St. Luke Community Healthcare

*The **HEART** of the Mission Valley*

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, or marital status.

All services billed by St. Luke Community Hospital are covered by this Policy.

All services billed by other organization are not covered by this Policy.

The following criteria will be used to determine eligibility.

1) Patient care, which is not emergent may not be considered for patient 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 may 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.
6) Assets in excess of those exempt by Montana Bankruptcy Laws may be required to pay down debt prior to granting financial assistance. This does not apply to patients seeking essential care in the clinics or emergency department.
7) Patients who receive Public Assistance through another public program will be eligible for financial assistance based on the income guidelines of that program.

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) Patients seen in the clinics and emergency department for essential services are only required to fill out Part 1 of the application. Otherwise each application must be completed in its entirety unless patient is currently on another public assistance program. In that case, only Part 1 of the application will be required, and St Luke reserves the right to complete Part 1 on behalf of the patient, contingent upon availability of documentation proving specific public assistance. The following proof of income **must** be included with the Financial Assistance Application for patients required to fill out part 2:

    - 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 schedules.

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 the balance of the adjusted account is defaulted on, it may 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 the patient is in the position they are. The letter is required for applicants filling out part 2 with a bill greater than $15,000.

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

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 size								Write Off
Family income	1	2	3	4	5	6	7	8	%
300% poverty	45,180	61,320	77,460	93,600	109,740	125,880	142,020	158,160	25
250% poverty	37,650	51,100	64,550	78,000	91,450	104,900	118,350	131,800	50
200% poverty	30,120	40,880	51,640	62,400	73,160	83,920	94,680	105,440	75
150% of Poverty Level	22,590	30,660	38,730	46,800	54,870	62,940	71,010	79,080	100
100% Poverty	15,060	20,440	25,820	31,200	36,580	41,960	47,340	52,720	100

WIC 75% TANF 100% SNAP 100% HMK 50% LIEAP 75% MCD 100%

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PATIENT FINANCIAL ASSISTANCE APPLICATION

Part 1

St. Luke Community Hospital is committed to providing all of your medical services with sensitivity to your medical and financial needs. St Luke serves all patients regardless of ability to pay. Please help us by completing the following questionnaire to determine if you may qualify for reduced fees under our Patient Financial Assistance Program.

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 spouse's employer provide Health Insurance Y or N.
If yes please list Insurance Company:_____

Number of Dependants:_____ Ages: _____

Estimated Annual Household Income: _____
Are you currently on any Public Assistance Program (WIC, TANF, SNAP, HMK, LIEAP, MCD, etc.)
Yes ___ No__ If yes, please list: _____

Please provide proof (i.e. copy of letter or card) of which program you are currently on and attach it to Part 1 of the Application.

For patients being seen in the clinic and emergency department you only need to complete Part 1 of this application.. For patients with accounts other than clinic and emergency department and if you answered NO to the previous question please fill out

Part 2 of the application.

Part 1 cont.

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

_____ $_____

I hereby request Financial Assistance from St. Luke for me, or my family member named above. I certify that all the information submitted 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, I agree to supply St. Luke, its managers, operators; agents or employees, any additional information as reasonably requested in order to verify my income.

I authorize any financial institution, government agency, or like entity, as well as St. Luke, its respective agents and employees, to release any information necessary to verify the contents of this application, and further release all parties from any and all liability arising out of their reasonable efforts to do the same.

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 to validate this application.

_____ _____
Patient Signature Date

_____ _____ _____
Requestor Signature Relationship to Patient Date
(Requested on behalf of patient)

ACCEPTED **DECLINED**

_____ _____
Authorized Signature Date

_____ _____
Authorized Signature Date

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Part 2:

Note: Only complete Part 2 if you are not on any Public Assistance Program.

Have you applied for Medicaid…….Yes…..No.

A copy of the following information, proving income, must be included with your 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 schedules.

ASSETS:

Checking Account Balance	$_____	
Savings Account Balance	$_____	
Other Account Balance	$_____	
Stocks, Bonds or Retirement funds	$_____	
Automobile	$_____	
Automobile	$_____	
Automobile	$_____	
Home and Land	$_____	
Other Real estate	$_____	
Other Real estate	$_____	
Livestock	$_____	
Recreation Vehicles	$_____	
Recreation Vehicles	$_____	
Other assets	$_____	
Total assets		$_____

Liabilities:

Auto Loan Balance	$_____	
Auto Loan Balance	$_____	
Auto Loan Balance	$_____	
Home and Land Balance	$_____	
Rent __ Own__		
Other Loan	$_____	
Credit Card Balances	$_____	
Medical Bills	$_____	
Total Liabilities		$_____

Monthly

Income:

Employment	$_____
Commissions	$_____
Bonuses/Tips	$_____
Alimony	$_____
Child Support	$_____
Disability	$_____
Pension	$_____
Retirement	$_____
Social Security	$_____
Unemployment	$_____
Other Income	$_____
Total Income	$_____

Expenses:

Home Mortgage or Rent	$_____
Auto Loan	$_____
Auto Loan	$_____
Insurance (Home)	$_____
Insurance (other)	$_____
Insurance (Auto)	$_____
Utilities	$_____
Credit Cards	$_____
Cell Phone	$_____
Home Phone	$_____
Television	$_____
Medical	$_____
Food/Groceries	$_____
Collections	$_____
Prescriptions	$_____
Childcare/Child support	$_____
Total Expenses	$_____