Pushmataha Hospital BUSINESS OFFICE	**Subject: CHARITY CARE** **Policy Number:** **Page:** 1 of 5
Approved by:	**Generated by: Stormy Tollison**
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1. Purpose

   The purpose of this policy is to establish guidelines for Charity Care for indigent patients who incur significant financial burden as a result of the amount they are expected to owe "out-of-pocket" for acute health care services. Pushmataha Hospital exists to promote, improve and restore health. We provide care for individuals who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the expenses incurred in receiving healthcare.

2. Definitions

   A. "Charity Care" means inpatient and outpatient medical treatment and diagnostic services for uninsured or underinsured patients who cannot afford to pay for the care according to Pushmataha Hospital guidelines as established in this policy. Such treatment is provided by this facility without expectation of payment. Charity Care does not include bad debt or contractual allowances from government programs or insurance contracts, but may include insurance co-payments, co-insurance and unpaid deductible amounts. Once a patient is determined to be eligible for Charity Care, he/she *should not be issued a bill* and will be deemed indigent; however, an invoice will be prepared and then "written off" to Charity Care cost adjustments.

   B. "Bad Debt" is defined as expenses resulting from treatment for services provided to a patient who, having the requisite financial resources to pay for health care services, has chosen not to do so. This would include the patient's guarantor.

3. Policy

   A. Non-discrimination

      Pushmataha Hospital shall render **medically necessary** services to all members of the community who are in need of medical care regardless of the ability of the patient to pay for such services. The determination of full or partial Charity Care will be based on the patient's ability to pay and that determination will not be influenced because of age, sex, race, creed, disability, sexual orientation or national origin.

   B. Charity Care Services

      All **medically necessary** health care services shall be available to all individuals under this policy. Charity Care is intended solely for the benefit of the patient and does not relieve third parties of their liability for payment.

   C. Eligibility

The patient must currently maintain his domicile in Pushmataha County, Oklahoma and must have done so for one year prior to the medical services related to this application. He/she must also be unable to afford to pay (as defined in this policy under Section 5.A.i) for **medically necessary** services.

D. Determination of Eligibility

The determination of Charity Care should be made ***before*** providing non-emergency services, if at all possible. If complete information on the patient's insurance or financial situation is unavailable at the time of service, or if the patient's financial condition changes, the designation of Charity Care may be made after rendering services. All efforts will be made to establish whether the patient is eligible for Charity Care before leaving the Hospital.

E. Confidentially

The need for Charity Care may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for all who seek charitable services. Orientation of staff and the selection of personnel who will implement this policy should be guided by these values. No information obtained in the patient's Charity Care Application may be released unless the patient gives express permission for such release.

F. Staff Information

All Pushmataha Hospital employees will be fully versed in Pushmataha Hospital's Charity Care policy, have access to the application forms, and be able to direct questions to the appropriate Pushmataha Hospital representatives.

G. Patient Accounts Representative

Pushmataha Hospital has designated the Controller to process Charity Care Applications, coordinate outreach efforts and oversee Charity Care practices.

H. Staff Training

All staff with public and patient contact will be trained to understand the basic information related to Pushmataha Hospital's Charity Care policy and procedures and are to provide patients with printed material explaining the Charity Care Program.

4. <u>Application Process</u>

A. Application

The attached application **(Appendix B)** will be used by patients to apply for Charity Care from Pushmataha Hospital. Patients who do not have insurance may qualify for Charity Care based on their monthly or annual income and their family size. Patients having insurance may also be eligible for Charity Care for

the portion of their bill that is not covered by insurance, including deductibles, coinsurance, and non-covered services.

B. Application Assistance

Pushmataha Hospital's Controller (as provided under §3.G) will offer and provide application assistance to all patients.

C. Requests for Information

Pushmataha Hospital shall send (or hand deliver) an application packet **(Appendix A, B, C, D)** to anyone who requests information regarding Pushmataha Hospital's Charity Care Program.

D. Timing

All attempts should be made by Pushmataha Hospital personnel to have the patient fill out a Charity Care Application at or before the time services are rendered. Failing that, the application should be completed within 30 days of discharge. Failure to return the completed Charity Care Application within 30 days will result in not being eligible for charity.

