Morrison Community Hospital

MORRISON COMMUNITY HOSPITAL DISTRICT
MORRISON, ILLINOIS

SUBJECT:	Financial Assistance, Uninsured Patient, and Charity Care Discount
FROM:	Administration
TO:	All Departments
DATE:	November 9, 2004
EFFECTIVE:	January 1, 2005

REVISION DATES: January 1, 2014, February 25, 2019, January 10, 2022, August 8, 2022, February 2, 2023

Forms specific to this policy:

F-BUS3030-A	Patient Financial Assistance Application
F-BUS3030-B	Uninsured Discount & Financial Need Determination Forms
F-BUS3030-C	Financial Need Acceptance Letter
F-BUS3030-D	Financial Need Denial Letter
F-BUS3030-E	Financial Need Offer Letter
F-BUS3030-F	Financial Need Sign
F-BUS3030-G	Assistance Reduction, Denial Letter based on Consumer Reporting Agency Info
F-BUS3030-H	Financial Need Presumptive Eligibility Determination Form

POLICY

Morrison Community Hospital will provide financial assistance discounts to individuals who have demonstrated an inability to pay for the services received. Inability to pay will be determined on a case-by-case basis.

PRESUMPTIVE ELIGIBILITY

1. Presumptive eligibility may be determined on the basis of individual life circumstances. In these situations, a patient is deemed to be eligible for a 100 percent reduction from charges (i.e. full write-off). A patient is presumed to be eligible and therefore does not need to complete a financial assistance application if they meet one of the following criteria:
   a. Participation in state funded prescription programs.
   b. Participation in Women's Infants, and Children's Programs (WIC)
   c. Food stamp eligibility.
   d. Subsidized school lunch program eligibility.
   e. Low income/subsidized housing is provided as a valid address.
   f. Patient is deceased with no known estate.
   g. Patient states that he/she is homeless. The due diligence efforts must be documented.
   h. Patient is currently eligible for Medicaid, but was not eligible on a prior date of service. Instead of making the patient duplicate the required paperwork MCH will rely on the financial assistance determination process from Medicaid.
   i. Situations where a patient does not complete an application and there is adequate information to support the patient's eligibility

PURPOSE

To provide guidelines for financial assistance/charity care discounts to individuals who have demonstrated an inability to pay for hospital services rendered.

PROCEDURE

1. Eligibility – Determination of eligibility for financial need will occur with each incident and a new application. Patients who meet one of these criteria are eligible to apply for financial assistance/charity care:
   a. Uninsured patients who do not have the ability to pay based on criteria set by the Hospital in this policy
   b. Patients who demonstrate ability to pay part but not all of their liability

c. Deceased patients with no estate

2. Ineligibility – Patients are not eligible for financial assistance/charity care discounts when:
   a. They refuse alternate sources of payment from third parties (i.e. Medicaid). Patients must show they have applied for public aid assistance and have been denied by bringing in a copy of the denial.
   b. They refuse to provide information necessary to make a determination within the required amount of time
   c. They do not pay balance owing in accordance with agreed upon terms for graduated income level discounts

3. Applications
   a. Morrison Community Hospital will make information and applications for assistance available at each registration site or at the Business Office.
   b. Patients may also call the Billing Director and an application will be mailed with instructions.
   c. Requests for financial assistance/charity care discounts may be made at any time before, during, or after services are rendered but before the account is sent to collections.

4. Application Receipt – If the application is received within 30 days of the request, the Billing Director will review the application to verify it has been adequately completed and all required documentation has been supplied.
   a. If documentation is complete, the Billing Director will note the system indicating the account is under review.
   b. If documentation is incomplete, the Billing Director will note the system indicating what information is missing and generate a system letter to the patient requesting the required information. The Billing Director will add a follow-up date for one week. If the application is still incomplete after one week or there has been no response, the application is denied. The Billing Director will proceed with standard collection policy.
   c. If the application is not received within the 30 days, the Billing Director will review the account. One call will be placed to the patient inquiring on the status of the application.
      -If the patient plans to complete the application, they will be given a one-week extension. The Billing Director will note the system and add a follow-up date for one week. If the application is not received within one week, the Office Manager will proceed with standard collection policy.
      -If the patient is not planning on completing the application, the Billing Director will proceed with standard collections policy.

5. Approval – In making an evaluation, hospital personnel will take into consideration the patient's physical condition, available liquid assets, future sources of income, life-style, living expenses, and the amount of the hospital charges in question. The Hospital will also compare the annual gross family income to the discount guidelines and determine if the patient is eligible for charity care and at what level (See Federal Poverty Guideline on the next page). Once the determination is made, both the application and the system are noted with the decision.
   a. After the application has been reviewed and a decision made, the Billing Director will note the system and forward the appropriate letter to the patient informing them of the hospital's decision. If the application is denied, the patient will also be informed that they can contact the hospital to make payments with the Billing Office.

