

Summary of Financial Assistance Policy

Memorial Hospital and Health Care Center is a non-profit entity established to meet the health care needs of the citizens of Dubois and surrounding counties. Sponsored by the American Province of the Little Company of Mary Sisters, the Hospital is committed to treat all patients with respect and fairness regardless of their ability to pay. It is understood that a patient's financial status may change over time, and the Hospital will re-establish a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need.

Who Is Eligible?

Under the Financial Assistance Policy, a patient will qualify for full or partial financial assistance if the patient is not eligible for group health insurance through an employer, and the patient's household income is less than 200% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household, or if the patient's household income is between 200% and 400% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household. Patients who are eligible for financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage. Prior to seeking Financial Assistance under the this Policy, all patients or their guarantors are encouraged to consult with a Patient Resource Claim Aide Advocate to determine if healthcare coverage may be obtained from a government insurance/assistance product or from the Health Insurance Exchange.

What Services Are Covered?

Services eligible for financial assistance are all emergency and medically necessary inpatient and outpatient services wholly owned and offered by the Hospital. Services of Hospital employed physicians and healthcare providers are also eligible for financial assistance. Financial Assistance is not available for elective procedures such as cosmetic, surgical weight loss or experimental procedures (including non-FDA approved devices), specialty replacement lenses, hearing aids, services denied by insurance for no prior authorization or non-emergency services provided as a result of being out-of-network.

How Can I Apply?

To apply for financial assistance, an individual typically must complete a written application. The individual must provide particular supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Application. Both the policy and application can be downloaded from the Memorial website www.mhhcc.org or can be obtained for free from the Memorial Hospital at the main Registration Desk, the registration area of the Emergency Room, or the Cashier/Financial Counselor Office. The Financial Assistance Application can also be found on the back of your hospital bill/statement. You may request an application by emailing financialassistance@mhhcc.org or by calling 812-996-0413 and should be returned to the Cashier/Financial Counselor Office of Memorial Hospital and Health Care Center.

How Can I Get Help with an Application?

For help with a Financial Assistance Application, you may contact Patient Financial Services Department of Memorial Hospital and Health Care Center at (800) 852-7279 (toll free) or (812) 996-0637 for last names beginning with A-L OR (812) 996-0413 for last names beginning with M-Z. You may also request assistance through email: financialassistance@mhhcc.org.

How Can I Get More Information?

Copies of the Financial Assistance Policy and Financial Assistance Application form can be downloaded from the Memorial website www.mhhcc.org or can be obtained for free from the Memorial Hospital at the main Registration Desk, the registration area of the Emergency Room, or the Cashier/Financial Counselor Office. Request for an application can also be obtained by emailing financialassistance@mhhcc.org or by calling 812-996-0413.

The Financial Assistance Application can also be found on the back of your hospital bill/statement.

What If I Am Not Eligible?

Patients who do not qualify for financial assistance under the Financial Assistance Policy may qualify for other types of assistance. For more information, an individual may contact Patient Financial Services Department of Memorial Hospital and Health Care Center at (800) 852-7279 (toll free).

Translations of the Financial Assistance Policy, the Financial Assistance Application, and this plain language summary are available in the following languages upon request: Spanish, Chinese, and German.

MEMORIAL  HOSPITAL
And Health Care Center
Sponsored by the Sisters of the Little Company of Mary, Inc.
800 West 9th Street ▲ Jasper, IN 47546 ▲ 812/996-2345
www.mhhcc.org

FINANCIAL ASSISTANCE PROGRAM

Enclosed you will find the Memorial Hospital and Health Care Center Financial Assistance application. This application will be used to determine full or partial financial assistance on qualifying bills.

Please complete the financial disclosure and provide supportive documentation to be used to evaluate your request for a financial assistance. Return the *completed* Financial Assistance application within 21 days.

