Southern Illinois Medical Services — Policy and Procedure

Title:	Healthcare Assistance Program	**Number:**	SM-FA-121
Applies to:	Business Services Department	**First Created:**	9/08
Issuing Dept:	Patient Financial Services	**Last Revised:**	2/14/17
Approved by:	Shannon Hartke, MBA, FHFMA, Corporate Director Patient Financial Services		

I. POLICY

Consistent with SIH Medical Group (SIH MG) mission, vision, values, and strategic plan, SIH MG believes it has a responsibility to meet the needs of the patients and the communities that it serves who have an inability to pay for healthcare services. This policy provides guidance for meeting this responsibility.

II. DEFINITIONS

Civil union – a legal relationship between 2 persons, of either the same or opposite sex, established pursuant to the Illinois Religious Freedom Protection and Civil Union Act

Covered services – emergent or medically necessary services

Financially Indigent – an uninsured or underinsured person who does not have the ability to pay for services rendered

FPL – Federal Poverty Level

HAP ADD-ON Acct – refers to account(s) that are identified while a HAP application is in the review process or the original application has been final approved. These accounts are not on the original HAP Worksheet.

Healthcare Assistance Application – allows for the collection of information for Healthcare Assistance consideration (see attached examples 1-4)

Healthcare Assistance Program – financial assistance provided to SIH MG patients who apply and meet financially indigent criteria

NHSC – a site certified by National Health Service Corps

Party to a civil union – a person who has established a civil union pursuant to the Illinois Religious Freedom Protection and Civil Union Act; party to a civil union means, and is included in any definition or use of the terms spouse, family, immediate family, dependent, next of kin, and other terms that denote the spousal relationship

Poverty Guidelines – the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services

Provider – a physician or mid-level (NP or PA) who treats patients medically

SIH MG Information System – computer related software used to register or scan information received or printed on behalf of a patient

Total Yearly Income – the sum of the yearly gross income

Uninsured patient – is a patient of SIH MG who is not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, worker's compensation, accident liability insurance, or other third party liability

Visit – a billable event where a patient is seen by a SIH MG provider in the office, hospital, clinic, or other setting

III. RESPONSIBILITIES

1.0 Business services staff or other designated staff members

1.1. Follows the guidelines established within this policy with regard to the completion and processing of healthcare assistance applications

1.2. Assigns the financial carrier for a Health Assistance Program (HAP) application

1.3. Scans the HAP application, and notes account when the HAP application is received.

A. Applicants who have not returned the required documentation are sent a letter requesting the information within 30 days.

B. Patients are not billed during the SIH MG review period.

C. When the review/approval process has been completed, the business services staff notes the account.

2.0 SIH MG is committed to protecting the confidentiality and security of all sensitive patient financial and demographic information in accordance with the Health Information Portability & Accountability Act (HIPAA).

2.1. The HIPAA guidelines call for all patient information whether it is verbal communication, faxed information, hard copy bills or terminal access be held secure at all times.

IV. EQUIPMENT/MATERIALS

1.0 SIH MG Information System

V. PROCEDURE

1.0 A party to a civil union is entitled to the same legal obligations, responsibilities, protections, and benefits as are afforded or recognized by the law of Illinois to spouses, whether they derive from statute, administrative rule, policy, common law, or any sources of civil or criminal law.

2.0 Application

2.1 SIH MG requests that each patient applying for financial assistance complete a financial assistance application form (“Healthcare Assistance Application”).

A. The Healthcare Assistance Application allows for the collection of information for healthcare assistance consideration (see attached examples 1 through 5).

2.2 Accounts are considered for healthcare assistance after an exhaustive investigation of other funding sources indicates no coverage (e.g. Medicaid denies coverage, etc.).

A. Lack of completed claim form or lack of cooperation from insured is not considered a valid denial.

2.3 Applications are accepted for self pay or bad debt accounts under the age of six months.

A. The only accounts that cannot be considered for HAP are those that are legal and a suit has been filed.

2.4 Minors

A. All patients under the age of 19 are considered full bill until they have applied for KidCare of Illinois.

B. Refusal to pay premiums into the KidCare program excludes patients for financial assistance consideration.

2.5 Immediate Family Members

A. SIH MG requests patients requesting financial assistance verify the number of people in the patient's household.

B. An approved HAP application extends to all accounts within a household.

C. Adults

1) In determining the number of people in an adult patient's household, SIH MG includes the patient, the patient's spouse and any dependents.

D. Minors

1) In determining the number of people in a minor patient's household, SIH MG includes the patient, the patient's mother and any dependents of the patient's mother and the patient's father.

