Origination:	*04/2009*
Last Approved:	*05/2021*
Last Revised:	*05/2021*
Next Review:	*05/2022*
Owner:	*BARBARA DURNAN: 084 REVENUE CYCLE*
Policy Area:	*Business Office*
References:	

Bath Community Financial Assistance Policy

Purpose:

Bath Community Hospital (BCH) and Bath Community Physician Group (BCPG) recognize that not all uninsured patients meet eligibility requirements for federal, state, or other programs. Therefore, in addition to assisting patients in determining eligibility for these programs, Bath Community Hospital offers financial assistance to eligible uninsured and insured individuals and families as is consistent with our mission. Bath Community Hospital will provide care, without discrimination, for emergency medical conditions and medically necessary conditions, to individuals whether or not they are eligible for financial assistance.

Policy:

I. Eligible Services

A. A hospital or clinic service meets eligibility when it is either emergent or medically necessary, per

CMS definition, and no more than 240 days have passed since the first post discharge statement of patient balance due was sent.

B.Services received in the Hospital by an insured or uninsured patient can be considered for financial assistance.

C. A patient that is uninsured or on a fixed Social Security Income that receives services in any of Bath

Community Hospital's On-site or Off-site clinics can be considered for financial assistance.

D.Physician services performed within the Emergency Department, by a BCH E.R. physician, are eligible for coverage under this policy.

E.Physician services performed by a BCH Hospitalist are eligible for coverage under this policy.

F.Physician or Nurse Practitioner services rendered by a (BCPG) clinic provider are eligible for coverage under this policy.

G.Physician services performed at BCH by any physician, other than those listed above, will be billed to the patient by the non-BCH physician practice or group and eligibility for any financial assistance will be at the discretion of that privately practicing physician or group.

H.Radiology interpretation services are provided by ARIS Radiology and are covered by this policy; however, ARIS Radiology needs to be contacted directly to receive any assistance, as adjustments

are not automatic.

II. Identifying Potential Financial Assistance

A. Any patient with limited insurance (non-elective service not covered by plan) or no insurance coverage will be considered potentially eligible for assistance through the Bath Community Financial Assistance Program. Patients are generally granted financial assistance for a term of one month. If the patient is on a fixed Social Security income, assistance may be granted for up to one year.

B. The Utilization Review Staff will screen inpatients as soon after admission as possible. A representative from the hospital will assist the patient with the program application, as well as, refer the patient/guardian to the Bath County Department of Social Services, and/or Pharmacy Connection Program, as applicable.

C. Outpatients can be referred to the program by healthcare providers, utilization review staff, or other departments when it is determined that the patient may need assistance with their accounts. Letters/Applications are given, to all private pay patients, at the time of service and are available by request at any time.

III. Eligibility for the Bath Community Hospital Financial Assistance Program

A. The family income for the household, as defined by the program, cannot exceed 200% of the federal poverty guidelines (FPG).

B. Does not currently have the funds to pay nor liquitable assets.

C. The patient must provide all required documentation.

D. An eligible service has been provided to the patient.

E. The total balance of all hospital and clinic accounts combined, and have not already received assistance discounts, is over $300.00.

F. Financial Assistance will not be available for NO SHOW and LATE CANCELLATION FEES.

G. At the discretion of the CFO and the Revenue Cycle Director, eligibility consideration may be made on an individual bases depending on the households unique financial situation.

IV.Financial Assistance Application

A. Any patient applying for assistance must complete a Bath Community Financial Assistance application as well as supply all required information.

B. The following additional information must accompany the completed application (if applicable):

1. The patient must provide a complete copy of their most recent tax return and/or a copy of W-2 forms and 1099 for the last year.
2. Copies of three (3) months of pay stubs, or a statement from your employer
3. In the event of direct deposit copies of three (3) most recent bank statements will be used to verify employment
4. Copies of bank statements for the last three (3) months, both checking and savings
5. Copies of unemployment or disability compensation benefits
6. Copies of pension benefits
7. Copies of Social Security income (yearly benefit statement, letter from Social Security)
8. Court order for alimony or child support.
9. Proof of debts may be requested at the discretion of the Financial Advisor or Revenue Cycle Director.

V. Calculation of Annual Income

A. Special circumstances in determining household income

1. Seasonal employment: Annual income should be determined by adding the total income of the past 12 months.
2. Unemployment: If an individual has been unemployed for less than 3 months, the eligibility determination should be made according to the previous year's income tax return. If an individual has been unemployed for 3 months or more, one of the following documents should be provided; copy of unemployment check, separation letter from employer, medical documentation of inability to work, or proof of recent incarceration and eligibility should be based upon the individual's current financial circumstances.

