

ADMINISTRATIVE POLICIES

SUBJECT: **Financial Grant**

FORMULATED: **April 2002**

REVIEWED: **May 2005**

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POLICY: St. Elizabeth Health Services, Inc. (SEHS) will provide health care services to all persons who are in need, regardless of age, race, religion, national origin, gender, handicap, sexual orientation or ability to pay. This statement of policy reflects our mission to be a leader in addressing the greatest healthcare needs in our community.

PROCEDURE:

1. The **Financial Grant (Charity Assistance) policy** will be modeled after the CHI policy effective July 1, 2004 (Attachment 1). Nothing in this policy will supersede the CHI policy unless actions taken here are more liberal in applying the financial assistance standards.

2. All patients of SEHS will have the option to make an application for a **Financial Grant**. When at all possible the determination to provide a grant should be made before the actual provision of services performed.

Patients receiving emergency services should be cared for in accordance with the hospital's Emergency Services policy as developed in accordance with EMTALA and other requirements. Upon registration, those patients without Medicare/Medicaid or adequate health insurance should receive a packet of information that discusses the hospital financial grant policy.

If complete information on the patient's insurance or financial situation is unavailable, or if the patient's financial circumstances change, the designation for a Financial Grant may be made after rendering services and in some circumstances even after the rendering of the bill. An account may be considered for Financial Grant at any time a patient qualifies for Financial Grant assistance.

3. Any employee of St. Elizabeth Health Services may give an application for Financial Grant determination to an interested patient.

4. The application process consists of:
 - a. Completion of the Confidential Financial Statement. (Attachment B)

- b. Proof of income; the previous year's tax return, a recent bank statement, two recent paychecks, or other income documentation as stated on the Confidential Financial Statement. Financial Grant applications will not be processed until information is received. In instances where the patient does not complete the application for financial assistance, the hospital may choose to grant charity care, without a formal request based on presumptive circumstances as approved by the Chief Financial Officer. Examples of presumptive circumstances are: patient is deceased with no known estate; patient is homeless or family/friends provide undocumented information establishing the patient's inability to pay
5. *Evaluation of the application will include a review of the income within the household and a review of the assets of the patient. The grant may be denied if a patient has excessive assets, or assets above the average living needs. Selected Patient Account Staff will review hardship cases individually for approval of Charity (Financial Grant). If a patient's account has been sent to collections and subsequently is determined to be eligible for charity, the account will be reclassified from bad debt to charity.*

The amount of charges eligible for Financial Grant adjustment will be based on the HUD very low-income guidelines. An account can only be considered for a Financial Grant once. Patients with family income below the HUD very low-income guidelines are eligible to receive free care. Patients with monthly family income between the HUD very low-income guidelines and a multiple of one and a half times the HUD very low-income guidelines are eligible for reduce-priced care.

The Income Eligibility amounts shall be updated annually, upon publication of the updated HUD very low-income guidelines. The current year (2004) monthly HUD very low-income guidelines, with sliding scale amounts also listed, are as in Attachment C.

- 6. Normal charging procedures will be followed for all charity care patients.
- 7. A committee consisting of the following individuals will meet monthly to review accounts for medical necessity and other possible actions for inclusion as an accepted applicant:

George Winn	President and CEO
Jeff Daniels	Chief Financial Officer
Janet Hanna	V.P. Patient Care Services
Michelle Paoletti	Patient Access Supervisor
Jerry Nickell	V.P. Mission Services
John Davis	Social Worker

8. Applications under \$2500 that meet all of the qualification will be processed without additional approval. Applications \$2500 and over shall be forwarded to the Patient Access Supervisor for review and then to the Chief Financial Officer for approval
9. The applicant shall be notified of approval or denial within two weeks of the completed application and documentation:
 - If a patient qualifies for a Financial Grant, a letter of approval is sent. The appropriate service area: CBO, MOB/Pro-fee or Long-Term Care will also receive notice for them to adjust the account.
 - If a patient does not qualify for a Financial Grant a letter of denial is sent. The Patient Account staff reviews the account and contact is made with the patient to set up payment arrangements.
10. Financial Limits (Charity Care Limits):
 - Hospital services, including emergency room, pro-fee and MOB services for emergency patients will have no annual limit.
 - Services in Long-Term Care and for MOB non-emergency services will be limited to the first \$5,000 of charity services during the fiscal year for each area.
11. Financial Grant Status shall remain in effect for three (3) months from the date of approval. After three (3) months a new application is then required. An account can only be considered for a Financial Grant once.
12. A running list of Financial Grant applications will be maintained. The list will contain at a minimum the following data:
 - Date approved
 - Patient's name
 - Discount percentage
 - Account number and division (Facility, MOB, Profee)
 - Dollar amount of charity by division.
13. Notwithstanding any of the forgoing if it is determined that an individual qualifies for financial assistance due to presumptive eligibility the appropriate checklist will be completed and the account will be noted appropriately.
14. This policy will not be modified without approval of the finance committee of the board.