E. Other

1) Anyone listed on the tax return as a dependent.

2.6 Calculation of Income

A. To determine eligibility for HAP, proof of income for the last 90 days from the time the application is completed, dated, and signed, must accompany the application.

B. If self-employed, Schedule C must be included with a copy of the last year's completed federal tax return.

1) The adjusted gross income for self-employed applicants is used for determination of income.

2) SIH MG has the right to request and review annual income on a case-by-case basis.

3) SIH MG has the right to consider the extent to which the person has assets other than income that could be used to meet his or her financial obligation, unless the site is a NHSC certified site.

4) SIH MG has the right to request additional information upon review of the Healthcare Assistance Application.

3.0 Income Verification

3.1 SIH MG requests that the patient verify the income set forth in the Healthcare Assistance Application.

3.2 Documentation Verifying Income

A. Income may be verified through any of the following mechanisms:

1) IRS form W-2 Wage and earnings statement

2) Pay check remittance

3) Tax returns

4) Social Security

5) Workers' compensation or unemployment compensation determination letters

6) Telephone verification by employer of the patient's annual gross income

7) Employee wage forms or

8) Bank statements

B. If the patient has not provided acceptable documentation, SIH MG may send the patient a letter requesting additional documentation or contact the patient by telephone.

1) The previous year's tax return is obtained when possible (see attached example 9)

3.3 Documentation Unavailable

A. In cases where the patient is unable to provide documentation verifying income, SIH MG may verify the patient's income.

1) By having the patient sign the Healthcare Assistance Application attesting to the veracity of the income information provided, or

2) Through the written attestation of SIH MG personnel completing the Healthcare Assistance Application that the patient verbally verified SIH MG calculation of income.

a) For instances where the patient is unable to provide the requested documentation to verify income, or monthly expenses exceed the monthly income listed, SIH MG requires an explanation be provided. The patient must provide documentation and/or how expenses are being paid.

3.4 Classification Pending Income Verification

A. The account(s) are classed as self-pay and patient is billed until the time the Healthcare Assistance Application has been received.

1) Once the Healthcare Assistance Application has been received and during the verification process, while SIH MG is reviewing or collecting the information necessary to determine a patient's income, the patient is not billed.

2) If the patient has not responded to information requests after 30 days, the account is returned to patient responsibility status and billed according to normal self pay billing procedures.

3.5 Expired Patients

A. Expired patients with no estate may be deemed to have no income for purposes of SIH MG's calculation of income.

B. Refer to Procedure section 6.0, Judgmental Health Care Assistance.

4.0 Falsification of Information

4.1 Falsification of information may result in denial of the Healthcare Assistance Application.

4.2 The financial assistance may be withdrawn after a patient is granted financial assistance if SIH MG finds material provision(s) of the Healthcare Assistance Application to be untrue.

5.0 Classification as Financially Indigent

5.1 Classification

A. SIH MG may classify patients whose income is less than or equal to 200% of the Federal Poverty Guidelines as financially indigent.

5.2 Copay amounts

A. Patients with an income less than or equal to 100% of FPL are charged a copay amount of $10 per visit.

B. Patients with an income above 100%, but not more than 200% of FPL, the copay amount is $20.

C. Patients with an income above 200% of FPL do not qualify for HAP for visits.

5.3 Patients who receive provider services for procedures performed outside the office or clinic setting (hospital or ASC) may qualify for HAP based on approval for HAP at the site of service.

A. SIH MG honors the percentage discount granted by the facility for the professional fees related to said procedure.

5.4 Poverty Guidelines

A. SIH MG utilizes the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services.

6.0 Judgmental Health Care Assistance

6.1 SIH MG reserves the right to provide Judgmental Health Care Assistance. The circumstances for which assistance may be provided are (see attached example 6):

A. Homeless

B. Resident of shelter facilities

C. Rape victim or victim of violent crimes

D. Deceased patients

E. Lawsuits initiated by hospital and there are no available assets for payment

6.2 Patients approved through Judgmental Health Care Assistance do not receive a letter of approval.

7.0 Approved Procedures

7.1 Business service staff or other designated staff members complete a Healthcare Assistance financial worksheet or a Judgmental Health Care Assistance worksheet.

7.2 The worksheets provide the documentation of the administrative review and approval process utilized by SIH MG to grant financial assistance (see attached examples 5, 6, and 7).

7.3 The patient is notified by letter of any reduction on their balance (see attached example 8).

7.4 If there are no changes to expenses or income, a HAP application can be used on current accounts for six months from the date the application was signed and dated.

