JH	03/2022 JH	01/2023 JH	01/2024 JH		
Administration Approval/ Date			7/2020 JH	8/2020 JH	11/2020 JH	01/2021 JH	03/2022 JH	01/2023 JH	01/2024 JH		

Charity/Indigent Care Application

Date:_____ Patient Name:_____

Date of Birth:_____ Sex: MALE FEMALE Marital Status: MARRIED SINGLE DIVORCED WIDOWED

Do you have any health insurance? YES NO Do you have a GA Medicaid Card? YES NO

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

Mailing Address:_____

Physical Address (if different from mailing): _____

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:_____

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, Relationship, and DOB.

1._____

(NAME) (SSN) (RELATIONSHIP) (DOB)

2._____

(NAME) (SSN) (RELATIONSHIP) (DOB)

3._____

(NAME) (SSN) (RELATIONSHIP) (DOB)

4._____

(NAME) (SSN) (RELATIONSHIP) (DOB)

5._____

(NAME) (SSN) (RELATIONSHIP) (DOB)

- 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: _____