

# MANAGEMENT GUIDELINE

**PMH** PROSSER  
MEMORIAL  
HOSPITAL

CATEGORY: PATIENT SERVICES

TITLE: CHARITY CARE

NUMBER: 150

PAGE: 1 of 4

## PURPOSE

1. To ensure that no person is denied emergency health care at Prosser Memorial Hospital because of an inability to pay for that care.
2. To establish a mechanism whereby eligibility for charity care be determined consistent with applicable law as well as sound fiscal policy.
3. To properly distinguish indigent care from bad debts in the hospital accounting system in compliance with the Department of Health guidelines.

## DEFINITIONS

1. "Indigent Persons" shall mean those patients who have exhausted any third party sources, including Medicaid and Medicare and whose income is equal to or below 200% of the federal poverty standards, adjusted for family size or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or co-insurance amounts required by a third party payor.
2. All responsible parties with gross family income at or below one hundred percent of the federal poverty standard adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship.
3. All responsible parties with family income between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with the hospital's sliding fee schedule and policies regarding individual financial circumstances.

4. Individual responsible parties whose income exceeds two hundred percent of the federal poverty standard, adjusted for family size, can be identified as an indigent person eligible for a discount from charges based upon that responsible party's individual financial circumstances.

POLICY

1. Any dependent person of the family classified as indigent or medically indigent, is eligible for consideration to receive discounted or free care. Medical indigence refers to those who are too impoverished to meet their medical expenses. It may also include those whose income is sufficient to pay for basic living costs, but not medical care and also those persons with generally adequate incomes who are suddenly faced with catastrophic medical bills.
2. All other benefits will be assessed to determine eligibility for charity care, including Medicaid assistance. Families with gross income below 200% of the federal poverty guidelines will be considered for charity care. A sliding payment schedule (see attached) will be used as a guide to help determine the amount of charges for which the family is responsible, modified by special circumstances. Charity care may also be considered for cases when the medical charges create a severe financial hardship or personal loss.
3. Patients not initially identified upon admission as having a potential inability to pay may be identified during the billing process and will be provided with the application materials. Those who meet the criteria mentioned above, will be considered for full or partial charity care awards, depending upon the patient's ability to pay for a portion of the amount owed.
4. Charity care application forms which provide documentation of sources of income and insurance coverage will be available through the business office and will be sent to anyone requesting them or who is identified as being a potential candidate for charity care. Notice shall be made publicly available both written and verbal, in English and in Spanish, that charges may be waived or reduced.

5. Any responsible party who has been initially determined to meet the criteria for charity care status, shall be provided with at least fourteen calendar days or such time as the person's medical condition may require, to present documentation as described, prior to receiving a final determination of sponsorship status. The failure to complete the application procedures shall be sufficient grounds to initiate collection efforts.
6. The business office will notify applicants of the approval or denial of charity care determination, in writing within 14 calendar days after receiving the required information. In the event that the hospital denies the responsible party's application for charity care, the hospital must notify the party of the denial and the basis for the denial. All parties denied charity care shall be provided and notified (in writing) of the appeals procedure that enables them to correct any deficiencies in the documentation or to request a review of the denial. All appeals will be reviewed by the Hospital's Chief Financial Officer or equivalent.

If this determination affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

#### APPLICATION PROCEDURE

Charity care application forms are available to all patients from the hospital's business office. It is preferred that the application form be completed prior to registration for admission. However, when circumstances prevent early completion the application form may be completed within fourteen days from the initial determination that the party was indigent. The criteria for determination will be for the 12 months prior to the date of the request.

All applications should be accompanied by documentation to verify income amounts indicated on the application form. The following types of documentation are acceptable for purpose of verifying income:

Payroll Check Stubs

IRS tax return from most recently filed calendar year

Determination of eligibility for unemployment compensation

Verification of ineligibility for DSHS assistance or patient liability

The patient will be asked to sign a statement attesting to the accuracy of the information provided to the hospital. If the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon the written and signed statement for making a final determination of eligibility for classification as an indigent person.

Information requests may not be used to discourage applications for indigent sponsorship. All information provided shall be kept confidential. Copies of documents that support application information will be kept with the application form. Determination of eligibility will be made by the hospital's business office.

