JACKSON GENERAL HOSPITAL FINANCIAL ASSISTANCE POLICY AND PROCEDURE

POLICY STATEMENT

Financial Assistance / Charity Care is provided by Jackson General Hospital, a nonprofit organization, providing quality healthcare services as our communities provider of choice. Eligible patients identified as "uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care is based on their individual financial situation.

PURPOSE

Jackson General Hospital shall assist a patient in applying under its charity care policy for necessary health care rendered to patients, to the extent that they are unable to pay for the care or pay the deductibles or coinsurance amounts required by a third party payer. A person in need of care is considered "indigent" if family income is at or below federal poverty level. No patient is denied uncompensated health care based upon race, creed, color, sex, national origin, sexual orientation, disability, age, or source of income. The safety and quality care, treatment, and services do not depend on the patient's ability to pay.

Basic distinction between bad debts and charity care in the health care setting can be made between un-collectible accounts arising from a patient's unwillingness to pay (bad debt) and those arising from a patient's inability to pay (charity care). Those individuals generally include the recently unemployed; those employed but without employer-provided health insurance; those whose health insurance requires significant deductibles or co-payments; single parents; those recently or currently experiencing a divorce; transients or those without a permanent address; students, as well as spouses and their dependents; retired persons not yet eligible for Medicare; and the elderly who have limited or no Medicare supplemental insurance coverage.

All services including Inpatient, Outpatient and Emergency Room services, are rendered to patients who are under specific guidelines and approved at Jackson General Hospital. Guidelines vary on yearly basis and must be satisfied according to government guidelines. It is the policy to take applications on any patient who has proof of income and meets the criteria set forth in the guidelines.

APPLICABILITY

All eligible patients receiving services for Jackson General Hospital, may include the Morad Hughes Health Center and Physician practices.

REFERENCES

Arnett & Foster, CMS, HFMA

PROCEDURE/GUIDELINES:

Individuals are notified of financial assistance opportunity via signage placed in various waiting areas of the hospital; front business office, registration, insurance billing, and collection offices. Signage lists days available, hours of operations, and contact

information. On the back of the financial statements also lists contact information for how to apply for financial assistance. Business cards are also utilized by registration at point of registration listing the hospitals physical address and contact number. Registration staff may add the financial counselor individual name and contact information to discuss possible financial assistance. Financial Assistance contact information is also provided by case management for inpatients and observation patients. Financial assistance information is also provided in the admission packets for individuals upon their admission.. All departments, including emergency, has access to the policy and procedure to print the documents.

A copy of the policy and procedure is also located online at our Jackson general website. In addition to the P&P a plain language summary and application is also located on our web site at www.jacksongeneral.com located under the patient services tab for patients, patients financial services.

All applicants may notify the hospital by calling the number on the statement 304-372-2731 or the Financial Counselors at 304-373-1510 or 304-373-1511 for assistance with the application process. Hospital identifies any uninsured, underinsured, or self-pay patients.

Patient completes application/determination of eligibility form. Patient may be told at this time, or by return mail, if the application is approved or denied.

Patient completes financial statement that may include income, assets, and liabilities. Patient supplies documentation of resources (w-2, pay stubs, tax forms) for review as proof of income. Patients with no income must provide three (3) letters from individuals not related to the patient as proof of income. The letters must contain the individuals name, address, and telephone number of the person submitting the letter along with a photo ID.

Personal ID – Social Security Card, Photo ID Required – if no Photo ID – Birth Certificate – Green Card, Letters notarized etc.

(Note: Previous year's tax return is acceptable for the date of service. Depending on patients receipt of billed statement, the current year's tax return may be used if receipt was in latter part of the current year.)

Hospital considers federal poverty guidelines and family size.

Hospital verifies any third-party coverage, if indicated.

Designated hospital staff interviews patient to assess the patient ability to pay in full; ability to pay reasonable monthly installments; and qualifications for charity care. All uninsured applicants are referred to the DHHR to apply for Medicaid assistance and must provide coverage denial letter before financial assistance applications can be completed or approved. An individual's failure to comply with required documentation

and or/soliciting Medicaid eligibility shall be excluded from financial assistance consideration.

Once the hospital makes an initial determination of insufficient funds, income, and health care benefits, the claim becomes eligible for final review. If further review is requested, the Revenue Cycle Director and or Administration will complete.

However, the hospital may resume collection efforts if a patient does not cooperate with the hospital in supplying information necessary to determine eligibility for its charity care policy and there is insufficient information for the hospital to make a determination of eligibility.