A. New job: Income should be projected out for 12 months based upon the new income. The following will be included in the calculation of annual income to determine eligibility for charity care assistance:

1. Gross annual wages for the household will be considered in the calculation. (Note: Part-time income earned by dependent children is not generally considered when making a determination).
2. Income earned from rental property, interest income, retirement-social security disability and/or worker's compensation benefits and child/spousal support payments, will be added to gross wages.

** Note: If the patient has no income, they will be asked to produce a letter verifying their unemployment status, as well as proof of residence.

VI. Medicaid Application:

A. As part of the Review process, all patients requesting financial assistance are screened for potential Medicaid eligibility.

B. Patients who are potentially Medicaid eligible are instructed that they must rule out eligibility before they can be considered for Bath Community Financial Assistance. Failure to apply for Medicaid will result in automatic denial for the program.

C. For patients who are accepted into the Medicaid program with an effective date of when the patient applied for and received write offs under the Bath Community Financial Assistance, the following action will be taken.

- Adjustments are reversed

- Benefits are reversed on the date patient becomes eligible for Medicaid

- Medicaid is billed for services

VII. Determination of Eligibility

A. Applications for Bath Community Financial Assistance are reviewed within 10 days of receipt of all necessary information.

B. All patients receive written notice once a determination of eligibility has been made.

C. Patients found to be eligible for the Bath Community Financial Assistance may receive a discount of balances that are due to Bath Community Hospital for hospital and clinic visits.

Exceptions:

1. A patient who has previously been instructed to apply for Medicaid and has not complied with that request.
2. Services that are not medically necessary are not eligible for financial assistance. Medically necessary services will be defined by the patient's provider or insurance policy coverage. Examples include, but are not limited to: Cosmetic procedures, some orthopedic procedures, ED visits in excess of limit, not a true emergency.

D. Patients eligible for the Bath Community Financial Assistance will receive assistance based upon the discount guidelines indicated below.

E. The Patient Financial Advocate will maintain a file folder for all completed applications. This file will contain documentation used to make a determination of eligibility. In addition, a database is maintained which contains current eligibility and account information.

F. All accounts recommended for financial assistance will be documented on an eligibility form and presented for administrative staff approval.

G. The CFO and Revenue Cycle Director may provide additional assistance to a patient based on a household unique financial situation.

VIII.Assistance Levels:

- Level 1 – Uninsured
  Patients at or below 100% of the Federal Poverty Guidelines (FPG) may be eligible for a 100% discount of their entire hospital account balance. Clinic patients may be eligible to have each of their visit charges reduced to a $30 co-pay.
- Level 1 – Insured
  Patients at or below 100% of the FPG may be eligible for a 100% discount of their hospital deductible but will be responsible for any and all co-pays or co-insurance. No reduction of visit charges will be made in the clinic at this level; however, payment terms can be arranged with a financial advocate.
- Level 2 – Uninsured
  Patients at 101% to 200% of the FPG may be eligible for an 80% discount of their entire hospital account balance. Clinic patients may be eligible to have each of their visit charges reduced to a $75 co-pay.
- Level 2 – Insured

Patients at 101% to 200% of the FPG may be eligible for a 50% discount of their hospital deductible but will be responsible for any and all co-pays or co-insurance. No reduction of charges will be made in the clinic at this level; however, payment terms can be arranged with a financial advocate.

IX. Denial of Request for Financial Assistance:

A. Patients who are not eligible for financial assistance are notified in writing and given the reason for denial. The letter also informs the patient that they can appeal the decision.

B. These patients are then informed of BCH payment plan policy.

C. If charges are pending legal action by an attorney or are considered to be workers compensation claims, they are not eligible for financial assistance.

D. The total balance of all hospital and clinic accounts combined, but have not already received assistance discounts, is under $300.00.

E. Charges are for NO SHOW or LATE CANCELLATION FEES.

X. Program Approval:

When the patient/family is approved for Bath Community Financial Assistance, the Patient Financial Advocate will send a letter of approval or proof of assistance card which will contain the following information:

A. Co-pay, co-insurance, or amounts due, if any, at the time of service.

B. Level of assistance provided.

C. Expiration date.

XI. Excess Real Estate Equity

If an individual otherwise qualifies for financial assistance but has equity in real estate in excess of $100,000, the excess will be added back to the patient's account after the financial assistance discount up to original amount of the bill. The excess amount can be deferred from payment by a lien on the real estate rather than being paid from current income.

