POLICIES AND PROCEDURES	Date:	Policy Number: **CMMC/BO1051**
	Approved: CFO 06/01/19	
	Approved:	
Department: **BUSINESS OFFICE/PATIENT FINANCIAL SERVICES**		Pg. 1 of 10
Subject: Financial Assistance		
Original Policy Date: 10/2013	Revision Date: 10/2019	

PURPOSE:
To assist patients who are uninsured or underinsured to qualify for a level of financial assistance, in accordance with their ability to pay. Financial assistance may be provided in the form of free care for patients who qualify or a discount may be applied to inpatient and/or outpatient service charges provided at Chicot Memorial Medical Center.

POLICY:
Chicot Memorial Medical Center (CMMC) is a not for profit Critical Access Hospital (CAH) existing to promote good health and provide quality healthcare with qualified staff in a caring and compassionate manner. CMMC is committed to providing emergency care and medically necessary services to patients regardless of their ability to pay. Through our financial assistance program, we offer discounted charges for services to eligible patients that may cover all or part of their bill. The program discounts the patient bill based on income and family size. The reduction is based on a sliding fee scale.
The determination of a patient's financial responsibility will be made according to a patient's ability to pay, as indicated by the eligibility criteria established within the procedural guidelines of this policy. The guidelines include, completion of the CMMC Assistance Application. Resources are limited, so it is necessary to establish limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the resources CMMC can afford to devote to its patients are focused on those who are most in need and least able to pay. Financial assessments and the review of patients' financial information are intended for the purpose of assessing need, as well as gaining a holistic view of the patients' circumstances. CMMC will not discriminate in the provision of services to an individual because the individual is unable to pay, because payment for those services would be made under Medicare, Medicaid, or CHIP, or based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

A. SERVICES COVERED UNDER POLICY

The following healthcare services are eligible for financial assistance, depending on program eligibility:
1. Emergency medical services provided in an emergency room setting
2. Medically necessary healthcare services
3. Chicot Memorial Medical Center's Physician office visits and services

The following healthcare services are not eligible for financial assistance:

1. Physical Therapy, Occupational Therapy, and Speech Therapy
2. Sleep Study
3. Home Health
4. All services that have entered into legal action for collection

The "NOTICE OF PARTICIPATING AND NON-PARTICIPATING PROVIDERS", other than CMMC, delivering emergency or other medically necessary care in the hospital, is included within this Policy.

B. EMERGENCY SERVICES

CMMC will provide, without discrimination, care for emergency medical conditions to individuals, regardless of their eligibility under this financial assistance policy.

C. ELIGIBLE PATIENTS

Eligibility for financial assistance will be considered for those individuals who are United States citizens and considered uninsured, underinsured, ineligible for any government health care benefit program, exhausted their benefits of a government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. A person whose individual or family income is not more than 200% of the current Federal Poverty Guideline (FPG) of the United States Department of Health and Human Services may be eligible for financial assistance. An eligible patient may not be charged more than amounts generally billed ("AGB") for emergency care or medically necessary care to individuals who have insurance. In the case of all other care provided, an eligible patient may not be charged more than the gross charges.

D. INELIGIBLE PATIENTS

Anyone who does not meet the organization's financial assistance criteria or who refuses to provide the information necessary to determine eligibility will be determined as ineligible for financial assistance.

E. DEFINITIONS:

Emergency Medical Care – Care provided by a hospital facility for emergency medical conditions.

Emergency Medical Conditions – Means emergency medical conditions as defined in section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary Services –

1. Are consistent with the person's symptoms, diagnosis, condition, or injury;
2. Are recognized as the prevailing standard and are consistent with generally accepted professional medical standards of the provider's peer group;
3. Are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
4. Are not furnished primarily for the convenience of the person or the provider; and
5. There is no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

Application Period – The period during which an application must be accepted and processed under this policy. The application begins on the date the care was provided and ends on the later of the 240th day after the date that

the first post-discharge billing statement for the care is provided. Applications may be accepted outside of the application period.

Medically Indigent Person – A person whom the organization has determined is unable to pay some or all of his/her medical bills because the individual's income is equal to or less than 200% of FPG.

Family Unit – Consists of individuals living alone; and spouses, parents and their children under age 21 or disabled living in the same household. A family unit may include minor children living with a legal guardian.

Gross Income – Total family unit income before taxes for the most recent twelve (12) months. Family unit income may include earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count. If an individual is a non-relative and living with a family, his/her income is not included in gross income.

