# Big Sandy Medical Center Charity Care Policy

Big Sandy Medical Center's (BSMC) mission is to provide the best possible quality care for its patients, at the most reasonable cost in a competent, professional manner. As part of that commitment, Big Sandy Medical Center appropriately serves patients in difficult financial circumstances and offers financial assistance to those who have an established need.

Charity care reduces the cost of medical services for patients who do not have adequate financial resources or other means to pay for their care. This is in contrast to bad debt, which is defined as a patient and/or guarantor who, having the financial resources to pay for their health care services, has demonstrated an unwillingness to resolve a bill. The granting of the charity care discount will be based on an individualized determination of financial need, and shall not take into account race, creed, gender, national origin, disability, age, social immigrant status, or sexual orientation.

## 1. Purpose

The purpose of this Charity Care Policy is to ensure that processes and procedures exist for identifying and assisting hospital patients whose care may be provided at a discounted rate appropriate to their financial resources and ability to pay. This policy applies to all services rendered by all providers at the Big Sandy Medical Center Hospital; it does not apply to clinic or nursing home charges.

## 2. Definitions

A. **Family:** The patient, his or her spouse (including a legal common-law spouse), any minor children supported by the patient, and any adults for whom the patient is legally responsible. In the case of a minor patient, family includes both parents, the spouse of a parent, minor siblings, and any adults for who the patient's guarantor is legally responsible. A pregnant female counts as two family members.

B. **Family Income:** The sum of a family's annual earnings and cash benefits from all sources before taxes, less payment for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, training stipends, military allotments, regular support from family members not living in the household (other than child support), pensions, insurance, annuity payments, retirement, income from rent, royalties, estates, trusts, and other forms of income.

C. **Financial Assistance:** A reduction in charges, based on the charity care schedule (Attachment A), for patients who are financially eligible, as defined in this policy. Financial assistance does not include bad debt, but may include insurance co-payments, deductibles, or both.

D. **Bad Debt:** Uncollectable accounts receivable, where reasonable attempts to collect have been made, arising from the failure to pay by patients whose health care has not been classified as eligible for financial assistance or who have qualified for financial assistance but have failed to pay the remaining balance due after application of discounts pursuant to this policy.

E. **Financially Eligible:** A patient whose income is below 200% of the Federal Poverty Guidelines, as set forth in Attachment A.

F. **Patient:** The person who received/ is receiving medical services.

G. **Guarantor:** The people financially responsible for the payment of the patients account balance.

## 3. Eligibility for Financial Assistance

A. Financial assistance will be given for hospital services to patients who are Financially Eligible, based on the information provided on the Financial Assistance Application (Attachment B). In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by Big Sandy Medical Center's Board of Directors.

B. Patients seeking financial assistance will be asked to complete the Financial Assistance Application, Attachment B. Copies of the application form are available at the BSMC Business Office and at www.bsmc.org. If assistance is needed with gathering necessary information or materials requested as part of the Financial Assistance Application, patients are encouraged to contact BSMC's Business Office at 406-378-2188.

C. Patients completing the Financial Assistance Application must return the signed form and required supporting materials through any of the following measures:

- Hand-deliver to BSMC's Business Office located at 166 Montana Ave East, Big Sandy, MT 59520. If after business hours, please leave completed application in lock-box outside the business office door.
- Mail to BSMC, Attn: Business Office, PO Box 530, Big Sandy, MT 59520

D. If BSMC contacts the patient to request missing/additional information, the patient will have 30 days to respond. Failure to respond within that 30-day period will result in the application being denied. If a patient provides information that is inaccurate or misleading, he or she will be deemed ineligible for financial assistance and will be expected to pay his/her bill in full.

E. Once a Financial Assistance Application is received. BSMC's Business Office will review the application for completeness. Once an application is determined to be

complete, it will be presented to BSMC's Board of Directors at the next regularly scheduled board meeting. All decisions will be sent to the patient in writing within 30 days of the Board's decision.

F. In the event that BSMC determines a patient not eligible for financial assistance, BSMC will notify the patient in writing of such determination, including the basis for the denial; the notice will state that the patient may reapply if the patient's financial circumstances change. Patients who do not qualify for financial assistance may contact the Business Office to discuss payment options, including the availability of a payment plan.

G. All determinations of qualification for financial assistance will be effective 3 months prior to the date of the completed Financial Assistance Application and continuing for 12 months following the date of the completed Financial Assistance Application.

H. If a patient has been determined financially eligible for financial assistance with the hospital, and would like to apply for Big Sandy Medical Center's Sliding Fee Scale (clinic charges only), they would need to submit a letter to the Business Office that requests the sliding fee scale discount. This letter would then be presented to the BSMC Board of Directors for consideration.

## 4. Impact on Billing and Collection Process

A. The applicable discount percentage from Attachment A will be applied to the gross charges billable to the patient.

B. Patients qualifying for discounted care will be notified in writing regarding any remaining balance. Any such remaining balances will be treated in accordance with the Billing and Collection policy, a copy of which is available at the BSMC Business Office.

C. In the event that a patient qualifies for financial assistance but fails to timely pay the remaining balance due, the hospital may take any of the actions defined in the Billing and Collection Policy.

## 5. Publication

A. This policy and the Financial Assistance Application will be made widely available to BSMC Hospital patients. Copies of this policy and the Financial Assistance Application will be posted on the Hospital Website.

B. BSMC will post, in the patient admitting areas, signage providing information regarding the availability of financial assistance and describing the application process.

C. BSMC will cause each billing statement sent to a patient to include a statement regarding the availability of financial assistance, including a phone number where they can request more information.

## 6. Confidentiality

A. BSMC will keep all completed Financial Assistance Applications, along with required supporting information, in the Business Office. Such records will also reflect whether the application was approved or denied.