8.0 Denied Procedures

8.1 Business service staff or other designated staff members review the Healthcare Application for complete information and financial qualification.

8.2 If it is determined the patient is not eligible for HAP, the patient is notified by letter as to the reason for denial (see attached example 9).

9.0 Document Retention Procedures

9.1 SIH MG maintains the Healthcare Assistance Program application for a period of seven (7) years from the date of application.

10.0 Modification

10.1 The Director of Finance, Corporate Director of Patient Financial Services, and the Vice President and Administrator, Ambulatory and Physician Services, must approve any modifications to the standards set forth in this policy.

11.0 Reservation of Rights

11.1 SIH MG reserves the right to limit or deny financial assistance at the sole discretion of SIH MG.

12.0 Non-covered Services

12.1 SIH MG reserves the right to limit the services subject to SIH MG Healthcare Assistance Program policy.

12.2 Elective and/or services deemed not medically necessary may not be eligible for financial assistance consideration.

13.0 No Effect on Other Hospital Policies

13.1 This healthcare assistance policy does not alter or modify other policies regarding efforts to obtain payments from third-party payers, patient transfers, or emergency care.

VI. DOCUMENTATION

1.0 Refer to attached Examples 1-4 for documentation to be provided by patient.

2.0 Refer to attached Examples 5-9 for documents to be completed by SIH MG representative.

VII. CHARGES

N/A

Additional Approvals and Review/Revision Dates			
Review Dates:			
Revision Dates:	6/8/12, 4/12/13, 4/25/14, 12/11/15, 10/28/16, 2/14/17		
Replaces:	N/A		
Additional Approvals:	**Name (print)**	**Title**	**Signature**
	Michael Kasser	Vice President/CFO	
	Darrell Bryant	Chief Operating Officer	
	Phil Schaefer	VP/Administrator Ambulatory and Physician Services	
	Kim Lingle	Director of Finance	
	LuAnne Warren	Reimbursement Director	

Example 1 (Print on SIH MG letterhead stationery)

Dear Patient/Guarantor:

IMPORTANT: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE.

Completing this application will help determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. You can submit this application to any SIH MG facility or office.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help determine whether you qualify for any public programs.

Please complete this form and submit it in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 business days following the date the application was given.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist in determining whether the patient is eligible for financial assistance.

Please understand in order to receive assistance with your bill, you will need to show all payment sources such as medical insurance, Medicaid, work comp, liability, etc. must be fully exhausted before healthcare assistance will be considered.

Please return the application with the following information:

1. A complete Healthcare Assistance Program application signed and dated.
2. A copy of your last federal tax return filed and a copy of all W2s. If self employed you must include Schedule C.
3. A copy of your most recent check or check stub for employment, unemployment, Social Security, pension, workmen's compensation (or work comp determination letter) or any other source(s) of income you have received for the past thirteen (13) weeks. We will accept one of the following three documents for proof of wages:
    a. An employee wage form filled out and signed by your employers for each wage earner in the household (see application for this form)
    b. Copies of check stubs for the last 13 weeks
    c. A print out of your wages from your employer for the last 13 weeks
    d. The above wage information must be provided for all family/house hold members
4. If applicable, proof of participation in Governmental assistance programs such as food stamps, WIC, Medicaid, Link, school lunches, Child Care Resource or Referral Program.

If you want to submit an appeal of our decision or request re-consideration it must be in writing. Please include the reason or provide additional information that may be beneficial for our review.

Please mail the completed application to the address listed above for the facility where you incurred charges. Only one application is required if you have accounts at any SIH MG facility or office. If you need assistance in completing the application please contact the Financial Counselor at the address or phone number listed above. You may reach us Monday thru Friday 8:00 am to 4:30 p.m.

For your convenience, you can also e-mail your application and required documents to the Central Business Office at the following e-mail address: sihmedicalgroup.hap@sih.net

Completion of this application does not relieve you of your financial obligation to SIH Medical Group; SIH Medical Group reserves the right to deny any application upon review.

This application is only valid for SIH MG, however, upon request, it can be forwarded to any Southern Illinois Healthcare hospital listed above for a separate approval consideration.

Sincerely,

SIH Medical Group Customer Service

1239 E. Main Street

Carbondale, IL 62901

Telephone Number: 618-457-5200 ext. 67575

Example 2 – (Print on letterhead stationery)

Healthcare Assistance Application

Name: _____ Date of Birth: _____

Address: _____ _____ _____ _____
Street Address/PO Box City State Zip Code

Phone Number _____ Social Security Number_____(not required)

Family/Household Information:

1. Number of persons in the patient's family/household: _____
2. Number of persons who are dependents of the patient: _____
3. Ages of patient's dependents: _____ _____ _____ _____

_____

Employment and Income Information

1. Enter patient's, patient's spouse or partner's employer information.
2. If patient is a minor, enter the patient's parent's or guardian's employer information.

