PALACIOS COMMUNITY MEDICAL CENTER
POLICY / PROCEDURE

SUBJECT: CHARITY CARE PROGRAM	DATE: 1/1/2019
APPROVAL: David H. Mak, CFO BOARD APPROVAL DATE:	REVISED:

POLICY

All patients who cannot provide major medical insurance, Medicare, Medicaid, or other third party payment services and who request assistance through the Palacios Community Medical Center (Hospital); Charity Care Program (CCP) will be screened for their ability to pay charges. Also, those patients with insurance whose co-insurance amount is excessively high may apply under the same CCP guidelines as those with no insurance. Hospital reserves the right to refuse assistance for debts incurred due to drug and/or alcohol related diagnosis. The amount of charity applied to an account will be determined by the guidelines established through this policy. Charity care does not include private physician charges, tests performed by other facilities, or care provided in other hospitals. Charity care will always be a payer of last resort. A program will be established to monitor and verify all charity applications.

STATEMENT OF PURPOSE

As part of the Hospital's mission to serve the health care needs of Matagorda County, and as required to be a Medicare provider, Hospital will provide financial assistance to patients without financial means to pay for Hospital services.

Financial assistance will be provided to all qualifying patients who present themselves for care at Hospital without regard to race, religion, sexual orientation or national origin and who are classified as financially indigent or medically indigent according to this policy.

Hospital shall determine the ability of patients and/or legally responsible individuals to make payments for Hospital services taking into consideration the rights and human dignity of the individual. Every effort shall be made to stimulate an attitude of independence through encouraging the person to develop his or her own resources; however, prompt determination of need and supplying care and treatment is in the best interest of the patient's welfare.

The individual's right of self-determination dictates the retention of choice of whether or not he or she seeks financial assistance. Therefore, in all cases the request for aid and the proof of eligibility is the responsibility of the patient. Hospital will maintain the confidentiality of patient's financial and medical information.

This policy is intended as a guideline for determining eligibility of the individual and the charity responsibility of the Hospital. Because the policy addresses individuals in a healthcare environment, it may become necessary for the Hospital to make an exception or to override this

policy. With appropriate documentation, the Hospital Administrator along with approval from the Chief Financial Officer may make exceptions in catastrophic cases.

DOCUMENTATION

1. Each patient applicant will be required to complete and sign the Charity Care Questionnaire and Application in forms similar to that attached as Exhibit A.

2. Data requiring verification to determine eligibility for Charity Care Program are in the areas of patient identification, income and patient or responsible party, debt and financial responsibilities, and the number of dependents in the family.

3. Identity may be established by producing any two (2) of the following:

   a. Social Security Card
   b. Driver's License
   c. Voter Registration
   d. Credit Card
   e. Employee Identification
   f. Birth Certificate
   g. Baptismal Record
   h. School Transcript
   i. Marriage License
   j. Medicaid or Medicare Card

4. The following sources must be included as income verification. Verification of these sources of income and amounts requires last year's IRS 1040 Form or W-2 or a statement from an employer. Check stubs may also be used to determine current income status.

   a. Wages and Salaries before deduction
   b. Self-Employment Income
   c. Farm Income
   d. Public Assistance
   e. Social Security
   f. Unemployment Benefits
   g. Worker's Compensation
   h. Strike Benefits
   i. Veteran's Benefits
   j. Child Support
   k. Pensions
   l. Annuities
   m. Income from Dividends
   n. Income from Interest
   o. Rents
   p. Royalties
   q. Income from Estates and Trusts

5. Proof of dependency is the responsibility of the applicant. Any person dependent on the family income for over 50% of his or her support may be considered a dependent. Dependency may be evidenced by any of the following:

   a. Current Income Tax 1040 and 1040A, listing dependents
   b. School Records
   c. Birth Records
   d. Hospital Records
   e. Baptismal Records

f. Proof of Guardianship
g. AFDC Records

6. Copies of all documents used for certification of identity, income and dependency will be attached to the Charity Care Questionnaire, and retained in Hospital's records.

7. When proof of identity, income and dependency have been established, the patient's financial qualifications will be established from the Charity Care formula, as attached at Exhibit B.

8. When it is established that the patient is to be either Charity or Partial Pay, the following processes will take place:

   a. Patient or guarantor will be required to either pay or sign a note and make arrangements to pay the obligations, if any.
   b. The balance of the account will be reduced if patient qualifies.
   c. If the patient qualifies under the CCP, then that determination will be effective for the next six (6) months from the date of determination.