Financial Grant Policy

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Approved: Finance Committee and Board of Directors
Date: August 1, 2004 formulated (presented at following meetings of above bodies).

St. Elizabeth Health Services
Confidential Financial Statement

Financial Assistance Application

Patient Name		Account #		Date of Birth	Social Security #
Guarantor's Name		Relationship to Patient		Date of Birth	Social Security #
Spouse or Significant Other		Relationship to Patient		Date of Birth	Social Security #
Guarantor's Address		City, State, Zip		Home Phone #	Length of Residence
Previous Address (if less than 2 years at above)		City, State, Zip		Marital Status	# Of Dependents in Household
List first and last Names, and Ages of All dependents in Household:					
LIST ALL INCOME FOR THE LAST 12 MONTHS ATTACH PAPER IF NECESSARY. IF UNEMPLOYED PLEASE ATTACH AN INCOME EARNINGS STATEMENT FROM THE EMPLOYMENT OFFICE					
Employer (Guarantor/Patient)		Previous Employer (Guarantor/Patient)		Spouse Employer	Spouse previous employer
Address					
Job Title/Length of Employment					
Business Telephone #					
Hourly Rate					
Monthly Income Gross					
Monthly Income Net					
Other Income Source and Amount		Total Family Monthly Income		Total Family Income last 12 months	
Have you applied for Medicaid or any other State/County Assistance? (check one) YES _____ NO _____					
Application Date			Caseworker Name/Telephone Number		
Have you filed Bankruptcy? Yes _____ No _____		Chapter 7	Chapter 13	Date Filed	Date of Discharge
Are you a Homeowner? Yes _____ No _____		Approximate S Value		Approximate Balance on Loan	Years left on Loan
Bank Name		Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance
AUTOMOBILE(S)		Model:	Year:	Pymt Amount:	Balance Due:
1. Make:		Model:	Year:	Pymt Amount:	Balance Due:
2. Make:		Model:	Year:	Pymt Amount:	Balance Due:

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Other Assets (Stocks Bonds, Property, Boat, Business, etc.)					
Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	\$			\$	\$
Charge Cards	\$			\$	\$
	\$			\$	\$
	\$			\$	\$
Bank Loans	\$			\$	\$
	\$			\$	\$
School Loans	\$			\$	\$
List Other Expenses Below:					
	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	\$	MEDICATION	\$	AUTO INS	\$
UTILITIES	\$	LIFE INSURANCE	\$	OTHER	\$
GAS (CAR)	\$	MEDICAL BILLS	\$	OTHER	\$
TOTAL MONTHLY EXPENSE	\$				

Note: Attach additional sheet if necessary. Important: Income verification must be attached – W2, Pay Stub, Tax Return, etc. Failure to attach income verification and to fill out application the application will be returned.

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of _____ information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize _____ to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)	Date	Witness	Date
Signature (Spouse)	Date	Witness	Date

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DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

- 1: Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.
- 2: Complete the guarantor and spouses name, relationship to patient, date of birth, and social security number. If the guarantor or spouse is the same as the patient, note "Same as patient" in this field.
- 3: Complete the guarantor's address, home telephone number and length of residence at this address.
- 4: Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-" in the dependent field.
- 5: List the names and ages of all dependents.
- 6: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.
- 7: Complete the previous employer information for the guarantor/patient for past 12 months. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A".
- 8: Complete the income information for the guarantor/patient's spouse for past 12 months. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A".
- 9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), and then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.
- 10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.
- 11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.
- 12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".
- 13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.
- 14: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.
- 15: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

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HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

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AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this section.

PLEASE READ THE FINE PRINT!!!!!!

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DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. **All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.**

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing St. Elizabeth Health Services to obtain credit information and perform a credit check.