5. Application Review Process

A. Eligibility Criteria

i. Charity Care Review

Upon review of the patient's financial and employment situation as recorded in the Charity Care Application, Pushmataha Hospital will determine whether the patient qualifies for Charity Care. To qualify for Charity Care a patient's medical expenses must outweigh the ability to pay, constituting a medical hardship **(Appendix C)** or a patient's monthly or annual income must be 150% or less of the **2012** federal poverty guidelines **(Appendix D)**. Patients, upon the request of Pushmataha Hospital, must fill out an application for Medicaid coverage.

The patient may be eligible for discounted services if Pushmataha Hospital's bill is 15% of the patient's annual income. These discounts are based on a sliding scale **(Appendix D)**.

ii. Financial Information

Pushmataha Hospital retains the right to offer charity discounts only if the patient completes a Charity Care Application and supplies other information as requested by Pushmataha Hospital. Patients may use a variety of information to substantiate financial circumstances, such as paycheck stubs or employment verification from the patient's

employer, W-2 forms, income tax returns, documentation of unemployment, or disability statements.

B. Approval

i. Approval and authorization of individual charity care write-off will require two signatures and Pushmataha Hospital's decision will be made by the following individuals:

Amount to be Written Off as Charity Care	Proper Authorization
Any amount	Chief Executive Officer

ii. Approval Notification

The patient shall be notified in writing within ten (10) working days after receipt of the Charity Care Application and any supporting materials as to whether the patient qualifies for the Charity Care Program. The patient will be notified that she or he is eligible for Charity Care by letter **(Appendix E)**.

iii. Expired Patients

Patients who have died and leave an estate valued at less than $25,000 are deemed eligible for Charity Care.

C. Denial

If a patient is denied Charity Care, the patient shall be informed within ten (10) working days of the denial. All reason(s) for denial shall be provided at that time and the patient shall be informed of the appeal process under Section 5.D **(Appendix F)**.

D. Appeal

Each patient denied Charity Care may petition Pushmataha Hospital within thirty (30) days for reconsideration based on extenuating circumstances. The patient will be notified of the appeal process in the correspondence informing the patient of the Charity Care denial and he/she may appeal using the Charity Care Appeal Form **(Appendix G).** The appeal form will be mailed along with the denial letter.

6. Publication

A. Publication Inside Pushmataha Hospital

The application for Charity Care at Pushmataha Hospital can be obtained from the Registration Clerk.

7. Notification
   A. Patient Notification Inside Pushmataha Hospital
      Pushmataha Hospital shall provide all patients with oral or written notice of Pushmataha Hospital's Charity Care Program at the patient's request.

8. Recordkeeping
   A. Internal Recording
      All Charity Care applications will be logged in the Charity Care control log **(Appendix H)** and will be given a sequential control number. The completed applications will be kept on file for seven (7) years.
   B. Accounting
      Charity care shall be recorded using the direct write-off method and shall comply with all accounting regulations by the American Institute of Certified Public Accountants.

9. Reporting
   Pushmataha Hospital shall report the amount of Charity Care provided in cost and charges in its annual financial statements.

10. Attachments
    Appendix A, B, C, D, E, F, G, H

Appendix A
Letter to Patient Regarding Charity Care Availability

Dear Patient:

You may be eligible for medical care even if you cannot pay for it.

Pushmataha Hospital has a Charity Care Program for patients who cannot afford to pay for medically necessary care. Eligibility for the program is based on your family's income and the number of people in your family. It may also be based on whether your medical expenses would constitute a medical hardship.

In order to be considered for care you need but cannot pay for, please complete the attached application form. If you have any questions or need assistance in completing this application, please contact our Registration Department or Controller at (580) 298-3341. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please fill out the forms completely. Pushmataha Hospital will also need the following:

1. Must have proof of residency of Pushmataha County for the previous 6 months (Ex. Utility bills, bank statements, etc.)
2. Must have denial letter from Pushmataha County DHS (dated within the last 30 days)
3. Must have proof of income with application
4. Must have previous year's tax return or signed statement that none was filed

Please send your application to:

Pushmataha Hospital
Controller
PO Box 518
Antlers, OK 74523

We will notify you within thirty (30) business days as to whether your Charity Care Application has been approved.

If you are denied Charity Care, you may: 1) appeal the denial; 2) re-apply for Charity Care at any time if your financial situation changes; or 3) work out a payment plan with our Controller, considering your existing financial obligations.

