FINANCIAL ASSISTANCE POLICY
COMMUNITY HOSPITAL
805 FRIENDSHIP ROAD, TALLASSEE, AL 36078
(334) 283-6541

Policy: It is the policy of Community Hospital, Inc. and the Patient Accounts department to provide uninsured (self-pay) and underinsured patient's assistance in obtaining medical care.

REQUEST FOR FINANCIAL DISCOUNT

Guidelines:

Community Hospital offers financial discounts on self- pay and underinsured balances. The Patient Accounts Department uses The Department of Health & Human Services' ("DHHS") Poverty Guidelines in the determination process of the Financial Hardship Policy.

Determining the eligibility for financial hardship is the responsibility of Community Hospital, Inc. In making this determination, Community Hospital, Inc. uses guidelines that are established by the DHHS and published annually in the Federal Register.

Any individual or agency may refer a patient to Community Hospital, Inc. for consideration for financial hardship. However, the patient, the patient's legal guardian, or the responsible party must assist us by submitting the application for Financial Hardship to us for approval.

Guidelines:

Discounts will be applied as follows:

1. Uninsured Patients

INPATIENT

A. Patients with annual household income(s) greater than 200% of the DHHS Poverty Guidelines will pay the equivalent of the facilities largest commercial payor per diem plus 5%.
B. Patients with annual household income(s) above the DHHS Poverty Guidelines but less than 200% of the DHHS Poverty Guidelines will pay the equivalent of the Medicaid per diem plus 5%.
C. Patients with annual household income(s) at or below the DHHS Poverty Guidelines will have any account balance written off as indigent care.

OUTPATIENT

A. Patients with annual household income(s) above the DHHS Poverty Guidelines but less than 200% of the DHHS Poverty Guidelines, will have the account balance discounted by 50%.
B. Patients with annual household income(s) at or below the DHHS Poverty Guidelines will have the account balance written off as charity care.

C. Patients with annual household income(s) greater that 200% of the DHHS Poverty Guidelines will be offered a 35% discount for payment in full. If the patient is unable to pay the account in full, payment terms will be offered.

2. Insured Patients

A. All deductibles and co-payments attributable to an insured patient's account are due by the date of discharge for inpatients and by the date of service for outpatients. This also includes estimated coinsurance amounts for both inpatient and outpatient services.

No individual determined eligible for financial assistance under Community Hospital Financial Assistance Policies will be charged more for emergency or medically necessary hospital care than the amounts generally billed (AGB) to individuals with insurance covering such care.

Financial Hardship Application Procedures:

1. An application for financial hardship will be taken by referral, patient/guarantor, request, or discovery of need for private pay patients (patients without insurance).
2. The patient/guarantor must present all requested documents as indicated on the front page:
    A. Verification of monthly income for self and/or anyone listed within the house hold (ex. 2 consecutive check stubs if paid bi-weekly, 4 consecutive check stubs if paid weekly, etc.) If you are unable to obtain check stubs, then a letter from your employer on letterhead with employment verification, hourly pay, how often paid, etc.
    B. Verification of social security/disability benefits for self and/or anyone listed within the house hold
    C. Verification of food stamp benefits received for self and/or anyone listed within the house hold
    D. Verification of child support payments received for self and/or anyone listed within the house hold
    E. Most recent tax return in its entirety. If patient has not filed taxes within past 5 years then they can contact the IRS at # 800-908-9946 to obtain a transcript for last time filed
    F. Three consecutive bank statements for checking and/or savings account
3. The application must be completed in its entirety with all appropriate documents, signed by the patient/guarantor, and returned to Patient Accounts Department within 15 days from being discharged or from the date on letter when requesting application via telephone call.
4. Applications are valid for 6 months after the application has been approved. A letter will be mailed to the patient/guarantor indicating dates of approval.
5. If the application is denied for any reason (missing documentation, over DHHS Poverty Guidelines, etc.) a letter will be mailed to the patient/guarantor indicating reason for denial of application.
6. If the application is approved, written notification will be sent to the address shown on the application.