XII. Falsification of Application

Any falsification in the application for financial assistance or the supporting documents will result in denial of financial assistance in the future.

Procedure: Initial Review Process

1.At the time of registration to the hospital or BCPG, all patients will be offered The Plain Language Summary of the Financial Assistance Policy along with instructions to return to Patient Financial Advocate (PFA) when completed. For any questions, patients are instructed to call the PFA at 540-839-7054.

2.All completed forms are received by the PFA. Each form will be reviewed by the PFA to determine if the patient may be eligible for Medicaid. If eligible for Medicaid, the patient is instructed that application to Medicaid is required and assistance will not be granted if the Medicaid application is not completed. The PFA, as well as the Utilization Review Staff, will inform the patient of other available services.

3.If the form is incomplete or does not include supporting documentation, the PFA will not accept the form or send the form back to the patient with a letter stating the reason it has been denied and what information is needed to process the financial application.

4.All completed forms and supporting documentation will be reviewed and assessed for all community resources by the PFA. The Bath Community Financial Assistance Worksheet will be completed to identify the level of assistance that is recommended.

5. The PFA will forward all applications to the Revenue Cycle Director for review and approval.

6. The Revenue Cycle Director will review the application, supporting documents, and determine approval or denial for assistance and will date and sign the eligibility form. If financial assistance is denied, the reason will be documented on the form.

7.After final approval, the packet is returned to PFA who will send the patient a letter or card stating the level of assistance and the guidelines of the program. The letter will be effective for one month and the card for up to a year, unless otherwise noted. Both will indicate the level of reduction in charges and the required co-pay amounts, if applicable, that are due at the time of service. If the patient is denied, a letter will be sent to the patient with the reason for denial of financial assistance.

Procedure: Continuation of Assistance

1. Every month, or at the PFA's request, the patient must provide supporting documents to reapply for financial assistance.
2. The patient continues to meet the eligibility criteria.

Bath Community Financial Assistance Sliding Fee Scale

2021 INDIGENT CARE GUIDELINES of VIRGINIA

Federal Poverty Guidelines – Annual Income

2021 POVERTY GUIDELINES				
Persons in family/household	Poverty guideline			
	100%	200%	300%	400%
1	$12,880	$25,760	$38,640	$51,520
2	$17,420	$34,840	$52,260	$69,680
3	$21,960	$43,920	$65,880	$87,840
4	$26,500	$53,000	$79,500	$106,000
5	$31,040	$62,080	$93,120	$124,160
6	$35,580	$71,160	$106,740	$142,320
7	$40,120	$80,240	$120,360	$160,480
8	$44,660	$89,320	$133,980	$178,640
For families/households with more than 8 persons, add $4,540 for each additional person.				

BATH COMMUNITY HOSPITAL FINANCIAL ASSISTANCE PROGRAMFINANCIAL ASSISTANCE APPLICATION

Bath Community Hospital understands that the cost of healthcare can be a financial worry for individuals in the community who do not have medical insurance or do not have the ability to pay for their care. In times of rising healthcare costs and insurance premiums and fewer resources to assist with medical expenses, we at Bath Community Hospital, long ago acknowledged our responsibility to assist our community and its families. From this desire to assist our community we created the Bath Community Hospital Financial Assistance Program

Bath Community Hospital Financial Assistance Program (BCHFAP) is a program designed to assist our patients. Assistance offered may include the discounting of one's bill for payment in full, otherwise known as a "settlement", or setting up monthly payment arrangements. Those that qualify for a charitable adjustment, may have their balance owed reduced or receive total forgiveness of the debt.

This application is being sent to let you know about our assistance program and the many ways the BCHFAP may be able to assist you. Dependent upon of the household income level and size, your charges could be reduced or eliminated. Please note that your financial information is kept confidential and only used to determine the level of assistance available to you. Those receiving a charitable adjustment will never be charged more that the hospital's average gross billed charges.

Before we can consider your application to the BCHFAP, you must apply for any other assistance programs that may be available for payment of your hospital charges (Medicaid, Medicare, medical insurance, auto insurance, etc.). You must take any action reasonably necessary to obtain such assistance and assign or pay to the Hospital any amount recovered for hospital charges. **There are no exceptions to this rule.** If your charges are pending legal action by your attorney, or are considered to be workers compensation claims, they are not eligible for financial assistance. If you have any question regarding this information or need assistance with other applications, please let us know, we will be happy to assist you.