Thank you

Appendix B
Charity Care Application Form

1. Applicant Information:

Last Name First Name MI	Charity Care Sequential Control Number (CCSN, completed by Pushmataha Hospital)
Street Address	Telephone Numbers Home:_____ Work: _____ Cell: _____
City State Zip Code	Mailing Address (if different from Street Address)
Date of Birth	____ Male ____ Female / Are you pregnant? Yes___ No___

Are you: **Homeless?** **Yes___** **No___**
Unemployed? **Yes___** **No___**
Uninsured? **Yes___** **No___**

2. If you are applying for someone else, please complete this section:

Last Name First Name MI	Relationship to Applicant:
Street Address	Telephone Numbers Home:_____ Work: _____ Cell: _____
City State Zip Code	Mailing Address (if different from Street Address)

3. **Family Information:** List the people in your family who live with you and you support with your income. Include your spouse, dependent children under age 18 and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M___ F___	Y___ N___
			M___ F___	Y___ N___
			M___ F___	Y___ N___
			M___ F___	Y___ N___

4. **List Earned Income** before taxes and deductions for each family member who works:

Name of Working Family Member	Employer Name & Address	Amount Earned	How Often? Weekly / Monthly / Annually

5. **Other Income not from an employer:**

Type of Income	Family Member Receiving Income	Amount	How Often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veterans' Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
County General Relief			
Refugee Resettlement Program			
Dividend Income			
Bank Account Income			
Other Income, please specify			

6. **Assets:**

Type of Asset	Estimated Value	Mortgage Balance
Personal Residence		
Other Real Estate		
Bank Accounts Checking Savings		
Retirement Accounts IRA Other		
Stocks and Bonds		

7. **Other Expenses:** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family in a nursing home.

Payment Type	Recipient Name / Relationship	Amount Paid	How Often? Weekly/Monthly/Annually
Alimony			
Child Support			
Personal Needs Allowance			

8. **Other Insurance:** Charity Care can pay for such things as your co-payments and deductibles even if you have other insurance.
   a. Are you covered under any health insurance program, including Medicare? Y___ N___

Policy Holder (Name)	Insurance Company	Policy Number

   If yes:
   b. Are you seeking Charity Care because of a work-related accident or injury? Y___N___
   c. Are you seeking Charity Care because of a car accident? Y___ N___
   d. Are you a student? Y___ N___ If yes, are you fulltime?___ part time?___
   e. Do you have an application pending for any of these programs? *(Check all that apply)*
      Medicaid ___
      Medicare ___

   f. Are you currently approved for Charity Care at another hospital or community health center? Y___ N___ If yes, where? _____

9. **Medical Bills:** Total medical bills _____

10. **Assignment of Rights:** *(Read this section carefully and sign)*

I agree to tell Pushmataha Hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Charity Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

I understand that Pushmataha Hospital cannot share confidential information with any state or federal agency without my prior approval.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Authorized Representative Date

If you have any questions about this application, contact the Controller at (580) 298-3341.

Mail or deliver the completed application to:

Pushmataha Hospital
Attn: Controller
PO Box 518
Antlers, OK 74523

Appendix C
Medical Hardship

In some instances there may be extenuating circumstances requiring special consideration in approving Charity Care. There may be patients who do not meet the established financial criteria for Charity Care but may still qualify because of financial and medical circumstances creating a "medical hardship". While it is not possible to provide a complete list of all of the extenuating circumstances that may arise, some important factors to consider include:

- The amount owed by the patient in relation to his/her total means.
- The medical status of the patient or his/her family's provider.
- The employment potential of the patient in light of his/ her medical condition and/or skills in the job market.
- The likely emotional and medical impact of financial indebtedness upon the patient and family.
- Whether the patient lives on a fixed income.
- Existing liabilities such as a mortgage, school tuition, or automobile or college loan.
- The effect a catastrophic illness has on the ability of the patient to work.