Patient	Spouse	Partner	Other
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____
Patient's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Spouse's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Partner's Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____	Other Employer Name: _____ Address: _____ City, State, Zip _____ Salary: Gross Amount _____

Other Income

Other Income		Patient's Monthly Income		Spouse/Partner/Other Dependent's Monthly Income
Wages		$		$
Self -Employment		$		$
Unemployment Compensation		$		$
Social Security		$		$
Social Security Disability		$		$
Veteran's Pension/Disability		$		$
Workers' Compensation		$		$
Temporary Assistance for Needy Families		$		$
Retirement Income		$		$
Child Support, Alimony, or Other Spousal Support		$		$
Other Income		$		$

Documentation of family income from paycheck stubs, benefit statements, award letters, court orders, federal tax returns, or other documentation provided by the patient.

Assets

Real Estate: Own _____ Rent _____		Bank: Checking	$
Market Value:	$	Savings	$
Amount Owed:	$		$
	$	Mutual Funds:	$
Auto/Truck/Type:		Stocks, CD's:	$
Market Value:	$	Rental Property Owned:	$
Motorcycles, Boats, Campers, Other Vehicles:		Other:	$
Market Value:	$		$
	$		$
	$		$

Monthly Expenses

Rent or House Payments:	$	Other:	$
Utilities:	$		$
	$		$
	$		$
	$		$
Child Care:	$		$
Food and Supplies:	$		$
Auto Payments:	$		$
Transportation:	$		$
Property Tax (Annual):	$		$
	$		$
	$		$
		Total Monthly Expenses:	

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this bill.

I understand that the information provided may be verified by SIH Medical Group, and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill.

Yes	No	
		Was the patient an Illinois resident when care was rendered?
		Was the patient involved in an alleged accident?
		Was the patient a victim of an alleged crime?
		Does the applicant (s) have any active or open Law/Legal suit for accounts that assistance is being requested?
		Does the applicant (s) have any insurance benefits?

Date: _____ Signed: _____
Patient/Applicant

Date: _____ Signed: _____
Patient/Applicant

Example 3

ADDITIONAL INFORMATION

Please use this form to provide additional information that might aid in the processing of your Healthcare Assistance application.

If any of the following statements or questions applies to your situation, please provide the required information on this form.

1. If your monthly expenses exceed your monthly income, please note how your expenses are being met.

_____
_____
_____

2. If your tax return is not included, please explain why.

_____
_____
_____

3. If you have no income how do you support yourself?

_____
_____
_____

4. If you are receiving financial support from anyone, include a written statement as to whom and how they are helping you.

_____
_____
_____

5. Other:

_____
_____
_____
_____
_____
_____
_____

Example 4

Employee Wage Form

(To be completed and signed by Employer)

Employee Name: _____

Employee Social Security Number: _____

Employer Name: _____Tele: _____Ext. _____

Address: _____
City State Zip Code

Wages for the Last 13 Weeks

Week	Pay Period Ending	Gross Wages
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

1. Is the employee currently working? _____(yes/no), If no, when was the last day worked? _____

2. If the employee is not currently working, will the employee be returning to work? _____ (yes/no)

   Expected return date _____

3. When did employment begin: _____ End: _____

I certify the wage information regarding the person named above is true and accurate.

Date: _____ Signed: _____
Signature of Employer or Employer's Representative

Example 5

Healthcare Assistance Financial Worksheet

For Southern Illinois Healthcare Internal Use Only

Patient Name: _____

Entity	Account Number	Amount	Partial Approved Adj'd Amt.	Entity	Account Number	Amount	Partial Approved Adj'd Amt.
		$	$			$	$
		$	$			$	$
		$	$			$	$
		$	$			$	$
		$	$			$	$
	Total	$	$		Total	$	$

MONTHLY INCOME:

Guarantor's Gross Salary $ _____

Spouse's Gross Salary $ _____

Other Income $ _____

Family Size _____ Gross Income $ _____ X3 $_____

90 day Income

Approval percentage from chart below _____%

Total Adjustment (total medical bill x approval %) $ _____

The Income Schedule Reflects Income For A Ninety (90) Day Period

Based on Health & Human Services 2017 Poverty Guidelines

Discount	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	6,030	8,120	10,210	12,300	14,390	16,480	18,570	20,660
90%	7,025	9,460	11,895	14,330	16,764	19,199	21,634	24,069
80%	8,050	10,840	13,630	16,421	19,211	22,001	24,791	27,581
70%	9,045	12,180	15,315	18,450	21,585	24,720	27,855	30,990
60%	10,040	13,520	17,000	20,480	23,959	27,439	30,919	34,399
50%	11,065	14,900	18,735	22,571	26,406	30,241	34,076	37,911
40%	12,060	16,240	20,420	24,600	28,780	32,960	37,140	41,320

For family units with more than 8 members, contact PFS Operations Manager.

