

## Patient Financial Assistance Policy

### **POLICY:**

St. Luke Community Healthcare, a not for profit hospital and affiliated medical clinics offering a broad range of medical care, and is committed to providing necessary, available medical services to patients with both efficiency and sensitivity to the patient's medical and financial needs. Patients may be eligible for financial assistance based on financial needs as defined by criteria in the policy. This assistance is available without regard to race, color, creed, national origin, age, disability, health care condition, or marital status.

The following criteria will be used to determine eligibility.

- 1) Patient care, which is not medically necessary, including elective surgery, cosmetic, or other care deemed to be generally not reimbursable by traditional insurance carriers and governmental payers, shall not be considered eligible for Financial Assistance.
- 2) Financial Assistance provided by St. Luke under this policy is secondary to all other third parties and financial resources available to the patient. If needed, a Patient Account Representative is available to help facilitate application for other sources of payment. (Medicaid, SSI, SSDI).
- 3) If a person applying for Financial Assistance, would have been eligible for other third party coverage but failed to comply with the terms of that payer and payment was denied, the denied amount will not be eligible for Patient Financial Assistance.
- 4) Accounts older than 6 months from the date of the application may be considered for Financial Assistance on a case by case basis.
- 5) Any account that is in a bad debt status will not be considered for Financial Assistance.

### **PROCEDURE:**

The Financial Assistance packet will be given to or sent to the patient, or legal guardian. The patient or legal guardian will be required to return the completed Financial Assistance Application, along with all required documentation, within 30 days.

- 1) Each application must be completed in its entirety and must be accompanied by a denial from Medicaid. The following proof of income **must** be included with the Financial Assistance Application:
  - Payroll check stubs, or other monthly income sources for the last three months for all persons living in the house, whether related or not.
  - Copy of all bank statements for prior 6 months.
  - Copy of latest Federal and State Income tax return, with supporting schedule.
- 2) The patient's financial status will be evaluated using the Patient Assistance Eligibility Guidelines table.
- 3) If St. Luke determines that any material documentation or information submitted is untrue or falsified, the application will be denied.
- 4) After all forms have been completed, applications for accounts up to \$15,000.00 will be sent to the Business Office Manager, the CFO and/or their designees for a decision to approve or deny. Applications over \$15,000.00 will need to go to the Board of Directors for further approval.
- 5) St. Luke will notify the patient or legal guardian in writing of the final determination regarding financial assistance within 60 days of receiving the completed packet.
- 6) Payment arrangements will be made for the adjusted balance. The minimum payment will be \$25.00 a month and the payment span is not to exceed 3 years for all balances. If payments are defaulted on, the full balance will be turned to collection.
- 7) Patients who expire with no estate or other known source of payment will qualify for full charity assistance. The patient record must contain verification of no estate.
- 8) Patients identified as transients with no permanent address or means of support will qualify for full charity assistance.
- 9) Patients who wish to appeal any decision made regarding eligibility must do so in writing within 30 days of receiving notification. This appeal must be directed to the Chief Financial Officer.
- 10) A letter stating why you are in the position you are, and what plans you have to change your situation.

These are guidelines; each individual situation will be reviewed independently. Allowances will be made for extenuating circumstances.



**ST. LUKE COMMUNITY HEALTHCARE**

**\*\*PLEASE ENCLOSE LATEST STATE AND FEDERAL TAX RETURN\*\***

**Personal Financial Statement**

**\*Confidential\***

You have indicated that you are unable to meet the St. Luke's payment requirements on your account(s). In certain instances we are able to consider reduced payments. In order for us to consider your proposal, all the fields must be completed. This form must be returned within ten (10) days. Your signature authorizes St. Luke to verify information provided in the financial agreement and to obtain a credit report.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouses Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouse: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Does your employer provide Health Insurance Y or N.

If yes please list Insurance Company: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Does your employer provide Health Insurance Y or N.

If yes please list Insurance Company: \_\_\_\_\_

Number of Dependents: \_\_\_\_\_ Ages: \_\_\_\_\_

Gross Monthly Income:

Self

Spouse

Employment: \_\_\_\_\_

Commissions: \_\_\_\_\_

Bonuses/Tips: \_\_\_\_\_

Other (specify): \_\_\_\_\_

Total Income: \_\_\_\_\_

Assets:

Checking Account Balance \$ \_\_\_\_\_  
Savings Account Balance \$ \_\_\_\_\_  
Other Account Balance \$ \_\_\_\_\_  
Stocks and Bonds \$ \_\_\_\_\_  
Name of Bank: \_\_\_\_\_

Other Assets:

Automobile \$ \_\_\_\_\_  
Automobile \$ \_\_\_\_\_  
Automobile \$ \_\_\_\_\_  
Home and Land \$ \_\_\_\_\_  
Other Real estate \$ \_\_\_\_\_  
Other Real estate \$ \_\_\_\_\_  
Other Real estate \$ \_\_\_\_\_  
Livestock \$ \_\_\_\_\_  
Recreation Vehicles \$ \_\_\_\_\_  
Recreation Vehicles \$ \_\_\_\_\_  
Other assets \$ \_\_\_\_\_