Once approved Charge-off is completed within Meditech with a financial class of **ACHAR.** Balance amount adjusted was at 100% with the look back method reviewing past services that qualified with proof of income obtained from the patient, according to Federal Poverty guidelines. Determination of FAP eligibility was approved only for those balances listed by the insurance that applied to copays/deductible, as an underinsured patient. Uninsured total charges were eligible. All individuals are charged the same amount for all services and no difference is made between uninsured vs. underinsured individuals.

January 16, 2018 sliding fee process became effective. Patient responsibility amount is determined according to the most current poverty guidelines listed on the federal registry. Patient must pay the patient responsibility amount according to the sliding fee requirements before the financial assistance application process can be completed. Once approved a write off is completed within Meditech with the adjustment code of **ASF**. There is no separate billing and collection policy. These adjustments are entered on the charity log/spreadsheet for easy report compilation. Actions that may be taken by the hospital (or other authorized party) related to obtaining payment including, but not limited to, any extraordinary collection actions (ECAs)

A Charity Log/spreadsheet is recorded by the Collection department on a monthly and year to date basis. To identify self pay (uninsured) patients on the charity log, those line items are highlighted in yellow. Original charity application and proof of income is attached to screen print of patients account and scanned and retained on Laserfiche. Copy of completed application is given to applicant with comments documented within Meditech.

An approved letter is given to the patient or mailed, upon completion of a qualified application, explaining financial assistance for services have been approved.

Financial assistance may be provided when patient is deceased and without an estate. A copy of the obituary is attached to a batch sheet and scanned into Laserfiche. If available from the courthouse probate office, the estate appraisement is also attached.

Charity application signed by patient who does not provide requested proof of income will be denied by Financial Counselor. Copy of denied application listing reason for denial will be mailed to the patient. Collection attempts can be resumed for remaining balance at which time account can be prepared for placement to an outside collection agency.

Any payment received on an account with a charity/sliding fee adjustment will be applied to the account and the adjustment reversed up to the amount of the charity/sliding fee adjustment.

Comments shall be entered on Meditech and or MARS by financial counselor regarding charity application status.

A Bankruptcy log is kept by the financial counselors on a monthly and year to date basis.

Bankruptcy notices are received listing debtor name, Social Security #, chapter of bankruptcy filed and date bankruptcy was filed. Guarantor information is entered in Meditech to obtain all family members covered under Bankruptcy chapter. All outstanding account balances as well as bad debt accounts are reviewed.
Accounts previously adjusted as bad debt, bad debt adjustments are reversed. Screen prints showing patient information along with balance due amounts are printed and attached to original copy of the bankruptcy notice. If account has been previously placed with a collection agency, a copy of the bankruptcy notice listing patients name and account number is mailed to the appropriate agency requesting closure of account due to Bankruptcy filed. All accounts affected by the bankruptcy filing are entered in the same batch.

PLEASE NOTE: Charity income guidelines updated every year and published in the Federal Register.

Effective 04/07, the Board of Directors, and Administration, approved that the Poverty Guidelines will be doubled for calculations. 02/2011 cards stopped. 10/2011 reinstated by Board of Directors and Administration. 09/30/2013 cards stopped.

DEFINITIONS

HFMA – Healthcare Financial Management Association
CMS – Centers for Medicare & Medicaid Services

SUMMARY OF CHANGES

Updated healthcare reform notices to patient, signage, location etc.

RESOURCES/TRAINING

Resource/Dept.	Internet/Link
Debbie Burge	Dburge@jacksongeneral.com
Angela Frame	aframe@jacksongeneral.com

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DOCUMENT APPROVAL & TRACKING

Item	Contact	Date	Approval
Owner	Debbie Burge, Revenue Cycle Director		
Consultant(s)	Arnett & Foster		
Committee(s)			[Y or N/A]
Director of Nursing	Jessica Pitts, RN		[Y or N/A]
Medical Director/Officer	Dr. James G. Gaal		[Y or N/A]
Human Resources	Jeff Tabor		[Y or N/A]
Finance Officer	Angela D. Frame		[Y or N/A]
Legal (if required)			
Official Approver	Stephanie McCoy		
Official Signature		[Day/Mo/Year]	
2nd Approver (Optional)			
Signature		[Day/Mo/Year]	
Effective Date		[Day/Mo/Year]	
Origination Date		[Month/Year]	
Issue Date			

ATTACHMENTS