DANIELS MEMORIAL HEALTHCARE CENTER
105 5TH AVE. EAST
SCOBEY, MT 59263

Department: Administrative	**Policy No:** **Approvals:**
Policy: Charity Care Program	**CEO: THOMPSON, MARIAN**
Effective Date: 2007	
Revised Date: January 1, 2021	

ETHICS AND COMPLIANCE: Employee performs within the prescribed limits of the hospital departments Ethics and Compliance Program. Is responsible to detect, observe, and report compliance variances to their immediate supervisor, or upward through the chain of command or the Compliance officer.

PURPOSE: This policy outlines the criteria to be used to determine a patient's eligibility for the Charity Care Program.

POLICY: It is the policy of Daniels Memorial Healthcare Center as a non-profit organization to provide care for all persons in need of care regardless of their ability to pay. DMHC will work to identify candidates for Charity Care based upon information submitted by the patient or patient's representative and will provide Charity Care for those meeting the criteria of this policy.

1. In order to assure funds will be available for as many people as possible, Daniels Memorial Healthcare Center will assist eligible people to become covered under any available outside assistance programs.
2. Within the limits of the facility's resources, DMHC will provide funds to cover the cost of healthcare provided to patients who meet the eligibility guidelines for Charity Care.

Definition

Charity Care shall be defined as the patient's demonstrated inability to pay, whereas, bad debt results from the unwillingness of a patient to pay.

Practice

A. Application Process

1. All patients (or their legal guardians) desiring consideration for DMHC's Charity Care Assistance Program must apply for assistance in writing and must disclose financial information that DMHC considers pertinent to the determination of the patient's eligibility for Charity assistance. Charity assistance is available only to cover charges billed to patients by DMHC (see Attachment A). If a patient qualifies

under the presumptive financial eligibility criteria outlined in D. below, no application in writing will be required to be furnished by the patient. If the patient and/or legal guardian have qualified for charity care previously within the past 6 months DMHC will re-evaluate the patient/legal guardian application for new charges or accounts as long as information or circumstances have not changed.

2. Patients (or their legal guardians) requesting charity assistance must authorize DMHC to make inquiries of employers, banks, credit bureaus, and other institutions for the purpose of verifying information DMHC requires in order to determine eligibility for charity assistance.
3. The completed Charity Assistance Application must be accompanied by legible and accurate photocopies of the following documents as needed for purposes of verifying eligibility:
    a. Complete IRS tax returns for the most recently completed calendar year of all responsible parties;
    b. Payroll check stubs or other documentation of monthly income sources reflection income of all responsible parties for at least the three months prior to the application;
    c. Written verification from public assistance agencies, such as Medicaid or county medical, reflecting denials for eligibility (upon request) and as appropriate;
    d. Written verification of denial for unemployment of worker's compensation benefits (upon request) and as appropriate.
4. Income will be annualized, when appropriate, based upon documentation provided.
5. Confidentiality of information will be maintained for all who seek and/or receive assistance, as required by DMHC policy and federal and state law. Copies of the supporting documents will be kept with the application form.
6. DMHC may request additional documentation and/or information, which, in the exercise of reasonable discretion, DMHC determines, is needed to verify eligibility for financial assistance and to complete the processing of the application.

B. <u>Eligibility Criteria</u>

1. Determination of eligibility of a patient for Charity Care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status, healthcare condition or marital status.
2. Patient care which is not medically necessary including elective, cosmetic, experimental, or deemed to be generally not reimbursable by traditional insurance carriers and governmental payers shall not be considered eligible for Charity Care.
3. Minor Children/divorced Parents – for the minor children of divorced parents, when both parents/legal guardians are responsible parties, information regarding both parents will be required to complete a Charity Care Application. However, if after reasonable efforts, circumstances prevent the applicant from obtaining financial information for all responsible parties, information from responsible parties residing in the same household of the minor child/children will be used to make determination.