APPENDIX D
PUSHMATAHA HOSPITAL
HHS POVERTY GUIDELINES 2012 FOR CHARITY CARE

	SIZE OF FAMILY UNIT	= OR > 100 PERCENT OF POVERTY	= OR > 125 PERCENT OF POVERTY	= OR > 150 PERCENT OF POVERTY	= OR > 178 PERCENT OF POVERTY	= OR > 206 PERCENT OF POVERTY	= OR > 234 PERCENT OF POVERTY	= OR > 262 PERCENT OF POVERTY	= OR > 290 PERCENT OF POVERTY	= OR > 318 PERCENT OF POVERTY	= OR > 346 PERCENT OF POVERTY	= OR > 374 PERCENT OF POVERTY	= OR > 400 PERCENT OF POVERTY	= OR < 420 PERCENT OF POVERTY
INCOME	1	11,170	13,963	16,755	19,883	23,010	26,138	29,265	32,393	35,521	38,648	41,776	44,680	46,914
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	2	15,130	18,913	22,695	26,931	31,168	35,404	39,641	43,877	48,113	52,350	56,586	60,520	63,546
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	3	19,090	23,863	28,635	33,980	39,325	44,671	50,016	55,361	60,706	66,051	71,397	76,360	80,178
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	4	23,050	28,813	34,575	41,029	47,483	53,937	60,391	66,845	73,299	79,753	86,207	92,200	96,810
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	5	27,010	33,763	40,515	48,078	55,641	63,203	70,766	78,329	85,892	93,455	101,017	108,040	113,442
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	6	30,970	38,713	46,455	55,127	63,798	72,470	81,141	89,813	98,485	107,156	115,828	123,880	130,074
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	7	34,930	43,663	52,395	62,175	71,956	81,736	91,517	101,297	111,077	120,858	130,638	139,720	146,706
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
INCOME	8	38,890	48,613	58,335	69,224	80,113	91,003	101,892	112,781	123,670	134,559	145,449	155,560	163,338
WRITE OFF %		100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%

PATIENTS/GUARANTORS QUALIFYING FOR CHARITY ASSISTANCE MUST, IF UNABLE TO PAY REMAINING BALANCE IN FULL, MAKE PAYMENT ARRANGEMENTS ACCORDING TO HOSPITAL POLICY. IF PATIENT/GUARANTOR DOES NOT COMPLY WITH THE ARRANGEMENT THEN COLLECTION ACTION MAY BE TAKEN.

Appendix E
Notification Letter for Patients Eligible for Charity Care

Dear Patient,

Your application for Charity Care for account number(s) _____ _____ in the amount of $_____ has been approved for a _____% discount. You are/will be responsible for $_____.

Your application for Charity Care for medical services to be provided during the month of _____ , _____ has been approved.

In the future, if you are in need of medical services at Pushmataha Hospital and your financial situation has not changed, you may be eligible for additional Charity Care. Please see our Controller and request an update to your Charity Application.

If you have additional questions, please call our Controller at (580) 298-3341.

Thank you

Pushmataha Hospital

Appendix F
Denial Letter / Appeal Form

Dear Patient:

Pushmataha Hospital cannot provide you coverage with Charity Care at this time because:

_____
_____
_____
_____
_____
_____

You can appeal this denial of Charity Care by completing the Appeal Application. Mail it to:

Pushmataha Hospital
Controller
PO Box 518
Antlers, OK 74523

Choctaw Memorial Hospital will notify you within (10) business days if your Appeal is approved.

If your financial circumstances change, you may be eligible for Charity Care. Please reapply if your income or expenses change.

You may be eligible for a reduced payment plan. Contact the Controller at (580) 298-3341 to discuss this.

You are allowed by law to get Emergency Medical Care from the hospital.

If you have further questions, call (580) 298-3341.

Sincerely,

Pushmataha Hospital

Appendix G
Charity Care Appeal Form

Complete this form if you have been denied Charity Care and want your case reconsidered.

If you have questions about this form contact (580) 298-3341.

Please mail the completed form to:

Pushmataha Hospital
Controller
PO Box 518
Antlers, OK 74523

Your Name _____
Address _____
_____
_____
_____
Patient Account Number _____
Services Provided / Dates of Service _____
_____
_____

I am appealing the denial of Charity Care. I request that my Charity application be reconsidered for the following reasons. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date this Appeal is submitted: _____

Signature _____

Appendix H
Charity Care Patient Log

CCSC Number	Date	Patient Number	Patient Name	Total Charges	Charity App. Returned?	Charity Approved?	Charity Amount	Notes