Amounts Generally Billed (AGB) – The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

Extraordinary Collection Action (ECA) – Includes any of the following actions:

- Selling an individual's debt to another party;
- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
- Deferring or denying, or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under this policy;
- Actions that require a legal or judicial process, which may include liens, foreclosure, attachment, seizure, commending a civil action, causing an individual's arrest, causing an individual to be subject to a writ of body attachment and garnishment.

F. AMOUNT OF FINANCIAL ASSISTANCE

The hospital bill may be discounted up to 100% if the qualified patient income does not exceed 200% of the FPG (family unit adjusted). To qualify for this program, the patient must not qualify for public aid or payment from other third-party sources, including Medicare and/or Medicaid.

Patients who qualify for a reduction in their patient bill or do not financially qualify for a reduction can arrange for installment payments. After a financial assessment, the appropriate monthly payment will be assigned with a prescribed timeframe.

Chicot Memorial Medical Center's "NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES" provides further details regarding the eligibility and amounts of financial assistance.

G. METHOD OF APPLYING FOR FINANCIAL ASSISTANCE AND DETERMINATION PROCEDURES

In order to determine if a patient is eligible for assistance, an application must be completed by the patient or guarantor. The hospital will then review the application and decide of eligibility. Approval is valid for a period of one year. Patients must apply (or reapply) for free or reduced charges with current financial information on an annual basis.

In order to qualify for assistance, the patient must:

- Complete an application form
- Provide documentation of gross income for the last twelve (12) months, including where applicable;
  - o Federal tax form 1040
  - o Last three pay stubs for all household members (or if unavailable, a letter from employer stating weekly wages)
  - o Provide evidence that patient has pursued all other payment sources, including public aid
  - o Provide bank statements for the last two months for all household members

Upon completion, the application and related material will be reviewed for a decision of eligibility by the Business Office Manager. Until the hospital has made reasonable efforts to determine the patient's eligibility, we will refrain from initiating extraordinary collection activities.

An application will be considered in a "HOLD" status if a third-party coverage is discovered that will pay for the related services. The determination process will not continue until the receipt of those monies.

Upon final approval, the eligible amount will be adjusted off the patient balance and a determination letter will be mailed to the patient informing them of the results of their application. Unless the application is placed in "HOLD" status, the determination process will be completed within ten (10) business days of receipt of the completed application.

If the application is not approved, a determination letter will be mailed to the patient informing them of the results of their application. If the patient believes the initial decision regarding his or her eligibility is incorrect, he or she may appeal the determination directly to the Chief Financial Officer. A decision regarding this appeal will be made within five (5) business days.

It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle prior to legal action. The need for financial assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than one (1) year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

H. COLLECTION ACTIONS

For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, Chicot Memorial Medical Center may offer extended payment plans. In these cases, the hospital will not send unpaid bills to outside collection agencies and will cease all collection efforts. Chicot

Memorial Medical Center will not impose extraordinary collection actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Verifying that the patient owes the unpaid bills;
2. Providing information to the patient regarding the availability of financial assistance;
3. Providing determination of eligibility on a timely basis;
4. Requesting that the patient identify all sources of third-party payments;
5. Determining that the hospital has pursued collections from the third-party payment sources identified by the patient;
6. Documenting that the hospital has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements; and
7. Documenting that the patient has been offered a payment plan but has not honored the terms of that plan.

I. MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE POLICY

Chicot Memorial Medical Center's Financial Assistance Policy is available to the public using various means, which may include, but is not limited to the posting of the policy:

- In patients' bills,
- In the emergency room, admitting and registration departments, and patient financial service offices which are located on hospital campus locations, and at other public places as Chicot Memorial Medical Center may elect;
- On the hospital website;
- In brochures available in-patient access sites; and
- At other places within the community served by the hospital as Chicot Memorial Medical Center may elect.

Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Chicot Memorial Medical Center. Referral of patients for financial assistance may be made by any member of the hospital staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religous sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to application privacy laws.

NOTICE OF AVILABILITY OF UNCOMPENSATED SERVICES

At Chicot Memorial Medical Center, free or discounted services are available for medically necessary, non-elective inpatient and outpatient services to qualifying individuals.

ELIGBILITY CRITERIA:

To be eligible to receive free or reduced-charge care, your family income must not be more than 200% of the U.S. Department of Health and Human Services Federal Poverty Guidelines based upon family size.

If you think you may be eligible for free or reduced-charge services, you may make this request at Chicot Memorial Medical Center. A written conditional or final determination of your eligibility will be made within ten (10) business days of your request.

