

Subject	Issued By	Date	Revised	Approved by
Financial Assistance Policy	Administration	January 1, 2005	10/19	

PURPOSE:

To establish programs to provide financial assistance to patients who qualify for Indigent Care or Charity Care.

POLICY:

Community Memorial Hospital (CMH) will make financial assistance programs available to all qualified patients who are U.S. citizens. CMH will follow the procedure outlined below for qualification of indigent care and charity care patients to accurately record amounts provided for indigent care and charity care in the financial statements and for reporting to State and Federal agencies. This policy will be available to all patients without regard to age, race, creed, color, religious affiliation, disability or national origin. Applicant confidentiality will be maintained in keeping with CMH and HIPAA guidelines.

DEFINITIONS:**Indigent Care:**

Total gross income of the applicant, and those of his/her legally responsible relatives with whom he/she resides, of 200% or less of the current Federal Poverty Guidelines (issued by the U.S. Department of Health and Human Services) published each February in the Federal Register.

Charity Care:

Total gross income of the applicant, and those of his/her legally responsible relatives with whom he/she resides, in excess of 200% but not greater than 300% of the current Federal Poverty Guidelines (issued by the U.S. Department of Health and Human Services) published each February in the Federal.

Family:

All individuals living in a household related by blood or marriage (mother, father and children) unless the child has reached the age of 18; or is receiving disability (that individual is treated as a family of one with its own resources/income). Unrelated adults residing in the home of parents/grandparents over 65 constitute their own individual family unit. Parents/grandparents under 65 residing in the home who are not employed or are not disabled and have no income may be included in the family unit.

Income:

For purposes of determining financial eligibility under the **CMH** Financial Assistance Program, income includes total cash receipts before taxes from all sources. Income includes money wages and salaries, including tips, before any deductions; net receipts from non-farm self-employment; net receipts from farm self-employment; regular payments from social security including disability, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income and non-Federally-funded General Assistance or General Relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, settlements such as from an accident, and net gambling or lottery winnings.

PROCEDURE:

1. Covered services include emergency and other medically necessary care, as defined by Medicare, and provided by the providers listed in Attachment #1. Procedures that are cosmetic, dental reconstructive, and certain other services are not covered by the Policy.
2. The Financial Assistance Policy is available to patients who indicate an inability to pay for all or a portion of their hospital bill including those with no third-party health insurance and those whose third-party health insurance coverage has been exhausted. To determine eligibility, the patient/guarantor must complete the Financial Assistance Application form (Attachment #2) and provide documentation to support the request. Documentation required includes most recent two pay stubs or verification from all employers, most recent W-2 forms, tax return, and proof of any other type of income received and bank statements. **CMH** reserves the right to review all information received, including the review of the applicant's credit history, for purposes of processing the application. Income screening/verification by other state, government or public non-profit agencies may be evaluated as an acceptable equivalent.
3. The Financial Assistance Application form will be submitted to the Financial Specialist in the CMH Patient Accounting Department.

4. The patient will be screened for other financial assistance programs (Medicare, Medicaid, FAMIS, COBRA, etc.) and determined ineligible after good-faith cooperation with this process. Good-faith cooperation includes, but is not limited to, the timely initiation of the assistance program's application/enrollment process, completion of the assistance program's application, and provision of all documents required by the assistance program's process within the timeframes required by the program.
5. If the applicant being reviewed was approved as an indigent care or charity care patient within the last twelve (12) months prior to the current review, he is considered indigent/charity at the time of the current review unless there is a change in financial circumstances, such as income or family status. Each patient will have to reapply at the end of each twelve-month period.
6. Should a patient be deceased, a copy of the death certificate must be attached to the application and documentation must be recorded that efforts were made to verify income and estate information through a family member or other close associate of the deceased patient. If the deceased patient/individual has no estate, the account will be considered a charity care account.
7. All documentation and information requested within this policy must be submitted in its entirety and the application signed by the patient/guarantor in order for an application to be complete. An incomplete application may not be eligible for indigent care or charity care discounts. CMH will provide written notice to applicants that describes what information is needed to complete an incomplete application. Failure to provide information necessary to complete a financial assessment may result in a negative determination. The account may be reconsidered upon receipt of the required information.
8. Applications for Financial Assistance must be initiated within 240 days after the first post discharge billing statement.
9. If a patient fails to pay amount due or to complete an incomplete application after receiving notice of additional requirements, CMH will provide a letter informing the individual about further collection efforts that will be performed or resumed after thirty (30) days.
10. CMH will process requests promptly and will make reasonable effort to make a final determination as to eligibility within thirty (30) business days following completion of the application process.
11. The Financial Specialist will be responsible for notifying the patient in writing of the determination.
12. CMH recognizes that not every patient is able to complete the financial assistance application or provide the required documentation. In such cases, CMH may deem patients presumptively eligible for Financial Assistance by utilizing a third-party to review a patient's information to assess eligibility. Patients will be given the normal