4. Charity Care assistance proved by DMHC under this policy is secondary to all other third parties and financial resources available to the patient.
   This includes but is not limited to:
   a) Group or individual medical insurance plans
   b) Employee benefit plans
   c) Workers Compensation plans
   d) Medicaid, State, or County Medical programs
   e) Other state, federal, or military programs
   f) Third party liability situations (e.g. auto accidents or personal injury claims)
   g) Any other persons or entities that may have a legal responsibility to pay for the medical service.
   h) Crime victims eligible for financial assistance
   i) Medical care cost covered by government programs of other countries
5. To the extent the hospital charges related to appropriate hospital based medical services are not covered by third-party coverage, a 100% Charity Care reduction may be provided to patients as adjusted for family size and the family's gross income is below 100% of the Federal Income Poverty Guidelines as adjusted for the family size.
6. Partial Charity Care may be provided to patients if family size and the gross family income is between 100% and 400% of the Federal Income Poverty Guidelines as adjusted for family size. The unpaid balance after third party payments for patients meeting this criteria will be discounted according to the following sliding fee scale considering individual circumstances such as extraordinary non-discretionary expenses relative to the amount of medical expenses, the existence and availability of family assets, the responsible party's future income earning capacity, and ability to make payments over an extended period of time.

SEE ATTACHED 2020 FEDERAL POVERTY GUIDELINES

SLIDING FEE SCALE % OF REDUCTION

INCOME AS A PERCENTAGE OF FERDERAL POVERTY LEVEL	PERCENTAGE REDUCTION
BELOW 100%	NOMINAL $0.00
101% TO 133%	80%
134% TO 138%	60%
139% TO 250%	40%
251% TO 400%	20%
401% +	FULL CHARGE

The financial obligations which remain after the application of this sliding fee schedule may be payable in monthly installments over a reasonable period of time which should be consistent with the established monthly payment plan guidelines.

7. Full Charity Care may be provided to patients with gross family income between 100% and 200% of the Federal Income Poverty Guidelines as adjusted for family size when circumstances as determined by the Administrator indicate that full payment may cause social and financial hardship so as to significantly harm the patient of the family unit.
8. Full or partial Charity Care may be provided to patients with gross family income above 150% of the Federal Income Poverty Guidelines as adjusted for family size when circumstances as determined by the Administrator indicate that full payment may cause social and financial hardship so as to significantly harm the patient or the family unit. Daniels Memorial Healthcare Center will determine if the family would

have a hardship from outstanding medical expenses and/or what monthly payment amount could be made for a period of 24 months and the remaining balance will be adjusted to Charity Care.

C. Eligibility Determination

1. The instructions required to complete the Charity Care Application will be furnished to patients, their legal guardians, or any persons authorized to act on behalf of the patient. DMHC will provide personnel to assist patients/legal guardians in understanding the criteria for eligibility and how to fill out the application.
2. The patient and/or responsible party will be given twenty (20) business days from receipt of an application to complete and return the Charity Care Application. Special circumstances may warrant an extension of the twenty (20) business days allocated to complete the Charity Care Application.
3. Charity Assistance may be determined at the time of application completion or may occur at any other time, upon request and qualifications under this policy.
4. If DMHC determines that any material documentation or information submitted is untrue or falsified, the application will be denied. DMHC will not reconsider an application if DMHC determines that the application has intentionally misrepresented material information related to eligibility criteria or documentation.

D. Presumptive Charity Assistance Eligibility

There are instances when a patient may appear eligible for Charity care discounts, but there is no financial assistance form on file due to lack of supporting documentation. Often there is adequate information provided by patient or through other sources, which could provide sufficient evidence to provide the patient with charity care, DMHC could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstance, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC)
4. Food stamp eligibility
5. Subsidized school lunch program eligibility;
6. Low income/subsidized housing is provided as a valid address; and
7. Patient is deceased with no known estate.
8. Energy assistance program

E. Communication of the Charity Program to Patients and the Public

Notification about the DMHC charity availability form, which shall include a contact number, shall be disseminated by DMHC by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, admitting and registration departments. Information shall also be included on the facility websites and in the Conditions of Admission form. Such

information shall be provided in the primary languages spoken by the population serviced by DMHC. Referral of patients for charity may be made by any member of the DMHC staff or medical staff, including physicians, nurses, financial workers, social workers, etc. A request for charity may be made by the patient or a family member, close friend, or associate for the patient, subject to applicable privacy laws.

F. Notification

DMHC will notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days of DMHC's receipt of a completed application. The notification will include a determination of the amount for which the patient and/or responsible party will be financially accountable. Denials will be written and include instructions for appeal or reconsideration.

G. **Responsibility**

The Charity Care Program will be managed by the Business Office. Determinations for eligibility and approvals for Charity Care will be made by the Administrator. A detailed departmental procedure will be maintained outlining responsibilities and guidelines for administration of the program which meet the requirements of this policy.

*FINANCIAL ASSISTANCE APPLICATION ATTACHED

Daniels Memorial Healthcare Center (DMHC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, creed, color, gender, age, national origin, disability, sexual orientation, or gender identity/expression.