B. BSMC recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to the Policy. No information obtained in the patient's Financial Assistance Application may be released except where authorized by the patient or otherwise required by law.

## Attachments:

| | |
|---|---|
| Attachment A | Sliding Fee Schedule |
| Attachment B | Financial Assistance Application |

## ATTACHMENT A

# Big Sandy Medical Center Charity Care Policy

2016 – **Big Sandy Medical Center, Inc.**
Charity Care Discount Schedule
Per 2016 Poverty Guidelines

| | **50% Account Reduction** | **25% Account Reduction** | **0% Account Reduction** |
|---|---|---|---|
| **Family Size** | | | |
| 1 | 17,820 | 20,790 | 23,760 |
| 2 | 24,030 | 28,035 | 32,040 |
| 3 | 30,240 | 35,280 | 40,320 |
| 4 | 36,450 | 42,525 | 48,600 |
| 5 | 42,660 | 49,770 | 56,880 |
| 6 | 48,870 | 57,015 | 65,160 |
| 7 | 55,095 | 64,278 | 73,460 |
| 8 | 61,335 | 71,558 | 81,780 |
| | | | |
| **Poverty Level** | 133% | 166% | 200% |

Discount Calculation: **Account Balance x Reduction Amount = Reduction Amount**

Payment Calculation: **Account Balance – Reduction Amount = Balance Due**

# Big Sandy Medical Center Charity Care Policy

## ATTACHMENT B

This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for discounted medical services.

**COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY**

**If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Sliding Fee Schedule. In that case, you will be responsible for the full balance due on your account.**

**If you need help in completing this form or gathering the supporting materials, please contact the Business Office at 406-378-2188.**

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office, etc.
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.

- ❖ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.
- ❖ NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

**Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided. Your completed application and supporting documentation may be submitted to:**

- **Hand-delivering to the Business Office at 166 Montana Avenue East, Big Sandy, MT 59520**
- **Mailing to Big Sandy Medical Center, Attn: Business Office, PO Box 530, Big Sandy, MT 59520**

# FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

## I. PERSONAL INFORMATION

**Personal information of applicant (or parent, if applicant is a minor):**

Name _____ Date of Birth _____
Last First MI

Address_____
Street City State Zip Code

Living at Address since _____ Phone # (_____) _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Social Security # _____ Date of Birth _____

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

| FAMILY MEMBER'S LEGAL NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

## II. INSURANCE INFORMATION

| | APPLICANT (OR PARENT, IF APPLICANT IS A MINOR) | APPLICANT'S SPOUSE |
|---|---|---|
| Do you have health insurance? (Y/N) | | |
| If yes, name of health insurance plan: | | |
| Medicare? (Y/N) | | |
| Medicare Part D? (Y/N) | | |
| Medicare Supplement? (Y/N) | | |
| Medicaid? (Y/N) | | |
| Veteran's Benefits? (Y/N) | | |

## III. EMPLOYMENT AND INCOME INFORMATION

***Employment information of applicant (or parent, if applicant is a minor):***

Employer _____ Unemployed (Y/N) ____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance? (Y/N) _____

Occupation / Position _____ Date of Hire _____

Student (Y/N) ____ Name of School_____ Number of Credits This Semester _____

| MONTHLY SALARY | | | |
|---|---|---|---|
| GROSS | $ | NET | $ |

| HOURLY PAY | $ | HOURS WORKED WEEKLY | |
|---|---|---|---|

Additional Source(s) of Income (per month):

| | | | | | |
|---|---|---|---|---|---|
| ❑ Other wages | $_____ | ❑ Child Support | $_____ | ❑ Self Employment | $_____ |
| ❑ Interest, Dividends | $_____ | ❑ Retirement | $_____ | ❑ SSI/Social Security | $_____ |
| ❑ Rental Income | $_____ | ❑ Worker's Comp | $_____ | ❑ Veterans Benefits | $_____ |
| ❑ Food Stamps | $_____ | ❑ Unemployment | $_____ | ❑ Other | $_____ |
| ❑ Alimony | $_____ | ❑ Farm Income | $_____ | | |

***Employment information of Spouse (if applicable):***

Spouse's Employer _____ Unemployed ? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance? (Y/N) _____

Occupation / Position_____ Date of Hire _____

Student (Y/N) _____ Name of School_____ Number of Credits This semester _____

| MONTHLY SALARY | | | |
|---|---|---|---|
| GROSS | $ | NET | $ |

| HOURLY PAY | $ | HOURS WORKED WEEKLY | |
|---|---|---|---|

Additional Source(s) of Income (per month):

| | | | | | |
|---|---|---|---|---|---|
| ❑ Other wages | $_____ | ❑ Child Support | $_____ | ❑ Self Employment | $_____ |
| ❑ Interest, Dividends | $_____ | ❑ Retirement | $_____ | ❑ SSI/Social Security | $_____ |
| ❑ Rental Income | $_____ | ❑ Worker's Comp | $_____ | ❑ Veterans Benefits | $_____ |
| ❑ Food Stamps | $_____ | ❑ Unemployment | $_____ | ❑ Other | $_____ |
| ❑ Alimony | $_____ | ❑ Farm Income | $_____ | | |

## IV. CERTIFICATION

*I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Big Sandy Medical Center, Inc., and I authorize Big Sandy Medical, Inc. to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for the sliding fee schedule, and any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.*

Applicant's Signature _____ Date of Request_____

Your completed application and supporting documentation may be submitted to:

- Hand-delivering to the Business Office at 166 Montana Avenue East, Big Sandy, MT 59520
- Mailing to Big Sandy Medical Center, Attn: Business Office, PO Box 530, Big Sandy, MT 59520

**To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application.**