If you think you may be eligible for financial assistance, please complete the enclosed form and submit it to the Patient Financial Advisor, at Bath Community Hospital. If questions do not apply enter N/A or zero amount and submit a letter explaining why you are unable to provide this information. Incomplete applications will be returned. Bath Community Hospital will make a written determination of your eligibility for financial assistance and notify you. Patient may be responsible for any associated co-pays and/or deductibles and this amount will not receive an adjustment. If you need assistance please call 540-839-7054. Completed applications should be mailed to:

Bath Community Hospital
Attn: Financial Assistance
PO Drawer Z
Hot Springs, VA 24445

Additional applications may be obtained at: www.bathhospital.org

Our Mission

Bath Community Hospital accepts primary responsibility for improving the health of our area by providing high quality, compassionate, and affordable health care to our region.

BATH COMMUNITY HOSPITAL

PO Drawer Z

Hot Springs, VA 24445

STEP 1: COMLETE INFORMATION BELOW

Name	Social Security #
Mailing Address	Birth Date
Physical Address	Telephone # Cell #
Marital Status: (Circle One) Single Married Divorced Separated Widowed	Are you Renting/Buying/Own/Other the property listed above?

STEP 2: FILL OUT INCOME/ASSET INFORMATION **If there is no reported income, explain your means of support**

Household Members- Include self and all persons living in household	Is this person requesting Financial assistance	Date of birth	Relation to head of household	Gross monthly Income (pretax)	Employer Name or Source of income (social security, retirement, unemployment, Etc.)	Employer Phone #

Does anyone in the household have a Checking or Savings Acct Yes / No (circle)	If yes please provide 3 months of statements for each account.
Does anyone in the household have Stocks, Bonds, IRA's, 401K, CD's, etc? Yes / No (circle)	If yes please provide most recent statement for each account.

Real Estate Property Address	Rent / Buy/	Total acreage	Monthly Payment $
Real Estate Property Address	Rent / Buy	Total acreage	Monthly Payment $

Taxable Personal Property: Yes / No (circle) List cars, boats, trucks, motorcycles, campers, mobile homes, etc.

Item	Make Model	Year	Owner	Amount Owed $	Value $
Item	Make Model	Year	Owner	Amount Owed $	Value $
Item	Make Model	Year	Owner	Amount Owed $	Value $

Do you have a life insurance policy for you or any dependent over 21 with a cash-in value over $1,500? Yes / No (circle)		
Name of Insurance company	Cash-in value	
Are you working with an attorney or insurance carrier on an accident claim? Yes / No (circle)		
Name of Attorney or Insurance company	Telephone #	Date of accident

Does anyone applying have health insurance including Medicare, Medicaid, VA Benefits or private insurance? Yes or No

Is yes please list person and insurance they have_____

Is anyone living in your home permanently disabled or blind? Yes or No

If yes please explain

_____

Does anyone living in your home pay court ordered child support for children not living in the residence? Yes or No

If yes please list who is responsible and amount paid

_____

Does anyone living in your home receive alimony/child support? Yes or No

If yes please list whom and amount received:_____

STEP 3: FILL OUT HOUSEHOLD EXPENSES & LIABILITIES INFORMATION

Total Utilities (Telephone, cable, water, sewer, etc.)	Electric Amount Other Amount Other Amount
Transportation	Loan payment amount Monthly gas expense
Food	Amount
Other Loans	Amount

Credit Cards	Amount
Other (List)	Amount
Medical Expenses such as supplies, Insurance premiums, Doctor or Dentist visits, hearing aids or glasses	
Totals:	

Have you quit, or been fired from employment, or refused a job offer in the last 60 days? Yes or No

If yes please explain_____

If you are unemployed please provide date employment ended _____. Have you applied for unemployment? Yes / No

If there is no reported income, have you applied for disability? Yes / No Are you planning on applying for disability? Yes / No

Employer(s)

Name	Address	Phone	Position	Years

NOTE: 1. You MUST attach proof of current income for past three months.

2. If you have zero income, attach a written explanation as to who provides your room and board. Also, provide an explanation of how expenses are being paid.