SPANISH

Daniels Memorial Healthcare Center (DMHC) cumple con las leyes federales de derechos civiles y no discrimina por razón de raza, credo, color, género, edad, origen nacional, discapacidad, orientación sexual o identidad/expresión de género.

FRENCH

Daniels Memorial Healthcare Centre (DMHC) est conforme à la législation fédérale droits civiques et ne pas discrimination fondée sur la race, croyance, couleur, sexe, âge, nationalité, handicap, orientation sexuelle ou l'identité/expression de genre.

Attachment A

DMHC Charity Care Financial Assistance

CHARITY CARE FINANCIAL ASSISTANCE PROVIDER LISTS	
ELIGIBLE FOR FAP	NOT ELIGIBLE FOR FAP
DMHC-HOSPITAL DMHC-EMERGENCY DMHC-CLINIC DMHC-OUTPATIENT DMHC-LAB DMHC-RADIOLOGY DMHC-RADIOLOGIST READS	VISITING PROVIDERS: ROBERT F. CROCHELT, MD PROFESSIONAL SERVICES DONNA L. SMITH, MD PROFESSIONAL SERVICES

2021 FEDERAL POVERTY GUIDELINES

Poverty Guidelines, 48 Contiguous States (all states except AK and HI)

Household/ Family Size	100%	133%	138%	250%	400%
1	$12,880	$17,130	$17,774	$32,200	$51,520
2	$17,420	$23,169	$24,040	$43,550	$69,680
3	$21,960	$29,207	$30,305	$54,900	$87,840
4	$26,500	$35,245	$36,570	$66,250	$106,000
5	$31,040	$41,283	$42,835	$77,600	$124,160
6	$35,580	$47,321	$49,100	$88,950	$142,320
7	$40,120	$53,360	$55,366	$100,300	$160,480
8	$44,660	$59,398	$61,631	$111,650	$178,640
9	$49,200	$65,436	$67,896	$123,000	$196,800
10	$53,740	$71,474	$74,161	$134,350	$214,960
11	$58,280	$77,512	$80,426	$145,700	$233,120
12	$62,820	$83,551	$86,692	$157,050	$251,280
13	$67,360	$89,589	$92,957	$168,400	$269,440
14	$71,900	$95,627	$99,222	$179,750	$287,600

Daniels Memorial Healthcare Center

BOX 400
Scobey, Montana 59263
Ph. (406) 487-2296

OPERATED BY
DANIELS MEMORIAL HOSPITAL ASSOCIATION
BOX 400
SCOBEY, MONTANA 59263

Financial Assistance Work Sheet

All other sources of possible payment must be exhausted before this office will consider any financial assistance. You are expected to apply for any Public Assistance, Supplemental Security Income, and /or Medicare which may be available to you.

PATIENT: _____

ACCOUNT # _____

HOUSEHOLD INFORMATION:
(Other family members living in the same residence)

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE/MED. COVERAGE? YES: _____ NO: _____ TYPE: _____

HOUSEHOLD MONTHLY INCOME:		HOUSEHOLD MONTHLY EXPENSES	
Wages	_____	Rent/House payment	_____
Social Security Benefits	_____	Utilities	_____
Unemployment Benefits	_____	Personal Items	_____
Worker's compensation Benefits	_____	Auto Payment	_____
Pension	_____	Insurances	_____
Child Support	_____	Medical Expenses	_____
Alimony	_____	Credit Cards (list)	_____
Any other (Please list)	_____	Loan Payments (list)	_____
_____	_____	Other:	_____
_____	_____		
TOTAL MONTHLY INCOME:	$_____		

REAL ESTATE AND PERSONAL PROPERTY:

Real Estate	_____
Money on Deposit	_____
Cash not on Deposit	_____
Life Insurance	_____
Investment Income	_____
Other	_____

FOR OFFICE USE ONLY:
Clinic Account Balance $ _____
Payments Made on Bal.$ _____
Application taken by:
_____
Approved _____
Not Approved _____
Name: _____

This is to certify that I am unable to meet my financial obligations to the _____ for medical services rendered. Completion of this form is my request for assistance to help satisfy my obligations. The completion of this form does not guarantee assistance will be provided. I further certify that the information given on this form is true and correct to the best on my knowledge. I agree to provide copies of documents supporting the above information as requested by this office.

Patient/Guarantor: _____ Date: _____

** Please attach a copy of your most recent pay stub and last year's tax return**

MFinAssist