CULLMAN REGIONAL MEDICAL CENTER
POLICY AND PROCEDURES MANUAL

Department: **Patient Financial Services**

Policy #: **PFS-141-103.03**

Title: **Financial Assistance**

Effective Date: **November 1, 2006**

Policy:

Consistent with our mission to promote wellness and provide excellent healthcare services in the most efficient manner, Cullman Regional Medical Center will extend Financial Assessment Applications to patients who require medically necessary services, who lack the ability to pay and are willing to submit supporting documentation. Medically necessary services are generally defined as services and/or procedures that if not provided will potentially result in loss of life or limb. Elective and cosmetic procedures will not be considered under this policy.

Financial Assistance consideration for High Cost drugs/biologicals, implants, equipment, orthopedic hardware and/or other non-routine items may be limited to residents of Cullman County. These considerations will be made in full compliance with EMTALA and will not impact the provision of emergent care.

Full discounts will be granted those eligible if income is less than 200% of the Federal Poverty Guidelines (FPG) in effect at the time. Partial discounts will be granted on a sliding scale up to 350% of the FPG (see page 5. for sliding scale). Patients who could be eligible for public assistance may be requested, but not required, to apply to the appropriate agency for potential assistance.

Procedures:

How to Apply

1. At any time during the initial financial screening and continuing collections process, including turnover to bad debt, patients who claim to lack the ability to pay will be offered a Financial Assessment Application. Applications will be accepted up to 240 days from the commencement of the first billing date. Any collection activity underway will be suspended until a determination on the application can be made.

2. Applications may be obtained in person at the hospital business office, located on the first floor of the main hospital. The address is:

   1912 Alabama Hwy 157
   Cullman, AL 35058

Applications may also be accessed on the hospital's website at www.cullmanregional.com or by calling the customer service line of the business office at 256-737-2986.

3. The Financial Assessment Application process will be explained by hospital business office representative and required documentation reviewed with the patient, the guarantor or the patient's designated representive. Supporting documentation includes, but may not limited to:

    - Most recent year's income tax return
    - Copy of social security cards or formal identification for all household members considered in income guidelines
    - Most recent month's checking and savings statement
    - All monthly payment obligations reported on application. Documentation requirements for routine expenses may be waived or reduced should they be deemed reasonable for the applicant's family size and housing situation. These items generally include utility bills, gasoline and groceries.
    - Proof of income in the form of check stubs or a notarized memo from employer; the employer name, address, and telephone must be shown on proof of income
    - Notarized verification of any support received from friends, family, churches, charitable organizations, etc.
    - Written verification of a pending disability case

4. Patients will be expected to complete the Financial Assessment Application and comply with the requirements outlined in the application for supporting documents. It is requested that applications be returned with 30 days from discharge in order to suspend unnecessary collection action. Applications may be returned by mail at P.O. Box 1108, Cullman, AL 35056, or in person at the address listed above.

5. Patients who do not complete an application, who fail to pay or fail to make suitable arrangements to pay may be subject to being turned over to a third party as Bad Debt for collections. Patients may apply after being turned over to Bad Debt. Turnover to Bad Debt will not be done any sooner than 125 days from the first dunning notice. The hospital's collection policy is explained in PFS-141-131.01 and may be obtained from the hospital's business office or off the website.

6. Patient's will be advised that our determination of approval of assistance is not necessarily taken into consideration by other providers unless employed by the hospital. Other providers may include, but not limited to, Radiologist, Pathologist, Anesthesiologist, Emergency Room physicians and/or other providers who may be consulted for specialized care . Patients will need to contact other providers directly regarding their accounts.

Exclusions to Supporting Documentation Requirements

1. Administrative Determination

    - CRMC Administration may, on a case-by-case basis, and not with prior determination, exempt a patient from requested documentation in the event of extenuating circumstances.

    - Details of extenuating circumstances will be documented in the Financial Counselor's summary and recommendations.

2. Medicaid Recipients

    - Patients who exceed their allowed Medicaid inpatient days, indicated on the Medicaid Remittance Advice, will receive a 100% adjustment to the specified account balance. The adjustment code will reflect "Medicaid Exhausted" and will allocate charges to the appropriate charity General Ledger number.

    - Business Office will confirm that the recipient ID was correct on the claim filed to Medicaid.

    - In the case of recipients under age 21, Business Office will confirm there is no EPSDT Referral that should have been used on the claim.

    - Medicaid recipients who are eligible under one program but receive services not covered under that program may be deemed as charity. The state's determination of eligibility will suffice as evidence of the charity status.

    - Medicaid patients who receive services normally covered by Medicare or commercial carriers, but not covered under the state's program, may be considered under the charity policy if the services are reasonable and necessary.

3. Good Samaritan Health Clinic Patients

    - Those with a qualifying *Good Samaritan Health Clinic Patient Identification Card* in effect for the date of service Financial Assistance is requested will not be required to complete the Financial Assessment Application.

    - Supporting documentation will be kept by Good Samaritan.

4. Duration

   Charity approvals will remain in effect for 180 days after the initial determination. Exceptions will be granted to those patients being approved under the cancer navigation setting. Those patients will generally be considered as charity throughout their treatment regimen; however, there may be circumstances where updates may be requested during that treatment span

Method for Calculating Free or Discounted Care

- All patients are charged the same amount regardless of their method of payment. For patients not receiving the full discount, the amount billed to them will be the Amounts Generally Billed Percentage.

- The AGB percentage will be determined each year in January 1st using the the paid claims from the preceding twelve (12) month period. The percentage will be updated February 1st each year and will remain in effect until January 31st of the following calendar year.

- As referenced previously, patients falling under 200% of Federal Poverty Levels (FPG) will be granted a 100% discount. Patient's with household income greater than 200% of FPG but less than 351% will be granted discounts on the following sliding scale.

Percentage of Threshold	Charity Discount
201% - 250%	75%
251% - 300%	50%
301% - 350%	25%

Charity Review and Assessment

1. Financial Counselors will review Financial Assessment Application with supporting documents, obtain a consumer credit report, summarize the information, and recommend approval or denial.

   - Patients with credit available at a bank, credit card, or other means may be asked for a deposit equal to no more than ½ of credit line.

   - Debt to income ratio will be calculated as net income divided by bills. If more than or equal to 2:1, patient may be reassessed for payment options.

2. Recommendations will be assessed by PFS Manager and returned to the Financial Counselor if additional information is needed. The PFS Manager may approve cases under $2,500.00. The PFS Director may approved cases up to $10,000.00 and the CFO must approve all cases over $10,000.00

3. Financial Counselor will notify patient of assessment outcome, request any additional information needed to process the application and explain any payment required.

<u>Reviewed:</u>	**09-18-2014, 12-06-2016, 02-01-18, 03-01-19**
<u>Revised:</u>	**01/01/2008, 01/01/2009, 10/10/2009, 10/10/2010, 06/01/2011, 02/28/2012, 08/15/13, 01/15/2014, 12-06-2016, 02-09-18, 04-02-19**
<u>Recommended by:</u>	**Gene Lee, Revenue Cycle Director**
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