The following information must be submitted with the application:

- 1. A letter that includes all circumstances which currently affects your income
- 2. Your most recent Federal Tax and W2 forms
- 3. Current bank statement
- 4. Two - most recent payroll check stubs, even if no longer employed
- 5. Proof or a copy of any Social Security, disability and/or pension income
- 6. Unemployment income verification, if applicable.
- 7. A list of your medical bills – include total amount owed and to whom
- 8. Out-of-pocket expense for prescription medications, monthly or yearly

After the information has been received, your application will be reviewed and a determination will be made. Please contact our office in approximately 30 days for the results of the determination.

Thank you for you for your interest in our program.

If you have questions or need further assistance, please contact:

Patient Financial Services Department

Memorial Hospital And Health Care Center

(800) 852-7279 Toll Free

(812) 996-0637 for last names beginning with A-L

(812) 996-0413 for last names beginning with M-Z

Fax (812) 996-8544

financialassistance@mhhcc.org

gdanhafe@mhhcc.org OR rrobinson@mhhcc.org

**MEMORIAL HOSPITAL AND HEALTH CARE CENTER
FINANCIAL ASSISTANCE APPLICATION**

Full and complete financial disclosure is required in order to evaluate your request for financial assistance. Incomplete or insufficient information will result in a denial of your request.

Name	Date of Birth	SS#
Spouse's Name	Date of Birth	SS#
Address	City	State/Zip Code
Phone Number	Marital Status	Email Address

Dependents and/or members living in your household:

Name/Age	Name/Age
Name/Age	Name/Age
Name/Age	Name/Age
Name/Age	Name/Age

Employer	Phone #
Rate of Pay \$ -- Hour/Week/Month	Length of Employment

Spouse's Employer	Phone #
Rate of Pay \$ -- Hour/Week/Month	Length of Employment

Group Health Insurance and/or Private Health Insurance: Yes No
If no, explain why no health insurance coverage

Have you applied for Medicaid? Yes No
If you have applied and did not receive, what was the reason?

OTHER INCOME SOURCE	APPLICANT	SPOUSE	OTHER
Social Security	\$ per month	\$ per month	\$ per month
Pension/Retirement Funds	\$ per month	\$ per month	\$ per month
Welfare/Public Assistance	\$ per month	\$ per month	\$ per month
Food Stamps	\$ per month	\$ per month	\$ per month
Unemployment	\$ per month	\$ per month	\$ per month
Child Support	\$ per month	\$ per month	\$ per month
Interest Income/Stock Bond/CD Investments	\$ per month	\$ per month	\$ per month

Bank Name:	Checking Account: \$
	Savings Account: \$
Life Insurance Company Name:	Cash Value: \$
Personal Property:	Value: \$
Vehicles:	Value: \$

Financial Obligations (Monthly):

Rent: \$	Mortgage: \$	Phone/Basic: \$	Cell Phone: \$
Electricity: \$	Gas/Propane: \$	Food: \$	Other: \$
Insurance: \$	Clothing: \$	Education: \$	Credit Cards: \$

Loans (Whom do you owe?):

Financial Institution:	Monthly Payment: \$
Financial Institution:	Monthly Payment: \$

Other Obligations:
Medical Obligations:

I understand that the information which I submit is subject to verification by Memorial Hospital And Health Care Center. I certify that the above information is true to the best of my knowledge.

Signature of Patient (Responsible Party)	Date:	Phone #:
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Current Status: Active

PolicyStat ID: 3926004



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800 West 9th Street ▲ Jasper, IN 47546 ▲ 812/996-2345

www.mhhcc.org

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Owner: Jodi Richardson: Director
Behavioral Health Services

Policy Area: Organizational

References:

Financial Assistance

POLICY:

Memorial Hospital and Health Care Center is a non-profit entity established to meet the health care needs of the citizens of Dubois and surrounding counties. Emergency and medically necessary treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. Sponsored by the American Province of the Little Company of Mary Sisters, the Hospital is committed to treat all patients with respect and fairness regardless of their ability to pay. The guidelines contained in this policy are to be used by the Patient Financial Services staff to make a good faith determination of financial need based on the individual patient's circumstances. It is understood that a patient's financial status may change over time, and the Hospital will re-establish a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need.