ELIGIBILITY

1. Financially Indigent.

   a. A financially indigent patient is defined as a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the Hospital's eligibility criteria set forth in the policy.

   b. To be eligible for complete financial assistance as a financially indigent patient, a person's income shall be: (i) at or below 300 percent of the federal poverty guidelines; (ii) between 300 and 700 percent a sliding scale benefit is available; and (iii) for patients with income exceeds 700 percent of the poverty guidelines may be eligible to receive discounted rates or adjustments based on charity care provisions, based on a case by case basis on their specific circumstances the final determination of such shall be solely within the Hospital's discretion. The Hospital may consider other financial assets and liabilities of the person when determining eligibility.

   c. The Hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The poverty income guidelines are usually published in the *Federal Register* in February of each year and for purposes of this policy will become effective the first day of the month following the month of publication.

   d. Other than as stated in Paragraph (b)(iii) in no event will the Hospital establish eligibility criteria for financially indigent patients which base the income level for financial assistance lower than that required for counties under the Texas Indigent Health Care and Treatment Act, or higher than 300 percent of the federal poverty guidelines. The Hospital may, however, adjust the eligibility criteria from time to time

based on financial resources of the Hospital and as necessary to meet the financial assistance needs of the community.

2. Medically Indigent.

   a. A medically indigent patient is defined as a person who's medical or hospital bills after payment by third-party payers exceed a specified percentage of the person's annual gross income as established in this policy and who is unable to pay the remaining bill.

   b. To be eligible for financial assistance as a medically indigent patient, the amount due and owing by the patient on the Hospital bill after payment by third party payers must exceed 10 percent of the patient's annual gross income and the patient must be unable to pay the remaining bill. The Hospital may consider other financial assets and liabilities of the person when determining ability to pay. Hospital bills greater than 10 percent of annual income may be eligible for discount, subject to Hospital approval.

   c. A determination of a patient's ability to pay the remainder of the bill will be based on whether the patient can reasonably be expected to pay the account in full over a three (3) year period.

   d. If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date.

3. Presumptive Financial Assistance Eligibility.

   There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, the Hospital could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

      1. State-funded prescription programs;

      2. Homeless or received care from a homeless clinic;

      3. Participation in Women, Infants and Children programs (WIC);

      4. Food stamp eligibility;

      5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/subsidized housing is provided as a valid address; and

8. Patient is deceased with no known estate.

9. Historical significance of non-payment that establishes a justification of future non-payment and lack of ability to pay.

PROCEDURE

1. Identification of Financial Assistance Cases.

   a. The Hospital will post notice of its financial assistance program and how a patient may apply for financial assistance.

   b. The Hospital's Chief Financial Officer or a designee will attempt to identify all cases that will qualify as financially indigent cases at the time of Hospital admission. Patients identified as possible financial assistance cases will be offered to complete a financial assistance form (Exhibit A).

   c. The Hospital's Chief Financial Officer or designee will refer those patients who may qualify for financial assistance from a government program to the appropriate program (e.g. Medicaid). Patients who are eligible for Medicaid and other indigent health care programs do not qualify as financial indigent, but the unreimbursed costs of providing services to recipients of these programs shall be reported as government-sponsored indigent health care, by the Hospital.

   d. As soon sufficient information is available concerning the patient's financial resources and eligibility for government assistance, a determination will be made concerning the patient's eligibility for financial assistance. No collection efforts will be pursued on a financial assistance account after such determination.

   e. The current federal poverty income guidelines are included in this policy as Attachment C. This guideline is to be updated annually based on federal data. The definition of "family income" and "exclusions from income" are included in the poverty guidelines and will be used in all financial assistance eligibility determinations.

2. Failure to Provide Appropriate Information.

Failure to provide information necessary to complete a financial assessment may result in a negative determination; however, the account may be reconsidered upon Hospital receipt of the required information. A determination of eligibility for financial assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances, subject to prior Hospital administrative approval.

3. Time Frame for Eligibility Determination.

   A determination of eligibility will be made by the Hospital's Chief Financial Officer or his/her designee within ten (10) working days after receipt of information necessary to make a determination.

4. Approval of Financial Assistance.

   Either the Hospital's Chief Financial Officer or designee shall approve or disapprove the financial assistance application. The patient will be notified in writing of the approval or denial. As a practical consideration, approval shall be valid for six (6) months from the date of determination. However, should information indicate the patient's financial resources have materially improved, the Chief Financial Officer or designee may require a new financial assistance application prior to the expiration of the normal six (6) month coverage.

EXHIBIT A

PALACIOS COMMUNITY MEDICAL CENTER

CHARITY CARE QUESTIONNAIRE

Applicant's Name _____ Relationship to Patient _____

Applicant's DOB _____ Applicant's Marital Status _____

Applicant's SSN_____ Applicant's Phone No. _____

Applicant's Current Address _____

Applicant's Previous Address _____
(if less than 2 years in current address)

Applicant's Email Address _____

Applicant's Spouse Name _____

Applicant's Spouse DOB _____

Applicant's Spouse SSN _____

Name of Patient _____

Patient's DOB _____ Patient's Marital Status _____

Do you have medical insurance? _____

Have you applied for Indigent Care with the County? _____

Were you denied Indigent Care from the County? _____

Have you applied for Medicaid? _____

Were you denied access to Medicaid benefits? _____

Have you applied for benefits with the Social Security Administration? _____

Were you denied benefits by the Social Security Administration? _____

Have you applied for Supplemental Security Income? _____

Were you denied Supplement Security Income benefits? _____

Assets

Home: ( ) Rent ( ) Buy ( ) Own Monthly payment $_____

Auto: Year Make Model Monthly payment $_____

Provide copies of all medical bills in or out of PCMC: Total medical bill amount $_____