To qualify for some level of free or reduced-charge care, your family income must be no more than 200% of the following income scale:

Sliding Fee Scale Income Thresholds 2019						
Percent Poverty Level	100%	125%	150%	175%	200%	>200%
Household Size	$5.00 nominal fee	20% of fee per visit	30% of fee per visit	40% of fee per visit	50% of fee per visit	100% of fee
1	$12,490	$15,613	$18,735	$21,858	$24,980	$24,981
2	$16,910	$21,138	$25,365	$29,593	$33,820	$33,821
3	$21,330	$26,663	$31,995	$37,328	$42,660	$42,661
4	$25,750	$32,188	$38,625	$45,063	$51,500	$51,501
5	$30,170	$37,713	$45,255	$52,798	$60,340	$60,341
6	$34,590	$43,238	$51,885	$60,533	$69,180	$69,181
7	$39,010	$48,763	$58,515	$68,268	$78,020	$78,021
8	$43,430	$54,288	$65,145	$76,003	$86,860	$86,861
Add $4,420 for each person over 8						

NOTICE OF PARTICIPATING AND NON-PARTICIPATING PROVIDERS

PROVIDER	PARTICIPATING INDICATION
Emergency Staffing Solutions (ER Physicians)	**No**
Dr. Michael B. Mayfield (Surgery / RHC)	**Yes**
Autumn Bennett (AFPN)	**Yes**
Paige Patrick (FNP)	**Yes**
Dr. Haley Burson	**Yes**

Chicot Memorial Medical Center

Application for Financial Assistance

Patient Name: ___________________________

Patient Number: _________________________

Dear Patient or Guarantor:

You may qualify for the Financial Assistance Program at Chicot Memorial.

Please fill out this application and submit it back to Chicot Memorial Medical Center within 14 days to see if you qualify for a discount on your healthcare costs.

Supporting documentation (where applicable):

- Federal tax form 1040
- Last three pay stubs for all household members (or if unavailable, a letter from employer stating weekly wages)
- Provide evidence that patient has pursued all other payment sources, including public aid
- Provide bank statements for the last two months for all household members

If you have any questions about the financial assistance program, please call or come by the Business Office at Chicot Memorial.

Business Office
(870) 265-9252

APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name: ____
(LAST) (FIRST) (MIDDLE)

Current Mailing Address: ______________________________________
(Street / PO Box) (CITY) (STATE) (ZIP)

Home Telephone: ______________________ Cell Phone: __________________________

Employer: _________________________ Employer's Phone: _________________________

Employer's Address:

____
(Street / PO Box) (CITY) (STATE) (ZIP)

Social Security Number: ______________________________ DOB: _________________

Spouse'sName: ____
(LAST) (FIRST) (MIDDLE)

Spouse's SS#: _______________________ Employer: ______________________________

Spouse's Employer's Address: ___________________________________
(Street / PO Box) (CITY) (STATE) (ZIP)

Spouse's Employer's Phone Number: _______________________

Do you have any Insurance Coverage? ___ Yes ___ No

If Yes, please list: _____________________________________

Household Members: (including yourself and/or patient)

Name	Age	Employer/School	Date of Birth

Income / Expenses: List gross income of total household for the previous 12 months & monthly expenses:

	Last 12 months		Monthly Expenses
Wages:	______	Rent:	______
Farm or Self-employment:	______	Electricity:	______
State Assistance:	______	Gas:	______
Social Security:	______	Water:	______
Unemployment:	______	Phone:	______
Alimony:	______	Car Payment:	______
Child Support:	______	Other:	______
Military Fam Allotments:	______	Other:	______
Pension:	______		
Other:	______		

(If there is NO income at all, please tell us how you pay for household expenses (electricity, water, etc.)

____

Landlord Phone # ____________________________________

Have you applied for Medicaid? ________________ If denied, why? _________________________________

I certify that the above information is true and accurate to the best of my knowledge. As part of the application process, CMMC may verify information contained in my application and in other documents required in connection with the application, either before the application is approved or as a part of its quality control program. Further, I will make application for any assistance (Medicaid, Medicare, insurance, etc.) which may be available for payment of my medical charges, and I will act reasonably necessary to obtain such assistance and will assign or pay to CMMC the amount recovered for medical charges. If any information I have given proves to be untrue, I understand that CMMC may reevaluate my financial status and take whatever action becomes appropriate.

____ ________________________

Signature Date