This Policy is intended to comply with Section 501(r) of the Internal Revenue Code and related regulations. Memorial Hospital and Health Care Center will provide services to all patients for emergency medical conditions without discrimination (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd) regardless of their eligibility under this Financial Assistance Policy. This policy covers all patient care services provided under Memorial Hospital and Health Care Center current Tax Identification Number including; Acute, Behavioral Health, Inpatient Rehab, Skilled Nursing, Professional/Physician, Medical Practice Management, Ambulance, Home Health and Durable Medical Equipment.

Financial Assistance is **not** available for elective procedures such as cosmetic, surgical weight loss procedures, experimental procedures (including non-FDA approved devices), specialty replacement lenses, hearing aids, services denied by insurance for no prior authorization or non-emergency services provided as a result of being out-of-network.

Financial Assistance may not be granted on zero balance accounts or accounts that may have established payment plans through financing options such as CarePayment. Accounts that have been placed with an external collection agency and are beyond the 240 day threshold may not be granted financial assistance.

This Organizational policy will address financial assistance for 1) Memorial Hospital Financial 2) Medical Practice Management (MPM) Sliding Fee Clinic-Based and 3) Memorial Counseling Center.

EQUIPMENT/FORMS:

Financial Disclosure Form

[Financial Application Cover Letter \(PFS 1\)](#)

[Financial Application Sliding Fee Notification Letter \(PFS 2\)](#)

[Sliding Fee Financial Application \(PFS 3\)](#)

[Federal Poverty Guidelines \(PFS 4\)](#)

Procedure:

Memorial Hospital Financial Assistance

- a. Appropriate signage will be visible in the Hospital and all Hospital-owned facilities, specifically in patient access areas, creating awareness for the financial assistance program and the financial assistance that is available. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area.
- b. Financial Assistance Applications can be downloaded from the Memorial website www.mhhcc.org or can be obtained for free from the Memorial Hospital at the main Registration Desk, the registration area of the Emergency Room, or the Cashier/Financial Counselor Office. Request for an application can also be obtained by emailing financialassistance@mhhcc.org or by calling 812-996-0413.
- c. Services eligible for financial assistance are all emergency and medically necessary inpatient and outpatient services wholly owned and offered by the Hospital. Services of Hospital employed physicians and healthcare providers are also eligible for financial assistance. A listing of physicians and healthcare providers covered by this policy is available: 1) in the attached Addendum A. 2) By contacting the Patient Financial Service Department or Cashier/Financial Counselor Office at 812-996-0413. 3) Accessing on Memorial website www.mhhcc.org. 4) Requesting a free copy by emailing financialassistance@mhhcc.org.
- d. The financial applications should address the following criteria:
 1. Marital Status
 2. Number of Dependents
 3. Income, Assets and Liabilities
 4. Estimated Medical Bill
 5. Other Hardships (unemployment, disability, extraordinary family expenses, etc.)
 6. Eligibility of Health InsuranceApplications should be made by the patient, parent(s) of a minor, Power of Attorney, legal guardian, guarantor, estate representative, or person with signed consent for the patient or family members before or during Hospital service, but may be made up to 240 days from the date of the first patient statement. In order to be eligible for financial assistance, patients must complete a Financial Disclosure Form and provide all required documentation needed to make eligibility determination. The Financial Disclosure Form will remain in effect for six months or until patient's financial circumstances change, whichever comes first.
- e. The Hospital reserves the right to request documentation of income, banking information and balances, tax returns, etc. to assist the Hospital in the determination of the ability to pay. Documentation (such as pay check or unemployment stubs, W-2's, income tax returns, etc.) to support the amounts identified on the financial worksheet must be obtained. It is recognized that needs and the availability of information vary among patients, and the Hospital will work with patients and families during the documentation

gathering process. A patient may be denied financial assistance if the patient knowingly provides false information on the Financial Assistance Application.

