Memorial Hospital and Manor

Financial Assistance and Charity Care Program

Statement of Purpose

The City of Bainbridge and Hospital Authority of Decatur County Georgia DMA Memorial Hospital and Manor is a publicly owned hospital, and it is the only provider of acute inpatient hospital care in Decatur County. The Hospital operates the only emergency services in the County equipped to handle minor trauma. Due to the Hospital's tax exempt status, its public ownership, and its ongoing Community Service obligations, it will continue to be faced with the prospect of rendering care to the economically indigent and the medically indigent (those who are above the poverty level, but have inadequate or no health care coverage and incur large hospital/physician debts).

As a matter of policy and to be in compliance with current generally accepted accounting standards (AICPA), it is necessary to identify and separately handle the accounts of those individuals who cannot pay (indigent) or (charity) from those who can pay but refuse to pay (bad debts). For purposes of this document indigent is defined as income or assets equal to or less than two hundred (200) percent of the poverty guidelines. Charity is defined as income or assets more than the two hundred percent increase in the Federal Poverty guidelines and less than the sliding scale set forth by Memorial Hospital and Manor.

In order for an account to be classified as indigent or charity, the guarantor of the debt must meet the qualifications established by the Board of as outlined in the accompanying guidelines. It is the intent of this policy to meet the needs of those who are truly indigent but not to reward irresponsibility. The ultimate goal of this policy is to insure as much as possible that the Hospital recovers as much of its receivables as is economically sensible and identifies and spends a minimum of time on those accounts that would be virtually uncollectible even after exhaustive efforts.

<u>Guidelines</u>

1) **Residency**

The Patient must be a resident of Decatur County or the secondary service area. If an individual lives outside of the area, but Memorial Hospital is the nearest facility that offers the required services, the patient or guarantor may be eligible for consideration. In all cases the patient and guarantor must have met the geographical residency requirement for not less than six months prior to admission to the hospital for which charity is requested. Residency requirements will be waived for insured Hospitals staff and their family members covered under Hospital's insurance policy as well as patients provided continuing care from an Emergency Room admission.

2) **Services Covered**

All inpatient services and all outpatient services are available for charity consideration except elective procedures.

CHARITY CARE GUIDELINES (cont.)

- All emergency services
- All non-elective, medically necessary inpatient admission
- Clinic services that are generally covered by Medicare and deemed urgent by a physician
- Outpatient diagnostics, procedures, or treatments which are generally covered by Medicare and deemed urgent by a physician

3) **Income and Asset Qualifications**

a. Patient and/or guarantor's total income will be considered. Income will be based on the immediate six month period prior to the date of application. This income will be doubled to achieve an annual equivalent. Income is to be defined as gross income from all sources without consideration for expenses or deductions.

b. Approval for charity care will be based on a comparison of the current Memorial Hospital and Manor Charity Care Income Guidelines and the patient/guarantor's established annual income. Dependents will include legal dependents only, i.e., those that could be legally claimed on their federal income tax return.

c. The U. S. Poverty Income Guidelines issued annually by the Department of Health and Human Services will be adjusted upward to arrive at the Hospital's Charity Income Guidelines.

d. In an effort to ensure as much as possible those who are truly indigent receive every consideration the Hospital will reduce outstanding amounts on accounts that exceed the Health Charity Care Guidelines according to income received and amount owed.

e. Personal assets and real property owned by the patient/guarantor will be considered as an extenuating circumstance. Available assets, other than those legally exempt, up to the value of the debt, must be applied to the debt owed the Hospital prior to any further consideration being given for charity care eligibility. If a patient/guarantor owns real property and that property has a value greater than the exempt amount and their equity is greater than twenty percent (20%) of the overall value, the accounts will not qualify for charity, however, special consideration may be made as stated in item five.

4) **Applicant Cooperation**

The applicant for indigent care must fully cooperate with the Hospital in the pursuit of any and all available third party sources of payment. They must provide all necessary documents and information required to insure that they

CHARITY CARE GUIDELINES (cont.)

a. meet the charity guidelines, including but not limited to proof of income, proof of residences, an a accurate listing of assets. Failure to do either of these will automatically disqualify them from consideration except as stated in item five

b. Should an applicant declare that they have had no income whatsoever for the last six months, they must provide a statement from two (2) different sources/persons who would be in a reasonable position to have knowledge of that fact. These sources must have been residents of Decatur County or the secondary service area for a period of not less than six months.

c. Should the Executive Director of Revenue Cycle be able to establish through alternate means that the patient would qualify for charity, then charity may be granted based on documentation of the alternate means, on balances not to exceed $100,000.00. Accounts having balances exceeding that amount will require approval of the Chief Financial Officer.

d. Once a guarantor has been approved for charity under the Hospitals guidelines charity shall be valid for a period of six months from the date of approval.

5) **Other Considerations**

a. Applicants will be evaluated for charity care without regard to race, sex, religion or national origin.

b. An applicant's personal debts normally will not be considered during the qualification process because the hospital bill will not be made subordinate to other debts for purposes of the charity qualification process.

c. Whenever possible, a credit bureau search should be performed to determine the applicant's credit history.

d. Should the applicant's adjusted charges be greater than three times the amount of their income the applicant charges shall be reduced to an amount equal to twenty five percent (25%) of the applicant's income and arrangements for payment shall be offered in accordance to Hospital policy. (Medically indigent)

e. Applicant's applying for financial assistance for the second time may be required to complete an application for the ACA insurance plan before financial assistance will be considered.

