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

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

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 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: _____