Co-pay	1	2	3	4	5	6	7	8
$10	2,918	3,933	4,948	5,963	6,978	7,993	9,008	10,023
$20	5,835	7,865	9,895	11,925	13,955	15,985	18,015	20,045

Example 5 – Page 2

Healthcare Assistance Financial Worksheet

For Southern Illinois Healthcare Internal Use Only

Patient Name: _____

Comments: _____

_____

_____

_____

_____

_____

Approvals Approved Denied

_____ _____

Customer Service Representative Date

Example 6

Guidelines for Use of the

Judgmental Healthcare Assistance Program

For Southern Illinois Healthcare Internal Use Only

1. A Judgmental Healthcare Assistance form will be initiated and completed explaining the circumstances and why this form was used in place of the regular form.

2. The following types of patient accounts will qualify for Judgmental Healthcare Assistance:
    a. Homeless
    b. Resident of Shelter facilities.
        i. Verify there is no insurance available for reimbursement or any other means of payment.
    c. Rape victims or victims of violent crimes, when no other source of reimbursement is available.
    d. Accounts of patients who are deceased, have no assets, no estate, and no other party responsible for payment.
    e. Accounts that have lawsuits initiated by the hospital once a citation has been conducted and it is shown to the Court that there are no available assets for payment.

3. Patients approved through Judgmental Healthcare Assistance will not receive a letter of approval.

4. Accounts not considered for Judgmental Healthcare Assistance:
    a. Patients serving time in prison.
    b. Patients giving false information.
    c. Patients who are aliens and programs for payment have not been researched.

Example 7

Judgmental Healthcare Assistance Worksheet

For Internal Use Only

Date:_____ Patient Name:_____

_____

Address City, State, and Zip Code

Entity	Account Number	Amount	Entity	Account Number	Amount
		$			**$**
		$			**$**
		$			**$**
		$			**$**
		$			**$**
	Total:	$		Total:	**$**

Reason for Judgmental Adjustment:

- ☐ Homeless
- ☐ Resident of shelter facility and no source of payment is available
- ☐ Rape victim or violent crime victim when no other source of payment is available
- ☐ Deceased, no assets, no estate, and no other source of payment is available
- ☐ Other (Explain):_____

_____

_____

_____

Submitted By: Date

Approvals Approved Denied

_____ _____

Customer Service Representative Date

Example 8 (Print on letterhead stationery)

[Insert Date]

[Insert Patient Name]
[Insert Patient Address]
[Insert City, State, Zip]

Dear [Insert Patient Name]:

Your application for the Healthcare Assistance Program has been approved for SIH Medical Group.

Your application is good for six months from the signed date. Our records indicate your application was signed [Insert Date signed]. This approval allows you to schedule appointments with your SIH doctor and pay a [Insert $10 or $20] copay for each visit.

If you have any questions, please contact a Service Representative at 618-457-5200 Ext. 67575.

Sincerely,

[Insert Service Representative Name]
SIH Medical Group
1239 E. Main Street
Carbondale, IL 62901

Example 9 (Print on letterhead stationery)

[Insert Date]

[Insert Patient Name]
[Insert Patient Address]
[Insert City, State, Zip]

Dear [Insert Patient Name]:

The SIH Medical Group application for Healthcare Assistance cannot be approved at this time. It was determined you do not meet the eligibility requirements for the following reason(s):

Failure to provide:

- ☐ Most recent W2 or 1040 tax form
- ☐ A signed letter of support from the person(s) or group helping you financially
- ☐ Verification of Social Security/ Disability/Pension benefits
- ☐ Paystubs/income information

☐ Income exceeds policy guidelines

☐ Covered under insurance plan

Missing or incomplete information may be submitted to our office within 30 days. SIH Medical Group will reconsider your application after receipt of information. Please contact a Service Representative at 618-457-5200 Ext. 67575.

Sincerely,

[Insert Service Representative Name]
SIH Medical Group
1239 E. Main Street
Carbondale, IL 62901