North Florida Rehabilitation Hospital

SUBJECT: **CHARITY CARE**
Policy: **BO 170**
Effective Date:
Revision Date:

Business Office Policies and Procedures

POLICY

As a part of North Florida Rehabilitation Hospital obligation to provide charity care and as part of the rehabilitation hospital's stewardship duty to use its resources as effectively as possible, manage its business affairs prudently and well, and preserve its capacity to continue serving in future years while fulfilling current needs, North Florida Rehabilitation Hospital strives to identify the dollar volume of charity care it provides to patients who cannot pay for hospital care because they lack the necessary financial resources. Identification of Charity Care will assist in providing care to a segment of the community served who cannot pay for that care.

GUIDELINES

1. Charity Care includes care to individuals who lack the ability to pay as determined by North Florida Rehabilitation Hospital, utilizing guidelines as outlined below. Uncollected accounts for other patients shall be subjected to full collection efforts, and if not collected, shall be considered for bad debt. All or part of the hospital bill may be considered charity care.

2. The determination of the ability to pay may take into account a number of variables, including but not limited to;
    a. the earning status and potential of the patient and family,
    b. other sources of income and assets,
    c. the level and type of liabilities,
    d. the ability to obtain additional credit,
    e. the amount and frequency of hospital/medical bills, and
    f. the family size.

    All or a part of the hospital bill may be considered charity care.

3. Patients eligible for charity consideration, including both Financially Indigent and Medically Indigent applicants who have inadequate resources to pay for services provided.

    a. Financially Indigent patients include those patients who are uninsured or underinsured, whose annual income is equal to or less than the Federal Poverty Guidelines as published and updated annually in the Federal Register, and who have no ability to pay for their medical care.

    b. Medically Indigent patients include those patients who are capable for paying for their living expenses, but who's medical and hospital bills, after payment by third party payers, would require use or liquidation of income and/or assets critical to living or earning a living.

4. The identification of charity care begins at time of registration with the gathering of information concerning third party payers and the patient's and guarantor's financial data and identification of community resources available to assist in paying the account. Generally, information will be gathered and potential community resources identified during the pre-admission process, where available, and while the patient is in the hospital because access to the patient and family is greatest during that period. However, identification can occur at any time sufficient information is available to make the determination, including well after the normal collection cycle.

5. Classification of an account as charity care generally will end efforts to collect the accounts from the patient and, in most instances, from family members. Routine activity may continue in order to ensure that North Florida Rehabilitation Hospital can identify changed circumstances in the future and ensure continuity with respect to subsequent visits. Efforts to collect from third parties will continue, and any resulting collection would be a charity recovery. Classification of an account as charity care should not occur until:

    a. It is determined that in accordance with Item 2 above, the patient and guarantor definitely do not have the financial resources to pay the account (or portions of the account), or in accordance with Item 7 below, treatment as charity is warranted under the circumstances determined by North Florida Rehabilitation Hospital.

    b. Even if an account is to be considered charity care under this policy, the patient and guarantor should receive at least one statement indicating the balance due on the account. They should also receive the routine follow-up statements and collection letters until such time as the charity care designation is made and it is determined that continuing such mailings will not result in collecting part or all of the account. These statements and collection letters should not indicate that the account is to be designated as charity care.

    c. It may be appropriate in some cases to notify a patient or guarantor that the account is classified as charity care, if doing so will enhance the public's understanding of the hospital's charity care or assist in the collection of a portion of the account. If a patient or guarantor is to be notified that the account will be classified as charity care, the notification should be from a member of North Florida Rehabilitation Hospital management. (Exhibit 3).

    d. The charity care classification is authorized in accordance with Item 7 below.

6. Failure to provide information necessary to complete a financial assessment may result in a negative determination. A determination of eligibility for charity may be made without a complete assessment if eligibility is warranted under the circumstances as determined by North Florida Rehabilitation Hospital.

7. No person shall be excluded from consideration for financial assistance based on race, creed, color, religion, spirituality, sex, national origin, or physical disability. Only exclusion would be if the patient does not meet rehabilitation appropriateness.

8. This policy may not be terminated, modified or amended without approval of the North Florida Rehabilitation Hospital Board. The North Florida Rehabilitation Hospital Board may, from time to time, and to the extent not inconsistent with the terms and requirements of the Agreement, develop and adopt and require implementation of changes, modifications and amendments to this policy that it deems appropriate.