Liabilities:

Auto Loan Balance \$ \_\_\_\_\_  
Auto Loan Balance \$ \_\_\_\_\_  
Auto Loan Balance \$ \_\_\_\_\_  
Home and Land Balance \$ \_\_\_\_\_  
Other Loan \$ \_\_\_\_\_  
Credit Card Balances \$ \_\_\_\_\_  
Medical Bills \$ \_\_\_\_\_

Monthly Expenses

Home Mortgage or Rent \$ \_\_\_\_\_  
Auto Loan \$ \_\_\_\_\_  
Auto Loan \$ \_\_\_\_\_  
Auto Loan \$ \_\_\_\_\_  
Insurance (Home) \$ \_\_\_\_\_  
Insurance (Medical, Vision, Dental) \$ \_\_\_\_\_  
Insurance (Auto) \$ \_\_\_\_\_  
Utilities \$ \_\_\_\_\_  
Credit Cards \$ \_\_\_\_\_  
Cell Phone \$ \_\_\_\_\_  
Home Phone \$ \_\_\_\_\_  
Television \$ \_\_\_\_\_  
Medical \$ \_\_\_\_\_  
Food/Groceries \$ \_\_\_\_\_  
Collections \$ \_\_\_\_\_  
Prescriptions \$ \_\_\_\_\_

**St. Luke Community Healthcare Uncompensated Services Statement**

Patient name: \_\_\_\_\_

Date \_\_\_\_\_

For **services already rendered** by St. Luke, list date of services and dollar amounts:

\_\_\_\_\_ \$ \_\_\_\_\_

I hereby request from St. Luke that Financial Assistance be provided to me, or my family member named above, as may be determined by St. Luke's policy. In requesting these uncompensated services I certify that the foregoing information is true, accurate and complete. I also certify that at this time I am unable to pay for the health services in full. I understand that the information, which I submit, may be subject to review by Federal and/or State enforcement agencies and others as required by law. In order that St. Luke may act upon my request for uncompensated services, I hereby agree to supply the Hospital, its managers, operators; agents or employees, such additional information as the Hospital may reasonably require in order to verify my income. I do hereby further release St. Luke, and its respective agents and employees, from all liability arising out of their reasonable efforts to verify the information I have stated in this request.

It is agreed that any balances not waived or reduced for past services are accepted to be owed by the undersigned and payment or payment arrangements will be made to St. Luke.

The undersigned hereby authorizes St. Luke to investigate any references listed or statements or other data obtained from me or from any other person pertaining to my credit and financial responsibility and to obtain a consumer credit report for the purpose of evaluation of this application.

\_\_\_\_\_  
Requester Signature  
(Requested on behalf of patient)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Relationship to Patient

**ACCEPTED**

**DECLINED**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**DEFINITIONS:**

Assets: Property of all kinds, real and personal, tangible and intangible that is legally applicable or subject to the payment of the patient’s debts, including, but not limited to , cash on hand, checking and savings accounts, vehicles, mineral rights, stocks, mutual funds, and any other investments; provided, however, that “income,” as defined herein, shall not be included in determination of assets.

Household: A household consist of all persons who occupy the same housing unit as the applicant, and would be recognized as in the same household under the Federal income poverty guidelines. However, if a responsible party is an adult living in a residence with relative (other than a spouse) who are not economically dependent on the responsible party (i.e. parents of an adult child living at home) or with other adults, “household size” for the purpose of determining eligibility of financial assistance excludes the non-economically dependent relatives and any other adults who may be living in the same residence.

Income: Income is the total annual cash receipts before taxes from all sources which includes, but is not limited to, wages and salaries before deductions, net receipts from non-farm self-employment income, net receipts from farm self-employment, social security payments, railroad retirement, unemployment compensations, workers compensation benefits, veteran’s payments, public assistance payments, Supplemental Security Income, Social Security Disability Income, alimony, child support, military allotments, private pensions, government pensions, annuity payments, college or university scholarships, grants, fellowships, dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, survivor dependents benefits, contract payments, and net gambling or lottery winnings.

Responsible Party: The patient or any individual legally obligated to pay for the patient’s debts for medical care, excluding third party payers. An adult patient, living in the household of a relative other than a spouse – including an adult, unmarried child living at home – will be considered the “responsible party” for purposes of this policy, without regard to the assets and income of the other relatives living in the household (except a spouse).

**Patient Assistance Guidelines Table**

Family income	Family size								Write Off %
	1	2	3	4	5	6	7	8	
300% poverty	32670	44130	55590	67050	78510	89970	101430	112890	25
250% poverty	27225	36775	46325	55875	65425	74975	84525	94075	50
200% poverty	21780	29420	37060	44700	52340	59980	67620	75260	75
150% of Poverty Level	16335	22065	27795	33525	39255	44985	50715	56445	100

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