PALACIOS COMMUNITY MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Patient Name		Account Number			
Guarantor Name		Birthdate		Age	
Address			Telephone		
Marital Status	Single	Married	Divorced	Widowed	Separated
Patient Social Security Number		Spouse Social Security Number			

County in which you reside in:

I am responsible for the support of the following:

Name	Birthdate	Relationship

Health Insurance / Medicare / Medicaid Information: (Circle One)

Group / Subscriber Number		Policy Owner	

Income: (Monthly)

Social Security	$	Unemployment Compensation	$
Veterans Pension	$	Workers Compensation	$
Railroad Retirement	$	Union Benefits	$
Employment	$	Child Support / Alimony	$
Dividends / Interest	$	Public Assistance, Food Stamps, Aid for Dependent Children	$
Rental Income	$	Other (Specify)	$
Retirement Income	$		$

Employment:

Name of Person Employed	Employer	Gross Pay		
		$	Weekly	Monthly
		$	Weekly	Monthly
		$	Weekly	Monthly

Deductions from Pay:

Federal / State Tax	Social Security	Union	Insurance	Pension	Other
$	$	$	$	$	$
$	$	$	$	$	$
$	$	$	$	$	$

I / We Own the Following:

Cash on Hand / Money in the Bank (Specify Bank)	$
Stocks / Bonds / Securities (Cash Value)	$
Real Estate	$
Other Real Estate (Location)	$

Monthly Expenses:

Automobiles	Car A	Car B	Car C
Year			
Make			
Model			
Balance Owed	$	$	$

Rent / Mortgage	$	Utilities	$	Transportation	$
Real Estate Tax	$	Food	$	Other (Specify)	$

Insurance (Specify Company)	$	Weekly	Monthly

Medical (Specify Hospital or Doctors Name)	$	Weekly	Monthly
Total Medical Bills Owed	$		

Installment Notes (Specify Creditor)	$	Weekly	Monthly

Other Debts (Specify Person or Entity Owed)	$

Comments:

I represent that the above information is true and correct to the best of my knowledge.

Signature: **Date:**

EXHIBIT B

PALACIOS COMMUNITY MEDICAL CENTER
CHARITY CARE FORMULA

Patient Name:

Applicant Name:

1.	Gross Family Income (from IRS 1040 or W-2):		
2.	Other income: (If tax form unavailable detail income Items. I.E. Child Support, Rental Income, Babysitting, And any in-home business)		
3.		:	+
4.		:	+
5.		:	+
6.		:	+
7.		:	+
8.	House payment or Rent (annual):		-
9.	Car payment (not to exceed $200/mo.)		-
10.	75% of Savings Account Balance:		+
11.	CD Balance:		+
12.	Other Liquid Assets: (i.e. Cash Value of Life Insurance)		+
13.	Available Resources:		SUM
14.	Total Medical Bills for Past Two Years:		
15.	Percent Available Resources: (Line 14/Line 13) x 100)		
16.	Any applicant scoring above 15% will be considered for Charity Care.		

APPROVED: ___ DISAPPROVED: ___

Additional Comments regarding determination: _____

PALACIOS COMMUNITY MEDICAL CENTER

CHARITY CARE AGREEMENT

I affirm that the information that I have provided in application for assistance through the Charity Care Program is true and correct to the best of my knowledge.

SIGNED:_____

PRINTED:_____

DATED:_____

EXHIBIT C

Medical Financial Assistance Discount (for 2019) Income Ranges)						
	Sliding Scale Discount based on 2019 FPL					
	100%	80%	60%	40%	20%	0%
Family Size	Base Income Guidelines					
1	$ 37,470	$ 47,462	$ 57,454	$ 67,446	$ 77,438	$ 87,430
2	$ 50,730	$ 64,258	$ 77,786	$ 91,314	$ 104,842	$ 118,370
3	$ 63,990	$ 81,054	$ 98,118	$ 115,182	$ 132,246	$ 149,310
4	$ 77,250	$ 97,850	$ 118,450	$ 139,050	$ 159,650	$ 180,250
5	$ 90,510	$ 114,646	$ 138,782	$ 162,918	$ 187,054	$ 211,190
6	$ 103,770	$ 131,442	$ 159,114	$ 186,786	$ 214,458	$ 242,130
7	$ 117,030	$ 148,238	$ 179,446	$ 210,654	$ 241,862	$ 273,070
8	$ 130,290	$ 165,034	$ 199,778	$ 234,522	$ 269,266	$ 304,010
9	$ 143,550	$ 181,830	$ 220,110	$ 258,390	$ 296,670	$ 334,950