CHARITY CARE GUIDELINES (cont.)

Applicants that do not meet the U. S. Poverty Income Guidelines issued by the Department of Health and Human Services or fall within the sliding scale set forth by MHM but have large hospital debts due to inadequate or no health care coverage may be classified as medically indigent. Accounts of this type may be referred to a Charity Care Review Board for special consideration.

In cases where the patient or guarantor has expired a probate claim will be filed whenever possible to protect the Hospital's interest. At such time as the estate is settled or all efforts to recover been exhausted, any outstanding balance shall be determined eligible for charity write off. In cases where the estate is deemed insolvent the entire balance shall be eligible for charity. In cases where the patient expires and no assets are listed or estate remains such accounts shall be eligible for a charity write off.

6) **Process**

a. Financial assistance should be discussed with the patient/guarantor only after an exhaustive effort has been made to secure any available third party reimbursement.

b. An application and any other necessary documentation should be obtained to establish charity care qualifications.

c. A list of patients/guarantors qualifying for charity based on approved guidelines will be presented in the next Board meeting agenda for official ratification. At this time, the Board may approve or reject any or all applications.

d. An additional list may be included in the agenda containing applicants who do not meet the charity guidelines, but may have been reviewed by a Charity Care Review committee and for valid reasons are deemed to merit special consideration. Charity Care ad-hoc committee will consist of an employee from the Patient Financial Services, Nursing, Quality Management Review and other areas as appropriate. These members shall be appointed by the Chief Financial Officer and approved by the Chief Executive Officer. Recommendations made by the Charity Care Review committee will be submitted to the Board for final approval.

e. Board approved accounts that meet the guidelines will be written off the Hospitals A/R and no further attempt at recovery from the patient/guarantor will be made. However, if it is later determined that third party sources are available for payment or if it becomes known that the patient's application was fraudulent, then the charity can be withdrawn as necessary to protect the Hospital’s best interest.

FINANCIAL ASSISTANCE PROGRAM DOCUMENTATION REQUIRMENTS

Along with the completed application for Financial Assistance please provide copies of income documentation for each household family member for the most recent three month period. Types of documentation to verify household income include:

1. Paycheck Stubs(LAST SIX MONTH REQUESTED LAST THREE MONTHS REQUIRED)
2. Tax Return / IRS W-2 Assistance Programs including CIDC,
3. Social Security Statement, Food Stamps, AFDC, Medicaid, etc.
4. Workers Compensation Statement
5. Unemployment Compensation Statement
6. Investment Income, Retirement Income
7. Proof of Participation in Governmental Programs
8. Bank Statements (most current last three months ending)
9. Letter from Employer, or if unemployed statement from unemployment office
10. Child Support/ Alimony/ Other (please explain other)
11. Proof of Residence/ Tax statement or Rent receipt (Home value) to include time at residence
12. If self-employed (completed UTD income and expense statement (last six months)
13. If unemployed two Notarized letters from people that have known you for at least six months

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Patient Name____

Account Number_____________________________________

Date of Service_______________________________________

Date of Request______________________________________

Return the above documentation to Memorial Hospital and Manor, 1500 E. Shotwell St. BainBridge GA 31717

Failure to complete the application or provide the required documentation may result in Denial of your request

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Hospital System Use Only

Date Received by Hospital______________________________

Name____

Department____Facility_____________________________________

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Memorial Hospital and Manor	Financial Assistance Request Application	Memorial Hospital and Manor will not discriminate against any patient because of race, creed, national origin, physical disability or because the patent is covered by a particular program or insurance.

I hereby request the hospital to make a determination of my eligibility for financial assistance.

Patient/Guarantor Name_________________________ Date of Birth_________________________
Social Security Number___________________________ Telephone Number___________________
Address____ CSZ_________________________________
Marital Status Married ( ) Divorced ( ) Widowed ( ) Single ( )
Spouse Name____________________________________
Your Employer_____________________________Spouse Employer_______________________________
Spouse SS#_________________________________ Spouse Date of Birth____________________________

Dependents- Members of your family whom you provide more than half of their support

Name	Social Security #	Age	Relationship

Income from all sources

Earned Income______________________________________ Retirement___________________________
Social Security Income________________________________ Other_________________________________
Child Support_______________________________

Financial Resources

Checking Account ( ) Rent ( ) Own ( ) Buying ( ) Saving Account ( ) Real Estate/ Property ( )

Expenses

Mortgage ( ) Rent ( ) monthly payment_____________ Loans Car ( ) Payment ______________
Hospital amount owed ______________ Payment amount _____________
Credit Cards ( ) Monthly Payments _______________ ______________ ____________ _____________

Medical Insurance

Company Name:____
Policy Number:____

Should the patient/guarantor be eligible for partial financial assistance, the balance of the account will be due in full unless satisfactory payments arrangements are made in compliance with Hospital policy.

I affirm the above information is true and correct to the best of my knowledge. Should it be determined that financial assistance has been provided based on false or incorrect information contained in the application I understand that the assistance provided may be reversed and may lead to legal recourse. I hereby authorize the Hospital to render the above information available to any government agency as may be required to substantiate any obligation to render such uncompensated services.

____ ____
Signature of Individual Making Request Date Witness Date