Munroe Regional Medical Center
1500 SW 1st Avenue
Ocala, FL 34471

Subject:	Originally Issued	Date of This Revision	Page	No.
FINANCIAL ASSISTANCE POLICY	*original policy date*	*Closing date or eff date*		

POLICY STATEMENT:

In order to serve the health care needs of our community, **Munroe Regional Medical Center** will provide financial assistance to patients without financial means to pay *for medically necessary hospital services.*

Financial Assistance will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent according to the hospital's eligibility criteria. Financial Assistance is limited to those services that meet Medicare medical necessity criteria.

All individuals presenting on hospital property requesting emergency medical services, individuals presenting to a Dedicated Emergency Department requesting medical services, and patients arriving/presenting via ambulance requesting medical services shall receive an appropriate Medical Screening Examination and Stabilization services as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395 and all Federal regulations and interpretative guidelines promulgated thereunder.

If there are state specific laws that conflict with any portion of this policy, those sections have been identified and edited to comply with said law. In addition, attached to this policy are copies of each law as verification of requirements.

PURPOSE:

To properly identify those patients who are financially and/or medically indigent, who do not qualify for state and/or government assistance with their medical bills, and to provide assistance with their medical expenses under the guidelines for Financial Assistance.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. **FINANCIALLY INDIGENT:**

   A. A financially indigent patient is a person who is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

   B. To be eligible for financial assistance as a financially indigent patient, the patient's total household income shall be at or below 200% of the current Federal Poverty Income Guidelines. (see exhibit D)

The hospital may consider other financial assets and liabilities for the person when determining eligibility.

C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication. (see exhibit E)

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for financial assistance lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 200% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the healthcare needs of the community.

E. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for financial assistance. Payment of copayments and spend-down amounts are a condition of coverage and should not be written off or discounted.

2. **PRESUMPTIVE ELIGIBILITY:**

A. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for financial assistance upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. No other documents will be required in order to approve the financial assistance application. The patient will not be required to make a formal financial assistance/charity application. The hospital may submit the application and verification of Medicaid coverage as proof of qualification.

B. Medicaid patients who exhaust their coverage and benefits will also be eligible for financial assistance for medically necessary hospital services.

C. Deceased patients with no estate will automatically qualify for financial assistance.

3. **MEDICALLY INDIGENT:**

A. A medically indigent patient is a person who is uninsured or whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income and who is unable to pay the remaining bill.

B. To be eligible for financial assistance as a medically indigent patient, the patient's total household income shall be at or below 400% of the current Federal Poverty Income Guidelines (see exhibit E) **and** their hospital medical expenses for the proceeding 12 month period exceeds 25% of the annual gross income.

C. The hospital may consider other financial assets and liabilities for the person when determining eligibility, but in no case will the hospital require a patient to 'spend down' more than 50% of their savings in order for the patient to qualify for financial assistance towards their remaining balance.

D. If a patient meets the medically indigent income and medical expense criteria, and have no savings or assets, they will be eligible for a full write-off of the hospital medical expenses.

PARTICIPATION IN THIS POLICY:

A. This policy covers all emergency and medically necessary care provided by the hospital and its employees.

B. Some third-party health care providers that provide emergency and medically necessary care within the hospital under contract to the hospital may not extend financial assistance in accordance with this policy, choosing instead to apply their own policies for financial assistance.

C. A list of all of the third-party health care providers that provide emergency and medically necessary care within the hospital under contract is available at (web site). This list indicates whether or not each third-party health care provider follows the criteria and procedures for extending financial assistance set forth in this policy.

FACTOR TO BE CONSIDERED FOR FINANCIAL ASSISTANCE DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for financial assistance:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for financial assistance are attached on *Exhibit "D"*. The current Federal Poverty Guidelines are attached as *Exhibit "E"* and they include the definition of the following:

1. Family
2. Income

FAILURE TO PROVIDE APPROPRIATE INFORMATION:

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.

B. The account may be reconsidered upon receipt of the required information, providing the information is received within 240 days from the first patient billing date.

EXCEPTION TO DOCUMENTATION REQUIREMENTS

The CFO may waive the documentation requirements and approve a case for financial assistance, at his/her sole discretion, based on their belief the patient does/should qualify for assistance. Waiver of the documentation requirements should be noted in the comments section on the patient's account, as well as the percent or dollar amount approved for financial assistance. Staff should print-out and attach the patient notes to the Financial Assistance (FA) application form.

TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

Exhibit A
Financial Assistance Form
(Hospital Name)
Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION	PARENT/GUARANTOR/SPOUSE
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
SS#_____	SS#_____
Employer_____	Employer_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Cash on hand: $_____

Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Financial Assistance:

Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

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The below signatures is indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Financial Assistance Write-Off:

Amount Approved $_____

BOM_____ **CEO_____**

CFO_____