7. For all emergency medical conditions, we will follow the applicable EMTALA, Federal, and State guidelines as applicable. We will provide emergent care for medical conditions to individuals, without discrimination and regardless of eligibility under the Financial Assistance Program. We disallow any action that would discourage individuals from seeking medical care, i.e., demanding emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care. Emergency room patients who cannot pay their bills may be classified as "charity" if they do not have a job, mailing address, residence or insurance. Consideration is also given to classifying emergency room patients as charity if they do not provide adequate information as to their financial status. In many instances, these patients are homeless and have few to no resources to cover the cost of their care.

8. For urgent non-emergency medical conditions, we will schedule the appropriate services and require a completed Financial Hardship Packet or payment arrangements will have to be made.
9. For non-urgent non-emergency medical conditions, a completed Financial Hardship Packet or payment must be made before scheduling the services.

NOTE: Certain factors may contribute to the approval or denial of the application.

- Community Hospital, Inc. will be granted the authority by the patient/guarantor to verify the account balance(s) in any bank or savings and loan institutions
- The patient/guarantor will be asked to provide to Community Hospital, Inc. his/her physician signature as verification of inability to work during a specified period of time prior to or after upcoming services at Community Hospital, Inc.
- The patient/guarantor will be asked to provide to Community Hospital, Inc. a written statement from his/her employer as to whether or not employment will be available to this patient/guarantor and the estimated amount of projected yearly income when his/her physician allows him/her to re-enter employment.
- When the patient's/guarantor's yearly family income for the past twelve (12) months exceeds the Federal Poverty Income Guidelines plus 200%, but the patient/guarantor does not anticipate returning to work within ninety (90) days of the date of discharge, the projected family income becomes the determining factor.

The Approval/Denial process is as follows:

1. The Collections Coordinator and/or the Supervisor will review the applications and approve/deny them based on the guidelines set forth in this policy.
2. If the application is denied for any reason (missing documentation, over DHHS Poverty Guidelines, etc.), a letter will be mailed to the patient/guarantor indicating reason for denial of application. Collections procedures will continue as normal.
3. If the application is approved, written notification will be sent to the address shown on the application once adjustments to account balances have been completed.
4. All applications will be filed in the Patient Accounts Department by alphabetical filing, and kept on file for one (1) calendar year.

Community Hospital will not engage in extraordinary collection actions before it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this policy.

Community Hospital will request payment for any known patient responsibility for medical care (including co-pays, co-insurance or deductibles) at the time of service. When medically necessary care is needed, Community Hospital will not deny or delay that care if an outstanding bill form a previous visit exists. The patient will be billed if they do not qualify for financial assistance or are not able to pay at the time of service.

If the application is denied, any account balances will be processed through normal billing and collection procedures.

Dear Valued Customer/Patient,

Thank you for choosing Community Hospital, Inc. for your healthcare needs. Community Hospital, Inc.'s Financial Hardship program is available to assist those patients determined to qualify without regard to race, ethnicity, creed, or national origin. Eligibility for this service is income-based. In order to process your application, the following documentation, if applicable, will be required for accurate processing of your application:

1. Verification of monthly income for self and/or anyone listed within the house hold (ex. 2 consecutive check stubs if paid bi-weekly, 4 consecutive check stubs if paid weekly, etc.) If you are unable to obtain check stubs, then a letter from your employer on letterhead with employment verification, hourly pay, how often paid, etc.
2. Verification of social security/disability benefits for self and/or anyone listed within the house hold
3. Verification of food stamp benefits received for self and/or anyone listed within the house hold
4. Verification of child support payments received for self and/or anyone listed within the house hold
5. Most recent tax return in its entirety. If patient has not filed taxes within past **5 years** then they can contact the IRS at # 800-908-9946 to obtain a transcript for the last return filed. If this situation exists, the patient can sign the last page of the application.
6. **Three consecutive** bank statements for checking and/or savings account; sign the last page of the application if you do not have a checking and/or savings account