- f. The patient should apply for all available assistance through external agencies, and be declared partially or fully ineligible for such assistance. The Hospital shall offer assistance to the patient during this process.
- g. If during Patient Financial Services' financial counseling or collection process, it appears that an individual may not have the financial resources to pay for services not covered by a third party payor, then a Financial Disclosure Form (Credit Assessment) should be completed by the patient. In addition, other members of the Hospital staff (e.g., Social Worker) may identify individuals who may qualify for financial assistance. This information should be forwarded to the Patient Financial Services Department. In no event, should any staff member, except the Patient Financial Services or Physician Office staff, communicate to the patient or family member that they **will** qualify for financial assistance.
- h. Presumptive Eligibility may be granted up to 100% charity level in the following situations:
 - 1. Deceased patients with no estate and have no surviving spouse.
 - 2. Patients who are homeless and receiving assistance from supportive services such as governmental, religious or community services. Presumptive Eligibility will require verification to be attached to a Financial Assistance Application.
- i. The Patient Financial Service Department will have the responsibility for taking action against patients for non-payment. Patients will be notified, in writing via statement or letter, 30 days prior to taking such action. These actions may include but is not limited to; placing accounts with external collection agencies, placing accounts with credit reporting or credit scoring services, taking legal action which may include garnishing wages and filing liens on property. These collection activities may occur after 120 days from date of the patient's first statement. Patients will have 240 days from the date of the first patient statement to apply for the Financial Assistance Program. The Director of Patient Financial Services will have the responsibility and authority to determine if reasonable efforts were taken to determine if an individual is eligible for Financial Assistance.

- j. A patient will qualify for full or partial financial assistance if either of the following exists:

Full Financial Assistance

The patient is not eligible for group health insurance through an employer, and the patient's household income is less than 200% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household, or;

Partial Financial Assistance

The patient's household income is between 200% and 400% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household. The amount of the partial financial assistance will be equal to the Amounts Generally Billed (AGB) and will be recommended by the Director of Patient Financial Services based upon disposable household income and the following criteria:

- 1. The patient's medical or hospital bills after payment by third party payors exceed 25% of the patient's household annual gross income as determined through a completed Financial Disclosure Form. The amount of the partial financial assistance will be recommended by the Director of Patient Financial Services.
- 2. The patient's medical or hospital bills are catastrophic in nature, and payment of the bill would require liquidation of assets critical to living or would cause undue financial hardship to the family support system. The amount of the partial financial assistance will be recommended by the Director of Patient Financial Services.

In no instance shall patient charges be written off when the patient's household income exceeds four times the Federal Poverty Guidelines for a family of four, as periodically published in the Federal Register.

3. Patients that are eligible for partial financial assistance will not be charged more for emergency or other medically necessary care than AGB (Amounts Generally Billed) to individuals who have insurance covering such care. The organization will use the Look-Back Method using commercial payment method for calculating AGB per IRC Section 501(r)(4)(b)(2)(i)(C) of the Treasury Regulations. Memorial Hospital and Health Care Center determines AGB by dividing the sum of all the hospital's claims for emergency and other medically necessary care that were allowed by health insurers by the sum of the total gross charges for such claims. The full amount allowed by a health insurer includes both the amount to be reimbursed by the insurer and the amount the individual is personally responsible for paying in forms of deductibles, coinsurance and copays. The AGB calculation is performed annually and is described in Addendum B of this policy. Once eligibility for financial assistance is approved, the hospital will apply the applicable partial Financial Assistance amount and provide additional discount amount to reduce the balance to the AGB percentage. See Addendum B. for the current AGB percentage.
- k. Waiver of Medicare cost-sharing amounts for those experiencing financial hardship will be considered for financial assistance after, determining in good faith, the financial need criteria for financial assistance established by this policy are met. Waivers will not be offered as part of any advertising campaign or solicitation, and will not be offered routinely without regard to financial need. The Hospital will claim such waivers of cost-sharing amounts as Medicare Bad Debts provided that the patient qualifies for financial assistance, and the Hospital determines that no other source other than the patient is legally responsible for the unpaid cost-sharing amounts.
- l. A review of the patient account should be made and final classification determined, subject to the following approval limits:
 1. Director of Patient Financial Services <= \$5,000
 2. Vice President Finance & CFO \$5,001 - \$25,000
 3. Board of Directors > \$25,000