APPLICATION FOR FINANCIAL NEED

Mail this completed form to:
Morrison Community Hospital
Attn: Business Office Manager
303 North Jackson Street
Morrison, IL 61270

Name of Patient _____ Birthdate _____ Social Security # _____

Spouse _____ Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Household Members:

	Name	Age	Relationship to Patient	Employer
1.				
2.				
3.				
4.				
5.				

INCOME: List Gross Income of **Total Household** for: Last Twelve Months

Patient's Gross Monthly Income*..... _____

Spouse's Gross Monthly Income*..... _____

Signature of Applicant:
By signing my name to this form I am saying that the answers I have given are true and complete to the best of my knowledge. I have been advised and understand that if I knowingly give wrong information, I am liable for prosecution under state law. I also understand that this application shall remain in the confidential property of Morrison Community Hospital. I hereby give my consent to Morrison Community Hospital to make inquiry concerning information in this application.

_____ _____
Applicant's Signature Date

FOR ADMISSIONS ONLY

APPROVED _____ DISAPPROVED _____

_____ _____
Signature Date

Date

Guarantor Name
Guarantor Address
Guarantor City, State Zip

Re: Charity Care-Financial Need

Dear Guarantor name,

We have reviewed your application for Charity Care relating to the following accounts:

1.
2.
3.

These accounts have a current total balance of $

We are unable to complete our review of this application until we receive the following information (marked with an X):

_____ Completed application
_____ W-2 Withholding Statements for all employed family members living at home
_____ Most recent Federal/State income tax returns for all family members living at home
_____ Paycheck/Unemployment check stubs (Past 3 months) or written statement of earnings from employer(s)
_____ Denial received from Illinois Medicaid program
_____ Other _____

Please forward this information to us within 10 days of the date of this letter. If we do not receive this information within this time frame, we will be unable to process your application.

Please feel free to contact me at 815-772-4003, extension 203, if you have any questions.

Sincerely,

Michelle Holcomb
Billing Director

Date

Guarantor Name
Guarantor Address
Guarantor City, State Zip

Re: Account #

Dear Guarantor name,

Morrison Community Hospital strives to provide quality health care to meet the needs of all people in the community it serves. Upon request, Morrison Community Hospital will process application for financial assistance from individuals who feel they are unable to pay for services rendered.

Based on the information you provided, Morrison Community Hospital has determined that you are eligible for assistance. Listed below are the self-pay portions minus the eligible percentage of assistance that Morrison Hospital will provide. Please note that this assistance applies only to the accounts listed below. If there are additional accounts, please contact the Billing Director at the number listed below.

Account Number	Patient Name	Self-Pay Portion	Amount of Assistance	Patient Responsibility

Please call 815-772-4003, extension 203 immediately to arrange payment of your remaining balance.

Sincerely,

Michelle Holcomb
Billing Director

Morrison Community Hospital

_____ Completed application

_____ W-2 Withholding Statements for all employed family members living at home

_____ Most recent Federal/State income tax returns for all family members living at home

_____ Paycheck/Unemployment check stubs (Past 3 months) or written statement of earnings from employer(s)

_____ Denial received from Illinois Medicaid program

_____ Date all papers completed

I, _____, on _____
Patient/Guarantor Signature Today's date

Believe the information provided for this application is true to the best of my knowledge. I furthermore agree the hospital has taken steps to assist me/and or my family following policy and Federal Poverty Guidelines.

Date

Guarantor Name
Guarantor Address
Guarantor City, State Zip

Re: Account #

Dear Guarantor name,

Morrison Community Hospital strives to provide quality health care to meet the needs of all people in the community it serves. Upon request, Morrison Community Hospital will process application for financial assistance from individuals who feel they are unable to pay for services rendered.

Morrison Community Hospital reserves the right to deny request for patients that do not meet the eligibility criteria.

Your request for financial assistance at Morrison Community Hospital was reviewed. It was denied for the following reasons:

_____ Failure on your part to present the necessary documentation (Completion of application or copies of requested information)

_____ Failure on your part to present a valid Public Aid denial

_____ You did not meet the Charity Care income requirements

_____ Other _____

_____

Please call 815-772-4003, extension 203, to resolve any questions concerning the disposition of your application. Your account balance remains your responsibility. Please contact us to make payment arrangements as soon as possible.

Sincerely,

Michelle Holcomb
Billing Director

IHA Charity Care and Collection Practices for the Uninsured

Hospital Responsibilities:

1. The hospital will have a charity care policy to evaluate and determine a patient's eligibility for financial assistance. Each will be reviewed and a determination of level of financial assistance will be decided.

2. The hospital will have a means of communicating the availability of charity care to all patients

3. Staff in the hospital's patient financial services and registration departments will understand the hospital's charity care policy and be able to direct questions regarding the policy to the proper hospital representative.

4. An uninsured patient will receive a full (100%) discount if he or she can demonstrate family income at or below 100% of federal poverty guidelines. Family income greater than 100% but equal to or less than 200% of federal poverty guidelines are eligible for a partial discount. Both of these are subject to eligibility requirements.

5. When looking at eligibility criteria the hospital may look at personal assets other than income.

6. After receiving request for financial assistance and any financial information to determine eligibility, the hospital must notify the patient of the decision within a reasonable amount of time.

