Tri-State Memorial Hospital & Medical Campus

Effective:	*07/2012*
Approved:	*02/2016*
Last Revised:	*03/2014*
Expiration:	*02/2017*
Owner:	*Alex Town*
Policy Area:	*Finance*

Financial Assistance

MISSION OF THE HOSPITAL WITH RESPECT TO FINANCIAL ASSISTANCE

Uninsured or underinsured patients may be eligible for financial assistance regardless of race, creed, color, national origin, sex, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by the disabled person.

DESCRIPTION OF ELIGIBILITY CRITERIA

Financial Assistance is available to qualified uninsured or underinsured patients for appropriate hospital based medical services in accordance with WAC 246453 section 010 which states: "Those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all;"

Financial Assistance is generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, county aid, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.

Uninsured or underinsured patients will have the opportunity to be considered for Financial Assistance under this hospital policy based upon the following criteria calculated upon the patient's financial documentation at the time of the request. Potential patient responsibility will be determined upon the sliding fee schedule and may have an expectation of payments set forth within Tri-State Memorial Hospital's collection policy:

A. The full patient balance for hospital charges will be evaluated to determine Financial Assistance eligibility for any patient whose gross family income is at or below 100% of the current federal poverty guidelines.

   Patients whose gross family income are 101% to 200% of the current federal poverty guideline will be eligible for a discount of 75% to be applied to the patient account balance and will be determined as a Financial Assistance discount.

	◦ **If you are a student**, please provide information regarding student loans and/or grants. ◦ Last pay stub with year to date earnings from all places worked for you and spouse. ◦ Copy of Social Security Awards Letter ***or*** bank statement showing monthly deposit. ◦ Letters approving or denying Medicaid medical assistance.
Option 3:	During the initial request period, the hospital may pursue other sources of funding including Medicaid, Crime Victims, or County Aid for Idaho residents.
Option 4:	Income shall be based on prior years Federal tax return and include documentation of current economic situation. Income will be calculated from the documentation provided by the patient or Medicaid. The process of calculation will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases of income. A. Time Frame for Final Determinations: The hospital shall provide final determination within fourteen (14) calendar days of receipt of a complete application. B. Denial appeals: Denials will be written and include instructions for appeal or reconsideration as follows: The responsible party may appeal the determination of eligibility for Financial Assistance by correcting any deficiencies in documentation to the Patient Accounts Manager or designated representative. Upon the receipt of an appeal, there will be a thirty (30) day hold in the collection process. The Chief Financial Officer will review and respond to all appeals within fourteen (14) days of receipt. If this review affirms the previous denial of Financial Assistance, written notification will be sent to the patient/guarantor and the Department of Health, in accordance with state law. If the denial is reversed the patient shall immediately be declared an eligible candidate.

DOCUMENTATION AND RECORDS

A. Confidentiality: All information relating to the application will be kept confidential. Complete copies of documents that support the application will be kept with the application form.

B. Documents pertaining to Financial Assistance shall be retained for four (4) years.

Policy submitted to DOH March 2014. All subsequent review/revisions to this policy will be forwarded in pdf format to hospitalpolicies@doh.wa.gov. The policy will also be updated on the hospital's website per regulation.

Attachments:

- A. Financial Assistance Worksheet
- B. Financial Assistance Application
- C. Special Consideration Application

Financial Assistance Worksheet

Tri-State
MEMORIAL HOSPITAL & MEDICAL CAMPUS

Date(s) of Service:	**Date of Worksheet:**
Patient Name:	**Guarantor:**
Account No(s):	**Insurance:**
Account Type ○ IN ○ OUT ○ CLINIC	**Patient Financial Counselor:**

Account Details

Total Charges:

Insurance Payments/Adjustments:

Patient Payments/Adjustments:

Finance Charges:

Current Account Balance

Eligibility Screening

Monthly Income:	**Yearly Income:**
Family of:	**Verification:** ☐ Verbal ☐ Attached

Medicaid Eligibility

Did not apply due to income	*Spend-down*
Not eligible on date of service	*Spend-down amount $*
Denied/Denial reason	

Determination

Federal Poverty Level:	**Financial Assistance Adjustment:**
Patient Cost Share:	**Requested Adjustment:**

Additional Comments:

Approval Signatures

Patient Financial Counselor	($0-$999)	_____
Director	($1,000-$2,999)	_____
Chief Financial Officer	($3,000-$4,999)	_____
Chief Executive Officer	($5,000+)	_____

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Financial Assistance Application - **CONFIDENTIAL**

Screening Information

Has the patient applied for Medicaid? ☐ Yes ☐ No **May be required to apply before being considered for Financial Assistance.*

Is the patient currently homeless? ☐ Yes ☐ No

Is the patient's medical care related to a car accident or work injury? ☐ Yes ☐ No

PLEASE NOTE

- We cannot guarantee that you will qualify for assistance, even if you apply.
- Once you send in your application, we will check all information and may ask for additional information and/or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for Financial Assistance.

Patient and Applicant Information

Patient First Name	Patient Middle Initial	Patient Last Name
Birth Date	Social Security Number	
Person Responsible for Paying Bill	Relationship to Patient	Social Security Number
Mailing Address _____ _____ City State Zip		Contact Number(s) ( )_____ ( )_____ Email Address _____

Employment status of person responsible for paying bill

☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

☐ Self-Employed ☐ Other (_____)

Family Information

List family members in your household, including yourself ("Family" includes people related by birth, marriage, or adoption who live together. **Family Size:** _____

Name	Date of Birth	Relationship to Patient	If 18 years old, Employer(s) name or source of income	Total gross monthly income (**before** deductions)

All family members' income must be disclosed. Sources of income include, for example:

Wages, Unemployment, Self-employment, Worker's Compensation, Disability, Social Security, Child/Spousal Support, Grants/Scholarships, Pension, Retirement Income, Other (*please explain* _____)

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Income Information

You must provide proof of your family's income. Income verification is required to determine Financial Assistance.
All family members' income must be included. Here are examples of how to provide proof of income:

- A "W-2" withholding statement
- Current paystubs (3 months)
- Last year's income tax return
- Bank statements (3 months)
- Profit/Loss statement (if self-employed)
- Written, signed statements from employer(s)
- Approval/Denial of eligibility for Medicaid and/or state-funded medical assistance
- Approval/Denial of eligibility for unemployement compensation
- If no income, you must provide an explanation in the "**Statement of Current Financial Situation**" section below

Asset Information

This information may be used if your income is above 101% of Federal Poverty Guidelines

Current checking account balance
$ _____

Current savings account balance
$ _____

Does your family have other assets? **Please check all that apply**

☐ Stocks ☐ Bonds ☐ Trusts
☐ 401K ☐ Own a business ☐ Property (excluding primary residence)
☐ Health Savings Account If **yes**, available balance $_____

Statement of Current Financial Situation

Please provide information about your current financial situation that you would like us to consider, such as financial hardship, seasonal or temporary income, or personal loss. If you have no income you must explain how you support yourself. (Use additional sheet if necessary)

Applicant Agreement

I understand that Tri-State Memorial Hospital & Medical Campus may verify information by reviewing my credit information and obtaining information from other sources to assist in determining eligibility of Financial Assistance and/or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of Financial Assistance, and I will be liable and expected to pay for all services provided.

Signature of Person Applying	Date

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Special Consideration

Financial Assistance Application - **CONFIDENTIAL**

Applicant	Co-Applicant
Full Name	Full Name
Birth Date	Birth Date
Social Security Number	Social Security Number
Mailing Address City State Zip	Mailing Address City State Zip
Contact Number(s) ( ) ( )	Contact Number(s) ( ) ( )
Email Address	Email Address
Employment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled ☐ Self-Employed ☐ Other (	Employment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled ☐ Self-Employed ☐ Other (

Income

All family members' income must be disclosed. Sources of income include, for example:
Wages, Unemployment, Self-Employment, Worker's Compensation, Disability, Social Security, Child/Spousal Support, Grants/Scholarships, Pension, Retirement Income, Other (*please explain*

Gross Monthly Income (**before** deductions): $ _____

Expenses

	Total	Monthly Payment		Total	Monthly Payment
Rent/Mortgage	$	$	Medical Bills **must provide copies*		
Homeowners Insurance	$	$	1)	$	$
Food/Household Goods	$	$	2)	$	$
Electricity	$	$	3)	$	$
Water/Sewer/Garbage	$	$	4)	$	$
Phone	$	$	5)	$	$
Primary Vehicle Loan	$	$	6)	$	$
Primary Vehicle Insurance	$	$	7)	$	$
Medical Insurance Premium	$	$	8)	$	$
Pharmacy	$	$	Other (_____	$	$

Signature of Applicant Date	Signature of Co-Applicant Date