Morrison Community Hospital
MORRISON COMMUNITY HOSPITAL DISTRICT
MORRISON, ILLINOIS

SUBJECT:	Sliding Fee Discount Program
FROM:	Administration
TO:	Rural Health Clinic
DATE:	September 28, 2007
REVISION DATES:	June 1, 2015, February 25, 2019, January 10, 2022, August 8, 2022, October 28, 2022, February 2, 2023, June 16, 2023

Forms attached to policy

POLICY

Morrison Community Hospital Family Care Clinic will provide financial assistance discounts to individuals who have demonstrated an inability to pay for the services received through use of a SLIDING FEE SCHEDULE. Inability to pay will be determined on a case-by-case basis.

PURPOSE

This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full. The Patient Account Representative's role is that of patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

Morrison Community Hospital Family Care Clinic will offer a Sliding Fee Discount Program to all who are unable to pay for their services. Morrison Community Hospital Family Care Clinic will based program eligibility on a person's ability to pay and will not discriminate on the basis of race, color, sex, national origin, disability, religion, age, sexual orientation or gender identity. The Federal Poverty Guidelines, http://aspe/hhs/gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

PROCEDURE: The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification** – Morrison Community Hospital Family Care Clinic will notify patients of the Sliding Fee Discount Program by:
    a. Payment Policy Brochure will be available to all uninsured/underinsured patients at the time of service.
    b. Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
    c. Sliding Fee Discount Program application will be made available to patients/guarantors during the collection process of Morrison Community Hospital Family Care Clinic.
    d. Morrison Community Hospital Family Care Clinic places notification of Sliding Fee Discount Program in the clinic waiting area.

2. All patients seeking healthcare services at Morrison Community Hospital Family Care Clinic are assured that they will be served regardless of ability to pay. **No one is refused services because of lack of financial means to pay.**

3. **Request for discount -** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Admitting Desks and the Business Office.

4. **Administration** – The Sliding Fee Discount Program procedure will be administered through the Business Office Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided charitable services.

5. **Completion of Application** – The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize Morrison Community Hospital access in confirming income

as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

6. **Eligibility** – Discounts will be based on income and family size only. Morrison Community Hospital Family Care Clinic uses the Census Bureau definitions of each.
   a. **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; non-related household members will also be included in calculating family size; all such people (including related subfamily members) are considered as members of one family.
   b. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension and retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

7. **Income verification** – Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed_. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. **Self-declaration of Income** may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to Morrison Community Hospital's Director of Patient Accounts or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

8. **Discounts** – Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, http://aspe.hhs.gov/poverty.

9. **Waiving of Charges** – In certain situations, patients may not be able to pay the discounted fee. Waiving of charges may only be used in special circumstances and must be approved by Morrison Community Hospital's Director of Patient Accounts or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).

10. **Applicant notification** – The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with Morrison Community Hospital Family Care Clinic. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

11. **Refusal to Pay** – If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be made available to them. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, Morrison Community Hospital Family Care Clinic can explore options not limited, but including offering the patient a payment plan, waiving the charges, or referring the patient collections efforts.

12. **Record keeping** – Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Director or Patient Account's Office, in an effort to preserve the dignity of those receiving free or discounted care.
    a. Applicants that have been approved for the Sliding Fee Discount Program will be logged in a protected document on Morrison Community Hospital's shared directory, noting names of applicants, dates of coverage and percentage of coverage.
    b. The Director of Patient Accounts will maintain this log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials will also be logged.

13. **Policy and procedure review** – Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CFO and/or CEO. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

14. **Budget** – during the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed in the budget as a deduction from revenue. Board approval for Sliding Fee Discount Program will be sought as an integral part of the annual budget.

APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM

Mail this completed form to:
Morrison Community Hospital
Attn: Director of Patient Accounts
303 North Jackson Street
Morrison, IL 61270

Name of Patient ________________________ Birthdate ____________

Address ________________________ City ____________ State ______ Zip ______

List dependents under age 18:

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

**These amounts are before taxes or any deductions.*
**Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.*

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, this application is null and void. 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

OFFICE USE ONLY

APPROVED ________________________ DISAPPROVED ________________________

APPROVED DISCOUNT: ____________________

________________________________ ____________________
Signature Date

Date

Guarantor Name
Guarantor Address
Guarantor City, State Zip

Re: Sliding Fee Discount

Dear Guarantor name,

We have reviewed your application for the Sliding Fee Discount Program 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)
_____ Other ____

Please forward this information to us within 14 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
Director of Patient Accounts

Date

Guarantor Name
Guarantor Address
Guarantor City, State Zip

Re: Account #

Dear Guarantor name,

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

Based on the information you provided, Morrison Community Hospital Family Care Clinic has determined that you are eligible for assistance. Listed below are the self-pay portions minus the eligible percentage of Sliding Fee Discount that Morrison Hospital Family Care Clinic will provide. Please note that this assistance applies only to the accounts listed below. If there are additional accounts, please contact the Director of Patient Accounts 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
Director of Patient Accounts

Morrison Community Hospital Family Care Clinic

_____ 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)

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

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

Your request for financial assistance at Morrison Community Hospital Family Care Clinic 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)

_____ You did not meet the Sliding Fee Discount 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
Director of Patient Accounts

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)											
Poverty Level*	100%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
						DISCOUNT					
Family Size	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
1	$14,580	$17,496	$18,954	$20,412	$21,870	$23,328	$24,786	$26,244	$27,702	$29,160	$29,161
2	$19,720	$23,664	$25,636	$27,608	$29,580	$31,552	$33,524	$35,496	$37,468	$39,440	$39,441
3	$24,860	$29,832	$32,318	$34,804	$37,290	$39,776	$42,262	$44,748	$47,234	$49,720	$49,721
4	$30,000	$36,000	$39,000	$42,000	$45,000	$48,000	$51,000	$54,000	$57,000	$60,000	$60,001
5	$35,140	$42,168	$45,682	$49,196	$52,710	$56,224	$59,738	$63,252	$66,766	$70,280	$70,281
6	$40,280	$48,336	$52,364	$56,392	$60,420	$64,448	$68,476	$72,504	$76,532	$80,560	$80,561
7	$45,420	$54,504	$59,046	$63,588	$68,130	$72,672	$77,214	$81,756	$86,298	$90,840	$90,841
8	$50,560	$60,672	$65,728	$70,784	$75,840	$80,896	$85,952	$91,008	$96,064	$101,120	$101,121
For each additional person, add	$5,140	$6,168	$6,682	$7,196	$7,710	$8,224	$8,738	$9,252	$9,766	$10,280	$10,281

* Based on 2023 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia.