801 N. State Street
Greenfield, IN 46140
(317) 468-4900
pfs@hancockregional.org

Hancock Regional Hospital
Financial Assistance Policy Summary

Overview

Hancock Regional Hospital is dedicated to being responsive to and working with the members of our community to provide and support preventative, acute, chronic and terminal care for the benefit of the people of Hancock County and surrounding areas. The hospital also recognizes the patient's right to considerate and respectful care regardless of age, race, creed, color, national origin, sex, handicap or ability to pay.

Hancock Regional Hospital is committed to offering financial assistance to those who have health care needs and are not able to pay for care. This would include those that are not insured, underinsured, not eligible for a government program, or do not qualify for governmental assistance (for example Medicare and Medicaid). The Hospital strives to ensure that the financial capacity of those who need health care does not hindered them from seeking or receiving care. The following is a summary of the Hospital's Financial Assistance Policy (FAP).

Availability of Financial Assistance

Financial assistance is available for those that do not have insurance, are underinsured, or if it would be a financial hardship to pay for the expected out of pocket expenses for services rendered by any department of Hancock Regional Hospital.

Eligibility Requirements

Financial assistance is determined by analyzing the household gross income with the most current Federal Poverty Level (FPL) guidelines. Parameters have been established to allow for an assistance adjustment if the household gross income is at or below 300% of the federal poverty guidelines and no there is no other eligible program available to assist with medical expense coverage. No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care.

Amounts Generally Billed (AGB) is the sum of all amounts of claims that have been allowed by health insurers (total charges less contractual allowances) divided by the sum of the associated gross charges for those claims.

AGB%=Sum of Claims Allowed Amount$/Sum of Gross Charges$ for those claims

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Hancock Regional reviews the calculated AGB on an annual basis.

- Look Back Method is used. A twelve (12) month period is used.
- Includes Medicare Fee for Service and Commercial payers
- AGB effective January 1, 2017 = 56%

Those with sufficient insurance coverage or assets available to pay for the care may not be eligible for financial assistance.

Where to Find Information

There are several ways to find information regarding our FAP application process, or obtaining copies of the FAP or FAP application form. To apply, please choose one of the following options:

- Download the information online from www.hancockregionalhospital.org
- Request the information in writing by mail or visiting HRH at 801 N State Street Greenfield, IN 46148.
- Calling our Business Office Monday – Friday 8a-5p at (317) 468-4900.
- Emailing us at pfs@hancockregional.org

For a listing of our available physicians, please reference one of the following:

- Our website www.hancockregionalhospital.org
  - Find a doctor link
    - Can search by specialty or obtain a listing of all affiliated physicians at Hancock Regional Hospital
- Call our physician referral line 317-468-GOMD (317-468-4663)

Availability of Translations

The Financial Assistance policy, application form and the plain language summary are offered in English: however, the Hospital may provide assistance through the use of a qualified bilingual interpreter upon request.

How to Apply

The application process involves filling out the financial assistance form and submitting the form along with the supporting documents to the Hospital for processing. There are also Financial Counselors available at our 801 N State Street location in Greenfield, IN. Financial assistance applications can be submitted to the Financial Counselor at the following address:

Hancock Regional Hospital
Attn: Financial Counselor
801 N State Street
Greenfield, IN 46140

Financial Assistance Policy

PURPOSE:

The intent of this policy is to provide medically necessary health care services for patients in the hospital's service area, as defined by the hospital from time to time. The hospital intends to establish a policy and appropriate procedures, compliant with all applicable federal, state and local laws, for use in circumstances in which financial assistance shall be offered to the hospital's uninsured or underinsured patients on a nondiscriminatory basis.

Hancock Regional Hospital is dedicated to being responsive to and working with the members of our community to provide and support preventative, acute, chronic and terminal care for the benefit of the people of Hancock County and surrounding areas. The hospital also recognizes the patient's right to considerate and respectful care regardless of age, race, creed, color, national origin, sex, handicap or ability to pay.

As a publicly owned county hospital, Hancock Regional Hospital recognizes its responsibility to provide reasonable medical care to the indigent residents of Hancock County. Financial assistance shall be extended to these residents within the guidelines and procedures of the Financial assistance Program for all emergency, elective, and non-elective services provided for by this hospital.

As a regional provider of medical care, Hancock Regional Hospital also recognizes the utilization of our services by indigent patients living outside of Hancock County. Given the necessity of maintaining an efficient, cost-effective operation, the hospital reserves the right within the guidelines and procedures of the Financial assistance Program to limit the access of these patients to elective medical services provided on a charitable basis. This policy is restricted to "elective" procedures only and does not pertain to emergency medical conditions as defined by State and Federal law.

Through this policy, the hospital will have financial assistance and financial assistance policies and practices that are consistent with its mission and values, and with federal and state laws, and that take into account each individual's ability to contribute to the cost of his or her care, as well as the hospital's financial ability to provide the care. As well, the Financial assistance Program shall contribute to the delivery of quality, efficient, cost-efficient care for residents of Hancock County and for the extension of emergency and immediate, non-elective medical services to non-residents.

POLICY:

1. <u>Administration of Program</u>

   a. Concern over a hospital bill will never prevent any individual from receiving emergency health services. The hospital will communicate this message clearly to prospective patients and to local community service agencies and make it clear that emergency services will be provided without regard to ability to pay.

   b. The hospital will assist patients in obtaining health insurance coverage from privately and publicly funded sources whenever appropriate. The Social Services Department and Patient Financial Services Department will be responsible for providing financial guidelines and information on programs for which patients may apply for assistance with their hospital bill. These programs include:

Healthy Indiana Plan (HIP)
Medicaid Pregnancy
Medicaid for Children
Medicaid Disability
Medicaid Old Age
Children with Special Health Care Needs
Qualified Medical Beneficiary (QMB)

Referrals may also be made to Social Security to apply for disability, SSI and assistance with Medicare verification.

c. The registration area of the Patient Access Services Department will be responsible for the identification of all self-pay elective surgery patients. All admissions of this type will be required to make a minimum deposit of $500.00 towards their hospital bill. If the patient is unable to make this deposit, Social Services is to be notified immediately to determine both the medical necessity of the admission and the payment ability of the patient/guarantor. Patients failing to meet the deposit requirement and whose medical condition does not meet the following definition of an emergency medical condition will be referred to their respective county health agencies for treatment.

d. The determination of medical necessity is to be made in only non-emergency medical conditions. An emergency medical condition as defined by state and federal law is "a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of individual in jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. The restriction of this medical necessity determination to purely "elective" procedures if necessary to comply with the Federal Anti-Dumping Statute. Any questions to the determination of medical condition shall be referred to a designated committee of staff physicians.

e. Hancock Regional reserves the right to evaluate all non-resident emergency admissions and admissions of Hancock County residents (including any insured patient who indicates an inability to pay his or her liability after his or her insurance has paid) on a case-by-case basis, especially where complex medical or financial situations exist.

f. All patients eligible for the Financial Assistance Program will be required to cooperate fully in the application process of the above stated programs. Eligibility guidelines are
   i) To be eligible for a 100 percent reduction from charges (a full write-off), the patient's household income must be at or below 150% of the current Federal Poverty Guidelines.
   ii) Patients with household income that exceeds 150% but is less than 300% of the Federal Poverty Guidelines will be eligible for a sliding scale discount.
   iii) Cases involving medically needy patient accounts will be considered on a case-by-case basis.The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.

g. Hancock Regional Hospital will not initiate/authorize a financial assistance application

   i) If false information was provided by the patient or responsible party; or
   ii) The patient or responsible party refuses to cooperate with any of the terms of the policy; or
   iii) The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs.

2. Documentation Requirements

a. Patients/guarantors will be required to submit the following information prior to the application for financial assistance services:
   i) Application for Financial Assistance (Exhibit A)

   Upon submission of this information, it will be reviewed for the determination of qualified financial assistance write-off. This analysis will focus primarily on the applicant's household income level and financial position.

b. Income Analysis – The gross monthly income of the applicant's household will be taken from the financial statement. In determining the adequacy or inadequacy of gross income, the most current federal poverty income guidelines will be utilized. Parameters have been established per the Financial assistance Application Worksheet (Exhibit B) to allow for a 0 *to 300*% financial assistance write-off. Determination of the write-off percentage shall serve as guidelines in the decision process and should not be utilized independent of an analysis on the applicant's financial position.

c. Medical Debt to Income Ratio – The net worth position on the applicant will be determined from the financial statement. Financial assistance write-offs will not be considered on individual net worth positions in excess of ten thousand ($10,000) dollars. In the case of joint applicants (i.e. Husband and Wife), the combined net worth position shall not exceed twenty thousand ($20,000) dollars. These dollar limits are consistent with exemptions allowed in personal bankruptcies

3. Approval Authority

a. The Social Services Manager, with the assistance of the Social Services staff, will make recommendations on financial assistance write-offs to the following levels of authority. Dollar amounts are based on the total charity request per patient/guarantor.
   i) Up to $10,000 Patient Financial Services Team Leader
   ii) Over $10,000 Vice President of Finance

b. Exceptions to these program guidelines can be made on a limited basis within the appropriate levels of approval authority. Reasons for these exceptions are to be well documented in the patient's financial assistance folder.

c. Write-off forms are to be given to the Patient Financial Services Team Leader on a weekly basis for approval for posting.

d. Written notification is to be made to the applicant of any amounts approved for financial assistance. Exceptions to this are allowed when an internal write-off to charity has been made based upon information gathered independent of the patient.

e. A monthly summary of all Financial assistance Program write-offs will be submitted to the Board of Trustees for review.

4. Maintenance of Financial assistance Program Records

a. A log of all financial assistance applications will be maintained in a separate file in the Patient Financial Services Department. Only that portion of the patient care services approved as charity will be logged.

b. A copy of the charity application and necessary documentation will be maintained for a period of seven years.

c. All information relating to the determination of financial assistance under this policy will be well documented and maintained on a confidential basis. All documents relating to the application will be maintained in the patient's financial assistance folder.

d. An annual review of the Financial assistance Program and a Quality Assurance (QA) analysis will be submitted by Patient Financial Services to the Vice President of Finance by February 1st.

REVIEWED: 10/95, 10/96, 02/99, 9/02, 7/05, 4/11, 6/12, 01/13

REVISED: 10/30/95, 10/15/96, 02/15/99, 9/02, 7/05, 12/08, 4/11, 6/12, 01/13, 02/14

FINANCIAL QUESTIONNAIRE

EXHIBIT A

MR Number & Account Number to be completed by hospital personnel	*COUNTY*	*Hospital*	*Account Number:*

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional household members if there are more than five (5) members.

Patient's name (first, MI, Last)	Date of Birth::	Total # Household Members
Address:	Phone numbers: Home: ( ) Work: ( )	
City, ST ZIP:	Responsible if not patient:	

List ALL household member names	**Date of Birth**	**Relation to Patient**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Monthly Income		**Monthly Expenses**	
Responsible Party's Gross Income (before taxes)	**$**	Rent or own	
Other Household Gross Income (before taxes)	**$**	Medical and Pharmacy Bills	**$**
Investment Income (Annuities/Stocks/Dividends)	**$**	Make and model of Car	
Child Support/Alimony Received	**$**	1st –year/make/model	
Rental Property Income	**$**	2nd –year/make/model	
Pension/Retirement/Unemployment	**$**	Pharmacy Expenses	**$**
Other:	**$**	Health Insurance Costs	**$**
Food Stamps (Yes/No)	**$**	Other	**$**
Total Monthly Income (before taxes)	**$**	**Total Monthly Expenses**	**$**

Assets	
Checking Account Balance	**$**
Savings Account Balance	**$**
Other:	**$**

Comments:

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Hancock Regional Hospital. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Hancock Regional to obtain such assistance and will assign to Hancock Regional, and upon receipt will pay to Hancock Regional, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Hancock Regional will result in the denial of this application. I also authorize Hancock Regional to check my credit history through the credit bureau, if deemed appropriate.

I also authorize Release of Information from the Division of Family Resources to Hancock Regional Hospital Social Services/Patient Financial Services regarding application approval/denial for Food Stamps and/or Hoosier Healthwise/Medicaid.

Signature of Patient/Responsible Party

Date

EXHIBIT B

CHARITY APPLICATION WORKSHEET

DATE: _____ **APPLICANT'S TOTAL GROSS MONTHLY INCOME $**_____

IF THE ABOVE INCOME IS LESS THAN THE MONTHLY AMOUNT SHOWN ON THE FOLLOWING 2014 POVERTY INDEX GUIDELINES, THE APPLICANT IS ELIGIBLE FOR A 100% CHARITY WRITE-OFF.

2016 Poverty Guidelines - Policy Effective 05/01/16				
		A	B	C
Family Size	Base	150%	300%	Difference
1	$990	$1,485	$2,970	$1,485
2	$1,335	$2,003	$4,005	$2,003
3	$1,680	$2,520	$5,040	$2,520
4	$2,025	$3,038	$6,075	$3,038
5	$2,370	$3,555	$7,110	$3,555
6	$2,715	$4,073	$8,145	$4,073
7	$3,061	$4,592	$9,183	$4,592
8	$3,408	$5,112	$10,224	$5,112

_____ **YES, APPLICANT QUALIFIES FOR 100% CHARITY WRITE-OFF.**

_____ **NO, APPLICANT'S GROSS MONTHLY INCOME EXCEEDS THE POVERTY INDEX GUIDELINES BUT IS LESS THAN 300% OF THE POVERTY INDEX. CALCULATE THE PERCENTAGE OF CHARITY WRITE-OFF BELOW.**

GROSS MONTHLY INCOME	(-) COLUMN A	(=) INCOME ABOVE POVERTY
INCOME ABOVE POVERTY	(/) COLUMN C	(=) PATIENT'S % OF BILL
TOTAL CHARGES	(*) PATIENT'S % OF BILL	(=) PATIENT'S PORTION OF BILL
TOTAL CHARGES	(-) PATIENT'S PORTION OF BILL	(=) AMOUNT OF WRITE-OFF
PATIENT ACCOUNT #	AMOUNT	AMOUNT OF WRITE-OFF

RECOMMENDATION;_____

_____

_____

_____

HOSPITAL USE ONLY

Application: Approved _____ Denied _____ Date: _____

Total Charges: _____ $ Write-Off _____

If Denial, Reason: _____

_____

By: _____