timeframes to submit an application for more generous assistance available beyond the presumptive determination.

13. Applicants denied charity care may qualify for a prompt payment discount or for an extended payment plan. These discounts are considered to be outside of this Financial Assistance Policy.
14. If CMH determines that a patient qualifies for financial assistance, the patient will not be charged more than the "amounts generally billed" (AGB) for emergency or other medically necessary care. CMH uses the "look back" method to calculate AGB, which is based on allowable charges and payments received for patients with Medicare Fee-For-Service (original Medicare). A paper copy of the calculation will be furnished free of charge upon request by contacting the Fiscal Services Department at (434) 447-3151. The calculation is also available on the CMH website at <https://www.vcuhealth.org/community-memorial-hospital/patients-and-visitors-cmh/financial-assistance-cmh/financial-assistance>.
15. Patient accounts qualifying for financial assistance will receive discounts based on their family size and level of poverty based on the attached Guidelines for Financial Assistance worksheet (Attachment #3).
16. A patient who qualifies for a Charity Care discount is expected to cooperate with CMH to establish a reasonable payment plan for the balance due and make a good faith effort to honor the payment plan; however, a payment plan is not a requirement for approval for a charity care discount.
17. The actions CMH will take on non-payment of balances on accounts after discounts are described in CMH policy 01-10-27, Billing and Collection. This policy is available for review and printing on the CMH website at <https://www.vcuhealth.org/community-memorial-hospital/patients-and-visitors-cmh/billing-and-insurance-cmh/billing-finance> and upon request in the Patient Accounting Department.
18. CMH will place notice of the Financial Assistance Policy and the Patient Financial Brochure in each registration department stating that we offer financial assistance and describing how to obtain more information about financial assistance.
19. CMH will place this policy on the CMH website at <https://www.vcuhealth.org/community-memorial-hospital> and will have a link to the policy and application form as well as the Financial Assistance Summary brochure.
20. CMH will place a note on statements regarding how to request information about financial assistance.
21. CMH will take measures to inform and notify members of the community about this policy.

22. The Director of Revenue Cycle must approve Indigent Care and Charity Care discounts up to \$25,000 and additional approval from the VP Finance or CEO is required for discounts greater than \$25,000.
23. Completed Financial Assistance applications will be maintained within the Patient Accounting Department.
24. The Chief Executive Officer must approve any exceptions to this policy.

ATTACHMENT #1

Providers subject to the Community Memorial Hospital Financial Assistance Policy:

1. Community Memorial Hospital
2. CMH Medical Oncology and Radiation Therapy
3. CMH Rehab Services
4. CMH Home Health and Hospice
5. Physician practices operated by CMH including the following:
 - a. CMH Physician Services, LLC
 - b. CMH Family Dental Clinic

Certain services provided by CMH are excluded from the Financial Assistance Policy including the following:

1. Community Memorial Hospital Hundley Center
2. CMH Health & Wellness

Exclusions from the Community Memorial Hospital Financial Assistance Policy:

Except for the physician practices identified above, the CMH Financial Assistance Policy does not apply to services provided by independent physicians or physicians that act as independent contractors to CMH entities. These would include:

MCV Associated Physicians
Lawrenceville Primary Care
Tri County Gastroenterology PC
Mid-Atlantic Eye Physicians
Raleigh Eye Center
Radiologist and Pathologist services.