We have enclosed an application for you to complete and return, along with the information requested above if applicable. It is very important that we receive this completed application and information within **fifteen (15) days from the date of service from the hospital.** If the required information is not received within this time frame or your application is incomplete when returned, your application may be denied, in which case you will have to reapply. In addition, your account will be subject to our normal collections procedures. Please note that all applications to this program are subject to credit check for verification of information. **Any false information provided will disqualify your application and may disqualify you from applying to the program in the future.**

You will be notified either by telephone call or written notification in the mail as to whether your application has been approved or denied. If your application has been denied, you will need to set up acceptable payment arrangements on your account(s). If your application is approved, you will be notified of the amount of the discount given and the remaining balance, if any, will need to be set up on payment arrangements.

Once you have completed the application and gathered the required documentation, please call Crystal Chandler at (334) 283-3736 (Last name A-L) or Sarah James at (334) 283-3850 (Last name M-Z) to arrange a time to finalize the application process.

Sincerely,

Patient Accounts Department

Request for Financial Hardship Application
Community Hospital, Inc.
Tallassee, AL 36078

I would like to apply for the Financial Hardship Policy, under the provision set for by Community Hospital Inc.

1. Patient Name: _____ Date of Birth: _____

   Address: _____

   Telephone Number(s): _____

   Employer Information: _____

2. List all members of your household (Including Self).

Name	Age	Relation	Occupation
_____	_____	SELF	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Income:

Monthly Wages: _____ Yearly Wages: _____

4. Public Assistance:
   A. Have you applied for Medicaid? _____
   B. What was the response received? _____
   C. Are you currently receiving Public Housing Assistance? _____ (If you answer "Yes", then please provide a letter from your Public Housing Authority)

5. Admitting Diagnosis: _____

6. List Patient Account Numbers & Date(s) of Service:

New/Add	Account #	Date of Service	Account Balance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby request that my application for Financial Hardship be reviewed by Community Hospital, Inc. Patient Financial Services. I understand that the information submitted herein is subject to verification by Community Hospital, Inc. I also understand that if the information that I have submitted is determined false, it will constitute fraud. Such determination will result in denial of Financial Hardship, and I will be liable for charges for services provided.

_____ _____

Signature (Patient/Guarantor) Date

OFFICE USE ONLY

_____
_____
_____
_____
_____
_____

Medicaid Request for Financial Hardship

This form is to be used for Medicaid patients who were **eligible for Medicaid at the time of service** but used all their inpatient days, had uncovered charges such as SNF, or had other extenuating circumstances that prevented them from meeting their financial responsibility to Community Hospital, Inc. These patients have already be determined to be indigent by the State of Alabama or other state, and therefore meet the Financial Hardship requirements.

Patient Name: _____ Date of Birth: _____

MEDICAID Number: _____

List of Account Number(s) & Balances: #_____ $_____
#_____ $_____
#_____ $_____

Did the patient also have Medicare on this date of service?
Yes (___) No (___) MEDICARE Number: _____

If the patient was a Medicare recipient, was Medicare filed?
Yes (___) No (___) If No, Why? _____

Reason for Financial Hardship: (Please indicate)

(___) Used all inpatient Medicaid days
(___) SNF Services
(___) Other (Please Explain): _____
_____
_____

Comments:
_____
_____
_____
_____

DATE: _____

APPLICANT'S NAME: _____

I, _____, do certify that I have not filed Income Taxes and therefore did not have any income that should have been reported to the Federal or State Government for the last five (5) years. I understand that any false information provided will disqualify my application and will prevent me from applying for this program in the future.

_____
Signature of Applicant

I, _____, do certify that I do not have any type of banking or savings account in which I have funds that I have not disclosed to Community Hospital, Inc. . I understand that any false information provided will disqualify my application and will prevent me from applying for this program in the future.

_____
Signature of Applicant