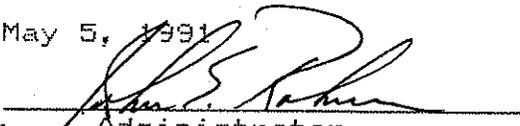
#### ALLOCATION OF SERVICES

All types of services normally available at the hospital will be made available to indigent care recipients, providing that the service is medically necessary. The medical necessity of any particular patient's care will be subject to review by the hospital's Utilization Review committee. If a patient receives services that are determined not necessary, those services will be excluded from Charity Care considerations.

#### RECORDKEEPING

Charges for necessary health care to patients who are unable (i.e. who meet the Financial Eligibility Criteria) will be written off as Charity Care. In the event that the responsible party pays a portion or all of the charges that are subsequently found to have met the Charity Care criteria, any excess of the amount determined to be Charity Care will be refunded within 30 days of achieving Charity Care status.

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**EFFECTIVE DATE:** May 5, 1991  
**AUTHORIZED BY:**   
Administrator  
**SOURCE:** Finance (Shrout/McMurphy); WAC 261-14  
**DATE OF REVIEW:**  
**REVISION NUMBER:**  
**UNITS PRIMARILY AFFECTED:** All Departments

1991 FEDERAL POVERTY INCOME GUIDELINES FOR ALL STATES  
(EXCEPT ALASKA AND HAWAII)

<u>SIZE OF FAMILY UNIT</u>	<u>INCOME GUIDELINE</u>
1	6,620
2	8,880
3	11,140
4	13,400
5	15,660
6	17,920
7	20,180
8	22,440

FOR FAMILY UNITS WITH MORE THEN 8 MEMBERS, ADD \$2,260 FOR EACH  
ADDITIONAL MEMBER.

PROSSER MEMORIAL HOSPITAL

Charity Care - Income Guidelines

Family Unit Size	Annual Income	Percentage of Bill which Patient is Responsible				
		0%	25%	50%	75%	100%
1	From	0	6,621	8,806	10,990	Over
	To	6,620	8,805	10,989	13,240	12,561
2	From	0	8,881	11,811	14,742	Over
	To	8,880	11,810	14,741	17,760	16,841
3	From	0	11,141	14,817	18,493	Over
	To	11,140	14,816	18,492	22,280	21,121
4	From	0	13,401	17,823	22,245	Over
	To	13,400	17,822	22,244	26,800	25,401
5	From	0	15,661	20,829	25,997	Over
	To	15,660	20,828	25,996	31,320	29,681
6	From	0	17,921	23,838	29,748	Over
	To	17,920	23,837	29,747	35,840	33,961
7	From	0	20,181	26,840	33,500	Over
	To	20,180	26,839	33,499	40,360	38,241
8	From	0	22,441	29,846	37,251	Over
	To	22,440	29,845	37,250	44,880	42,521

For family units with 9 or more members, add \$2,260 for each additional member.

## APPLICATION PROCEDURES

To apply for charity care, eligible persons must:

1. Complete a charity care application form, available through the business office, prior to admission or as soon as possible following the initiation of services to the patient
2. List sources of income and health care insurance coverage available to the applicant; and
3. Supply credit references and documentation of income

The following types of documentation are required:

X if available

- W2 withholding statement
- Payroll check stub, if employed
- IRS tax return from the most recently completed calendar year
- Determination of unemployment compensation
- Medicaid rejection or patient liability
- Statement of accounts owing
- Dependent birth certificates
- Bank statements

All information provided shall be kept confidential. Copies of documentation used to support the application shall be kept with the application

A determination of charity care eligibility shall be made within fourteen calendar days after the application form and supporting documentation has been submitted to the business office. The applicant will be notified of approval or denial of their application within fourteen calendar days.

If there are any questions in completing the application, contact the Business Office Manager at Prosser Memorial Hospital.

Phone 786-2222  
Extension 155

**PROSSER MEMORIAL HOSPITAL CHARITY CARE APPLICATION**

(If patient is a minor child, please provide information on responsible parent or guardian).