3. Social Security recipients must provide proof of Social Security income.

4. Provide a copy of checking, savings, stock and bond statements for the past three months.

5. Copy of tax return.

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance that may be available for payment of my hospital charges (Medicaid, Medicare, medical insurance, auto insurance, etc.). I will take any action reasonably necessary to obtain such insurance and will assign or pay to the Hospital any amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take appropriate action.

Bath Community Hospital reserves the right to request further income information and/or request that you apply for benefits through the Department of Social Services.

Date of Request:_____Applicants Signature:_____

FOR OFFICE USE ONLY

Names: _____

_____

_____

Financial Assistance Worksheet

Federal Poverty Guidelines Maximum: $ _____

Insured/Uninsured Carrier: _____

# of dependents _____

Income $ _____

Expenses $ _____

Income/Loss $ _____

Assets: If hardship, list expenses:

_____ _____

_____ _____

_____ _____

_____ _____

Screened for Medicaid? Yes No If yes, by who _____

Decision: Approved Denied If denied, reason _____

Reviewed by: _____ Date: _____

Please list account numbers and account balances for charity care consideration:

Please circle:

Approved Denied If Denied, Reason _____

_____ _____

Approved By Date

BATH COMMUNITY HOSPITAL

Bath Community Financial Assistance

Patient Notification Letter

Date: _____

Name / Address:

_____

_____

_____

Your application for the Bath Community Financial Assistance has been reviewed by Administration and the following level of assistance has been determined.

[ ] 1. You have been approved for the following level of financial assistance:

Insured:

( ) Level 1 Hospital – 100% reduction of Deductibles Only

( ) Level 2 Hospital – 50% reduction of Deductibles Only

You are approved for the month of _____. This letter must be presented when registering for any hospital services. **Co-pays, co-insurance, and, if applicable, deductibles are to be paid upon registration unless you have made other arrangements with the Financial Advisor**. For current balances, you will receive an adjusted bill that includes the approved discount, and will be required to pay any amounts owed in full unless other arrangements are made.

[ ] 2. Your application has been placed in pending status. Please provide the following information.

( ) Proof of current income

( ) Copy of previous year income tax return

( ) Copy of Social Security Income

( ) Current bank account statements including checking and saving account

( ) Current household income – letter signed by care giver

( ) Medicaid application results – approval or denial letter

( ) Application form was incomplete – complete all requested information

( ) Other _____

[ ] 3. Your application for financial assistance has been denied due to the following.

( ) Income exceeds 200% of the federal poverty guidelines for Virginia

( ) You have assets that provide for payment of your account

( ) Health insurance coverage is in effect

( ) Your account balances total less than $300

( ) Your balance is for fees not eligible for assistance

For questions, contact the Patient Financial Advocate at 504-839-7054. If you were not approved for a discount, you may request a payment plan.

Bath Community Financial Assistance

Patient Notification Letter

Date: _____

Name / Address:

_____

_____

_____

Your application for the Bath Community Financial Assistance Program has been reviewed by Administration and the following level of assistance has been determined.

[ ] 1. You have been approved for the following level of financial assistance:

Uninsured:

( ) Level 1 Hospital – 100% reduction ( ) Level 1 Clinic – $30 co-pay

( ) Level 2 Hospital – 80% reduction ( ) Level 2 Clinic – $75 co-pay

You are approved for the month of _____. This letter must be presented when registering for any hospital or clinic services. **Co-pays and other amounts due are to be paid upon registration unless you have qualified for a 100% reduction (Hospital only) or have made other arrangements with the Financial Advisor**. For current balances, you will receive an adjusted bill that includes the approved discount, and will be required to pay any amounts owed in full unless other arrangements are made.

[ ] 2. Your application has been placed in pending status. Please provide the following information.

( ) Proof of current income

( ) Copy of previous year income tax return

( ) Copy of Social Security Income

( ) Current bank account statements including checking and saving account

( ) Current household income – letter signed by care giver

( ) Medicaid application results – approval or denial letter

( ) Application form was incomplete – complete all requested information

( ) Other _____

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( ) Income exceeds 200% of the federal poverty guidelines for Virginia

( ) You have assets that provide for payment of your account

( ) Health insurance coverage is in effect

( ) Your account balances total less than $300

( ) Your balance is for fees not eligible for assistance

For questions, contact the Patient Financial Advocate at 504-839-7054. If you were not approved for a discount, you may request a payment plan.

Attachments

No Attachments

Approval Signatures

Approver	Date
BARBARA DURNAN: 084 REVENUE CYCLE	05/2021