ATTACHMENT #2

**COMMUNITY MEMORIAL HOSPITAL
PO BOX 90, SOUTH HILL, VIRGINIA 23970
(434) 447-3151**

FINANCIAL ASSISTANCE APPLICATION FORM

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Admission Date: _____ Discharge Date: _____

Address:

County: _____ Telephone Number: _____

Are you a U.S. Citizen? Yes _____ No _____

Third Party Information

Are you covered by Medicaid? Yes _____ No

If yes, Medicaid Number

Coverage Dates: From _____ To

Are you covered by Medicare? Yes _____ No

If yes, Medicare Number

Other Health Insurance? Yes _____ No

Company and Number

Is admission due to an accident? Yes _____ No

If yes, date of accident

Is Claim Pending? Yes _____ No

Was accident work related? Yes _____ No _____

If accident work related, name of employer and address

Assets

'''----- Checking Acct Balance Institution Name _____
(Copy of last monthly statement showing balance)

'''----- Savings Acct Balance Institution Name _____
(Copy of last monthly statement showing balance)

----- Money Market Account \$ _____ Stocks/Bonds (cash value)

''' ---- IRAs \$. _____ Real Property (net owned)

''' Primary Residence (net) \$ _____ Other Assets (describe)

Gross Monthly Income for Patient and Legally Responsible Relatives

''' ---- Wages \$ _____ General Assistance - DSS

''' ---- Social Security \$ _____ Pension Retirement

''' ---- Unemployment _____ Workers Compensation

''' ----- Child Support/Alimony \$ _____ Annuity/Dividends

\$ _____ Interest \$ _____ Awards/Settlements

''' ----- Military Pay \$. _____ Other - please describe

''' ----- Total Monthly Income \$. _____ Total Annual Income

Family Members in Household

Name	Birth Date	Relationship
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You must return copies of the following documents with this application. Any application without signature and the necessary documentation will be denied.

DOCUMENTATION CHECK OFF LIST

_____ Proof of income: 2 most recent pay stubs or verification from employers

_____ Current W-2 form

_____ Current filed Federal Income Tax Return

_____ Social Security Award Letter for current year

_____ Unemployment Compensation Benefit Letter

_____ Last statements for checking, savings, stocks, bonds, annuity, etc.

_____ If no income, notarized letter from someone other than yourself or family member explaining how expenses are met.

Please submit the completed forms and all requested documentation to:

Community Memorial Hospital
Attn: Financial Specialist
PO Box 90
South Hill, Virginia 23970

Please contact the Financial Specialist at (434) 447-0815 if you have questions or require any assistance.

Authorization and Agreement

I understand that the information that I submit is subject to verification by Community Memorial Hospital (**CMH**). I certify that the above information and all documentation provided are true, correct, and complete. I understand that if I have deliberately given any

false information or withheld any information I am liable for prosecution for fraud. Also, any discount awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

I give CMH permission to obtain a copy of my credit report to be used in determining eligibility for financial assistance.

Signature _____ Date _____

For Community Memorial Hospital Use Only

Discount Determination

Family Size	_____	Poverty Level	_____
Annual Income	_____	% of Poverty Level	_____

	Initial	Date
Date Application Received:	_____	_____
Income/Assets Verified:	_____	_____
Date Patient Notified:	_____	_____
Discount Percentage:	_____	_____
Discount Amount:	_____	_____
Application Processed By:	_____	_____

Approval Director Revenue Cycle: _____

Approval VP Finance: _____

Community Memorial Hospital
Guidelines for Financial Assistance
 For the Period July 1, 2019 - June 30, 2020

For each additional family member add the following amount:						
	4320	4862	5879	7337	8840	13260
Step #1:						
State Indigent Discount:	100%	95%	80%	55%	30%	0%
Step #2:						
CMH Indigent Discount:	0%	5%	20%	45%	70%	0%
Step #3:						
CMH Charity Discount	0%	0%	0%	0%	0%	80%