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ SS# \_\_\_\_\_  
 PHONE \_\_\_\_\_

How long a resident in county? \_\_\_\_\_

EMPLOYER \_\_\_\_\_ LANDLORD/MORTGAGE:  
 HOW LONG \_\_\_\_\_ NAME \_\_\_\_\_  
 MONTHLY INCOME \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 NET INCOME FOR LAST 12 MONTHS? \_\_\_\_\_ PHONE \_\_\_\_\_  
 MESSAGE PHONE \_\_\_\_\_

OTHER INCOME \_\_\_\_\_  
 BANK ACCOUNT BALANCE  
     CHECKING \_\_\_\_\_  
     SAVINGS \_\_\_\_\_

ATTACH MOST RECENT TAX RETURN \_\_\_\_\_  
 ATTACH PREVIOUS YEAR'S RETURN \_\_\_\_\_

ABOVE INFORMATION MUST BE DOCUMENTED

NUMBER OF DEPENDENTS (18 YEARS OR YOUNGER, LIVING AT HOME) \_\_\_\_\_

ASSETS:	DESCRIPTION	VALUE
_____	_____	_____
_____	_____	_____
_____	_____	_____

APPROX. AMOUNT OF MONTHLY LIVING EXPENSES (FOOD, UTILITIES, ETC.)  
 \$ \_\_\_\_\_

AUTOMOBILE(S) OWNED: MAKE \_\_\_\_\_ MODEL \_\_\_\_\_ VALUE \_\_\_\_\_  
 MONTHLY PAYMENT \_\_\_\_\_ AMOUNT OWING \_\_\_\_\_

OTHER DEBTS:

CREDITORS	ACCOUNT #	BALANCE	# OF PYMTS
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

MEDICAL/DENTAL ACCOUNTS OUTSTANDING:

DOCTOR'S NAME	DATE INCURRED	BALANCE	MO. PAYMENT
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

PLEASE HAVE DOCUMENTATION FOR ABOVE AVAILABLE UPON REQUEST  
HAVE YOU OR A FAMILY MEMBER BEEN A PATIENT AT PROSSER MEMORIAL  
HOSPITAL BEFORE \_\_\_\_\_ YES \_\_\_\_\_ NO.

WHEN \_\_\_\_\_ NAME \_\_\_\_\_

DO YOU HAVE MEDICAL INSURANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO.

NAME OF INSURANCE COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

HAVE YOU ATTEMPTED TO GET ASSISTANCE FROM ANOTHER SOURCE?(i.e.  
Dept of Health and Social Services, Veterans Admin., Medicare)  
\_\_\_\_\_ YES \_\_\_\_\_ NO.

IF YES, GIVE DETAIL (which agency, contact person, date, etc.)  
INCLUDE DENIAL NOTICES. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF NO, YOU MUST APPLY FOR ASSISTANCE FROM OTHER SOURCES OR FINAN-  
CIAL AID, IN ORDER TO QUALIFY FOR CHARITY CARE REVIEW.

INCLUDE ANY OTHER INFORMATION YOU THINK MAY BE HELPFUL TO US IN  
MAKING A FAVORABLE DETERMINATION.

PLEASE READ CAREFULLY BEFORE SIGNING:

I AUTHORIZE PROSSER MEMORIAL HOSPITAL TO OBTAIN SUCH INFORMATION  
AS REQUIRED CONCERNING THE STATEMENTS MADE IN THIS APPLICATION  
AND AGREE THAT THE APPLICATION SHALL REMAIN HOSPITAL PROPERTY  
WHETHER IT IS APPROVED OR NOT. I HEREBY CERTIFY THAT ALL STATE-  
MENTS IN THIS APPLICATION, INCLUDING THE DOCUMENTATION FURNISHED  
BY ME, ARE TRUE AND COMPLETE AND ARE MADE FOR THE PURPOSE OF OB-  
TAINING UNCOMPENSATED OR PARTIALLY COMPENSATED CARE. I FURTHER  
AGREE TO SUBMIT SUCH ADDITIONAL INFORMATION OR DOCUMENTATION THAT  
YOU MAY REQUEST CONCERNING MY FINANCIAL STATUS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DATE: \_\_\_\_\_

ACCOUNT NO. \_\_\_\_\_

DETERMINATION OF ELIGIBILITY FOR CHARITY CARE

APPLICANT'S NAME \_\_\_\_\_

1. The applicant is Eligible for \_\_\_\_\_ 100% discount  
or \_\_\_\_\_ a partial discount of \_\_\_\_\_%.

Total Account Balance: \_\_\_\_\_

Total Discount Amount: \_\_\_\_\_

2. The applicant is Ineligible for Charity Care \_\_\_\_\_.

3. If application is denied, state the reason : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3A An applicant denied eligibility has 30 calendar days from the date of this notification in which to request an appeal. During this period the applicant can correct any deficiencies in the documentation originally presented.

4. Date of determination of eligibility or denial for Charity Care \_\_\_\_\_.

Signed: \_\_\_\_\_

Date applicant provided with a copy determination \_\_\_\_\_.