Medical Practice Management (MPM) Sliding Fee Clinic-Based Assistance

- A. Martin County Health Center, Memorial Family Care and Petersburg Family Medicine offer a sliding fee. The sliding fee schedule is used to calculate the basic discount and is updated each year using the [Federal Poverty Guidelines \(PFS 4\)](#) . If approved, the discount will be honored for 6 (six) months and a patient sliding fee scale card will be issued to the patient with a six month span of coverage. Charges accrued three months before the completion of the Financial Application will be eligible for the discount. In the case of retroactive coverage the six month period begins at retroactive effective date.
- B. The sliding fee is applicable to **office charges only at office of issue**. For services received at another MHHCC location or Memorial Hospital, the patient should apply for Financial Assistance through Patient Financial Services office as detailed in this policy.
- C. For the Sliding Fee, the patient must first apply for Medicaid and have proof of ineligibility. After Medicaid denial is documented, a [Sliding Fee Financial Application \(PFS 3\)](#) will be completed to the best of the applicant's ability. Required documentation as listed on application must be provided to the office staff. The office staff at Martin County Health Center, Memorial Family Care or Petersburg Family Medicine will enter patient financial information into the Greenway EMR on Patient Registration screen using Sliding

Fee tab. Staff will attempt to determine eligibility at the time of service. In the event eligibility is not determined at the time of visit, a letter will be mailed to patient address on record as soon as determined.

Memorial Counseling Center:

- A. Given the unique needs of the behavioral health population that is served at Memorial Counseling Center, as well as the lack of insurance parity, it is necessary that Memorial Counseling Center utilize discounts for services and manage the application process and approval process within the office of Memorial Counseling Center.
1. Memorial Counseling Center offers an income based discount using the [Federal Poverty Guidelines \(PFS 4\)](#). The income based discount schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for 6 (six) months at Memorial Counseling Center only. Charges accrued three months before the completion of the Financial Application will be eligible for the discount.
 2. For the income based discount, the patient must first apply for Medicaid, if applicable, and have proof of ineligibility. After Medicaid has denied or if Medicaid is not appropriate given the patient situation (i.e. lack of insurance parity), then a [Sliding Fee Financial Application](#) will be completed to the best of the applicant's ability. Required documentation (i.e. W-2 form or 2 payroll stubs) will be provided with the Memorial Counseling Center Financial Application to the office workforce. The patient who does not have proof of income will be asked to write a letter explaining his/her circumstance (i.e. doesn't work at all or is paid cash.) Workforce at Memorial Counseling Center will determine the patient's eligibility and enter the determined discount into Greenway EMR and issue the patient a notification as requested using the [Financial Application Sliding Fee Notification Letter \(PFS 2\)](#). Memorial Counseling Center workforce will maintain a tracking document of all patients who are utilizing income based discounts. They will be able to determine eligibility at the time of service. The patient will need to reapply at the end of the 6 (six) months.

Attachments:

[Addendum A. Memorial Hospital Physician and Provider Group List \(01-08-18\).xlsx](#)
[Addendum B. Amounts Generally Billed Calculation.docx](#)
[FAP Application 04-18.pdf](#)
[FAP summary plain language 04-18.pdf](#)

Approval Signatures

Approver	Date
Ted Miller: Vice President of Finance and CFO	04/2018
Krista Schroering: Revenue Cycle Director	04/2018
Amy McConnell: Director Medical Practice Management	03/2018
Jodi Richardson: Director Behavioral Health Services	02/2018