7. The federal poverty guidelines must be updated annually.

2023 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Per Year

Household/ Family Size	25%	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%	200%
1	$3,645	$7,290	$10,935	$14,580	$18,225	$18,954	$19,391	$19,683	$20,120	$21,870	$25,515	$26,244	$26,973	$29,160
2	$4,930	$9,860	$14,790	$19,720	$24,650	$25,636	$26,228	$26,622	$27,214	$29,580	$34,510	$35,496	$36,482	$39,440
3	$6,215	$12,430	$18,645	$24,860	$31,075	$32,318	$33,064	$33,561	$34,307	$37,290	$43,505	$44,748	$45,991	$49,720
4	$7,500	$15,000	$22,500	$30,000	$37,500	$39,000	$39,900	$40,500	$41,400	$45,000	$52,500	$54,000	$55,500	$60,000
5	$8,785	$17,570	$26,355	$35,140	$43,925	$45,682	$46,736	$47,439	$48,493	$52,710	$61,495	$63,252	$65,009	$70,280
6	$10,070	$20,140	$30,210	$40,280	$50,350	$52,364	$53,572	$54,378	$55,586	$60,420	$70,490	$72,504	$74,518	$80,560
7	$11,355	$22,710	$34,065	$45,420	$56,775	$59,046	$60,409	$61,317	$62,680	$68,130	$79,485	$81,756	$84,027	$90,840
8	$12,640	$25,280	$37,920	$50,560	$63,200	$65,728	$67,245	$68,256	$69,773	$75,840	$88,480	$91,008	$93,536	$101,120
9	$13,925	$27,850	$41,775	$55,700	$69,625	$72,410	$74,081	$75,195	$76,866	$83,550	$97,475	$100,260	$103,045	$111,400
10	$15,210	$30,420	$45,630	$60,840	$76,050	$79,092	$80,917	$82,134	$83,959	$91,260	$106,470	$109,512	$112,554	$121,680
11	$16,495	$32,990	$49,485	$65,980	$82,475	$85,774	$87,753	$89,073	$91,052	$98,970	$115,465	$118,764	$122,063	$131,960
12	$17,780	$35,560	$53,340	$71,120	$88,900	$92,456	$94,590	$96,012	$98,146	$106,680	$124,460	$128,016	$131,572	$142,240
13	$19,065	$38,130	$57,195	$76,260	$95,325	$99,138	$101,426	$102,951	$105,239	$114,390	$133,455	$137,268	$141,081	$152,520
14	$20,350	$40,700	$61,050	$81,400	$101,750	$105,820	$108,262	$109,890	$112,332	$122,100	$142,450	$146,520	$150,590	$162,800

Household/ Family Size	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%	800%	1000%
1	$32,805	$36,450	$40,095	$43,740	$47,385	$51,030	$54,675	$58,320	$72,900	$87,480	$102,060	$116,640	$145,800
2	$44,370	$49,300	$54,230	$59,160	$64,090	$69,020	$73,950	$78,880	$98,600	$118,320	$138,040	$157,760	$197,200
3	$55,935	$62,150	$68,365	$74,580	$80,795	$87,010	$93,225	$99,440	$124,300	$149,160	$174,020	$198,880	$248,600
4	$67,500	$75,000	$82,500	$90,000	$97,500	$105,000	$112,500	$120,000	$150,000	$180,000	$210,000	$240,000	$300,000
5	$79,065	$87,850	$96,635	$105,420	$114,205	$122,990	$131,775	$140,560	$175,700	$210,840	$245,980	$281,120	$351,400
6	$90,630	$100,700	$110,770	$120,840	$130,910	$140,980	$151,050	$161,120	$201,400	$241,680	$281,960	$322,240	$402,800
7	$102,195	$113,550	$124,905	$136,260	$147,615	$158,970	$170,325	$181,680	$227,100	$272,520	$317,940	$363,360	$454,200
8	$113,760	$126,400	$139,040	$151,680	$164,320	$176,960	$189,600	$202,240	$252,800	$303,360	$353,920	$404,480	$505,600
9	$125,325	$139,250	$153,175	$167,100	$181,025	$194,950	$208,875	$222,800	$278,500	$334,200	$389,900	$445,600	$557,000
10	$136,890	$152,100	$167,310	$182,520	$197,730	$212,940	$228,150	$243,360	$304,200	$365,040	$425,880	$486,720	$608,400
11	$148,455	$164,950	$181,445	$197,940	$214,435	$230,930	$247,425	$263,920	$329,900	$395,880	$461,860	$527,840	$659,800
12	$160,020	$177,800	$195,580	$213,360	$231,140	$248,920	$266,700	$284,480	$355,600	$426,720	$497,840	$568,960	$711,200
13	$171,585	$190,650	$209,715	$228,780	$247,845	$266,910	$285,975	$305,040	$381,300	$457,560	$533,820	$610,080	$762,600
14	$183,150	$203,500	$223,850	$244,200	$264,550	$284,900	$305,250	$325,600	$407,000	$488,400	$569,800	$651,200	$814,000