APPLICATION FOR FINANCIAL ASSISTANCE – EXHIBIT 1

PATIENT INFORMATION							
Patient Name			Age	Telephone No.			Patient No.
Home Address			Rent ☐ Own ☐				Live with parents? No ☐ Yes ☐
SSN	Marital Status	Discharge diagnosis					If pregnant, due date?
Name & Address of employer				Employer Telephone No.			How long employed?
Position/Title				Supervisor's Name			
If unemployed, last date & place of employment				Position/Title			
RESPONSIBLE PARTY INFORMATION							
Name		Relationship to patient		Age	Telephone No.		
Street address, if different from patient							
SSN	Marital Status	Family Size	Names & Ages				
Name & Address of Employer				How long employed?	Employer Telephone No.		
Position/Title				Supervisor's Name			
If unemployed, last date & place of employment				Position/Title			
Name of Nearest Relative				Relationship			
Address				Telephone No.			
SPOUSE INFORMATION							
Name	Age	SSN		Name of Employer			
Employer Address			How long employed?	Employer Telephone No.			
Position/Title			Supervisor's Name				
If unemployed, last date & place of employment			Position/Title				
MONTHLY INCOME				**ASSETS**			
ITEM	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	☐ Patient ☐ Spouse ☐Father ☐ Mother	Checking Account(s) – bank & account number			Balance
Base Income							
Overtime				Savings Account(s) – bank &			Balance
Social Security							
Interest/Dividends				Other (bank & account number,			Balance
Rental Income							

Alimony/Child				Life Insurance (company &	Value
Unemployment					
State Assistance				Stocks, Bonds & Mutual Funds	Value
Food Stamps					
Pension				Automobiles/Trucks (make,	Value
Disability					
Worker's					
Other				Other Assets (personal,	Value
				Real Estate (list and describe)	Present Value
TOTAL				**TOTAL ASSETS**	

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. **MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX**
2. **BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)**
3. **VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC)**

MONTHLY EXPENSES		**OTHER EXPENSES**	**MONTHLY PAYMENT**	**BALANCE**	**PAYMENT CURRENT?**
ITEM	**MONTHLY PAYMENT**	Charge Accounts			☐ **No** ☐ **Yes**
Rent					☐ **No** ☐ **Yes**
Mortgage					☐ **No** ☐ **Yes**
Electricity					☐ **No** ☐ **Yes**
Gas/Propane					☐ **No** ☐ **Yes**
Water					☐ **No** ☐ **Yes**
Refuse		Personal Loan			☐ **No** ☐ **Yes**
Telephone					☐ **No** ☐ **Yes**
Cable TV		Automobile Loan			☐ **No** ☐ **Yes**
Food					☐ **No** ☐ **Yes**
Clothing		Real Estate Loan			☐ **No** ☐ **Yes**
Medicine					☐ **No** ☐ **Yes**
Baby Sitter		Cellular			☐ **No** ☐ **Yes**
Transportation					☐ **No** ☐ **Yes**
Alimony/Child		Miscellaneous			☐ **No** ☐ **Yes**
Auto					☐ **No** ☐ **Yes**
Home					☐ **No** ☐ **Yes**
Life Insurance		**TOTALS**	**TOTAL MONTHLY PAYMENTS**	**TOTAL BALANCE**	
Health					
Personal					
Real Estate		**SUMMARY**			
Sub-total					

Total Monthly Income **$**_____

Total Monthly Expenses **$**_____

Discretionary Income **$**_____

Monthly Payment Arrangements **$**_____

OTHER EXPENSES

Will the patient be unable to work or go to school due to physical impairment? ☐ No ☐ Yes

If yes, what is the disabling condition or diagnosis? _____

_____

How long will the patient be disabled? _____

_____ (Please attach a statement from the doctor.)

COMMENTS

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.

_____

Patient Signature

_____

Responsible Party or Spouse Signature

_____

Facility Representative Department

_____

Date

EXHIBIT 2

Date: _____

Patient Name: _____

Account Number: _____

Admission Date: _____ Discharge Date: _____

Estimated Insurance Liability $_____ Account Balance: $_____

Total Amount Due $ _____

Dear _____:

Attached you will find a financial assistance application form. Financial assistance is based on current balances. If you qualify for any financial assistance, payments already made to this account will not be refunded. Please fill out the application completely and provide me with the following indicated support documents within two (2) weeks:

_____ Last year's federal tax return with W-2, W-2G, or 1099-R forms and support schedules.
_____ Proof of income (i.e., check stubs, Social Security Benefits, etc.)
_____ Bank statements for the past three (3) months

The financial statement must be signed by the guarantor and the guarantor's spouse, if applicable.

Thank you for your anticipated cooperation in gathering the information needed for the application. Please be aware that if all information is not received, your application for assistance will not be processed.

Your account will be kept open for two (2) weeks pending the return of the above information. If you have any questions, please call toll-free at xxx-xxx-xxxx, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Sincerely,

xxxx
Director, Patient Accounts
Enclosures

EXHIBIT 3

Date: _____

Patient Name: _____

Account Number: _____

Dates of Service: _____

_____ Your application for financial assistance has been approved in the amount of _____%. This allowance will be applied to the hospital charges remaining after all applicable insurance benefits have been paid. This allowance does not apply to your physician's bill or non-covered items such as private room, take home items, etc. The balance remaining, after financial assistance has been applied, must be paid by cash, personal check or money order. Please contact the Patient Accounts Department regarding your choice of payment options.

Your current balance after financial assistance is $: _____.

_____ Your application for financial assistance has been denied. Your level of income is higher than the standard level used to compute our financial assistance allowance.

Sincerely,

Patient Accounts Department
Monday – Friday (8:30 a.m. to 4:30 p.m.)