

# Mat Su Regional Medical Center

Subject:  
**UNINSURED/SELF PAY DISCOUNT POLICY**

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## **POLICY STATEMENT**

In order to serve the health care needs of our community, **Mat Su Regional Medical Center** will provide discount care to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or government assistance with their health care bills.

Discount care will be provided to all patients without regard to race, creed, color, religious beliefs or national origin, and regardless of whether they qualify for financial assistance.

## **PURPOSE:**

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for the Uninsured/Self Pay Discount Policy.

## **ELIGIBILITY FOR DISCOUNT CARE**

1. To be eligible for a reduction in the patient balance through the Discount Policy, the patient must be uninsured and the hospital services are not covered in whole or part, by any other third party source.
2. The services provided must be on or after original issue date of this policy.
3. Patients who do not apply for financial assistance and/or do not provide the documents required to make a determination with respect to financial assistance will be eligible for a discount under this policy.
4. The services the patient receives must be emergency services or medically necessary based on Medicare Medical Necessity criteria.

## **THE AMOUNT OF THE DISCOUNT PROVIDED**

All patients are eligible for a discount of off billed charges.

## **EXCLUDED FROM COVERAGE**

1. Patients covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a hospital bill where the patient's insurance has denied or excluded certain services from coverage.
2. Patients who qualify for and receive financial assistance from the hospital. However, any patient eligible for financial assistance, whether or not covered in whole or in part by insurance or other coverage, may not be billed more than the applicable AGB percentage of the hospital's gross charges.
3. Patient's requesting cosmetic procedures or other non-emergency services not considered medically necessary based on Medicare medical necessity criteria. In the case of elective procedures such as cosmetic procedures or weight reduction procedures, package pricing often applies and a discount is automatically provided within the package pricing. These services should not be provided until the patient has paid for the service in advance.
4. Any other patient/account already receiving a discount, such as (but not limited to) Industrial Accounts or Client Accounts.

## **THE PROCESS**

### **1. Identification of Patients Eligible for Discount Policy:**

- A. All patients with no insurance who do not qualify for financial assistance or who do not apply for financial assistance will be eligible for a discount off billed charges under this policy.
- B. During the screening process for financial assistance and the Discount Programs, the financial counselor or self-pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process a "FA" will be completed. (Exhibit A) While it is not necessary that a FA be completed in order to receive a discount, when a FA is completed during the screening process, it will be used for the purpose of this policy as well.
- C. All uninsured patients will be screened for existing Medicaid coverage by using the hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.
- D. The hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed on prior hospital records. If so, the hospital will 'verify insurance coverage' and document the call and response.
- E. The hospital reserves the right to pull a copy of the patient's credit report for verification of information provided.
- F. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Charity Care, the patient will immediately qualify for a discount off billed charges. Information to make a determination of coverage and who do not provide the necessary information to make a Financial Assistance determination will be eligible for a discount off billed charges.

### **2. FAILURE TO PROVIDE ACCURATE INFORMATION**

If it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage or met the criteria for the hospital Financial Assistance program, any discount provided for under this policy shall be reversed.

### **3. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF**

- A. For those patients screened by the hospital financial counselor or self-pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account
- B. The discount will be set in the system and will not require hospital authorization.
- C. Transaction codes used will reflect 'Self Pay Discount' and will not be considered financial assistance
- D. The hospital will use transaction the appropriate code for Inpatient discounts, and for outpatient discounts (HMS hospitals).

### **4. REPORTING OF DISCOUNT CARE**

Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

**Exhibit A**  
**Financial Assistance Program Application**

**Mat Su Regional Medical Center**

Patient Account number: \_\_\_\_\_

Date of Application \_\_\_\_\_

**PATIENT INFORMATION**

**PARENT/GUARDIAN/SPOUSE**

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State / Zip \_\_\_\_\_

State / Zip \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State/ Zip \_\_\_\_\_

State/ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Length of Employment \_\_\_\_\_

Length of Employment \_\_\_\_\_

Supervisor \_\_\_\_\_

Supervisor \_\_\_\_\_

**RESOURCES**

Checking     \_\_ yes   \_\_ no

Vehicle 1: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Savings       \_\_ yes   \_\_ no

Vehicle 2: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

Cash on hand: \$ \_\_\_\_\_

Vehicle 3: Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

**Exhibit A (continued)  
Financial Assistance Program Application**

**INCOME**

Patient/ Guarantor Wages (monthly)	\$ _____	Spouse/ 2 <sup>nd</sup> parent Wages (monthly)	\$ _____
Other Income Child support:	\$ _____	Other Income Child support:	\$ _____
VA Benefits:	\$ _____	VA Benefits:	\$ _____
Worker's Comp:	\$ _____	Worker's Comp:	\$ _____
SSI:	\$ _____	SSI:	\$ _____
Other:	\$ _____	Other:	\$ _____

**LIVING ARRANGEMENTS**

Rent \_\_\_\_\_ Own: \_\_\_\_\_ Other: \_\_\_\_\_  
 Landlord / Mortgage Holder: \_\_\_\_\_  
 Phone number \_\_\_\_\_ Monthly Payments \$ \_\_\_\_\_

**REQUIRED DOCUMENTS**

The following documents must be attached to process your application for Financial Assistance:

- **Proof of Income:** Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.
- **Proof of Expenses:** Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

***The Hospital reserves the right to pull a copy of your credit report.***

Signature of applicant \_\_\_\_\_

Hospital Representative Completing Application: \_\_\_\_\_

Approval/ Authorization of Financial Assistance Write-Off Amount Approved: \$ \_\_\_\_\_

**BOM:** \_\_\_\_\_

**CFO:** \_\_\_\_\_

**CEO:** \_\_\_\_\_

# Mat-Su Regional Medical Center

Форма заявления на предоставление финансовой помощи  
Региональный медицинский центр Mat-Su  
Заявление на участие в Программе благотворительной поддержки/финансовой помощи

Стр. 1 из 2

Учетный номер пациента: \_\_\_\_\_

Дата обращения: \_\_\_\_\_

## ИНФОРМАЦИЯ О ПАЦИЕНТЕ

## РОДИТЕЛЬ/ПОРУЧИТЕЛЬ/СУПРУГ(А)

Имя и фамилия \_\_\_\_\_

Имя и фамилия \_\_\_\_\_

Адрес \_\_\_\_\_

Адрес \_\_\_\_\_

Город \_\_\_\_\_

Город \_\_\_\_\_

Штат/индекс \_\_\_\_\_

Штат/индекс \_\_\_\_\_

Номер социального обеспечения \_\_\_\_\_

Номер социального обеспечения \_\_\_\_\_

Работодатель \_\_\_\_\_

Работодатель \_\_\_\_\_

Адрес \_\_\_\_\_

Адрес \_\_\_\_\_

Город \_\_\_\_\_

Город \_\_\_\_\_

Штат/индекс \_\_\_\_\_

Штат/индекс \_\_\_\_\_

Служебный телефон \_\_\_\_\_

Служебный телефон \_\_\_\_\_

Стаж работы \_\_\_\_\_

Стаж работы \_\_\_\_\_

Руководитель \_\_\_\_\_

Руководитель \_\_\_\_\_

## Ресурсы

Чековый счет: да \_\_\_ Автомобили 1 Год \_\_\_\_\_ Марка \_\_\_\_\_ Модель \_\_\_\_\_

Сберегательный счет: да \_\_\_ Автомобили 1 Год \_\_\_\_\_ Марка \_\_\_\_\_ Модель \_\_\_\_\_

Автомобили 1 Год \_\_\_\_\_ Марка \_\_\_\_\_ Модель \_\_\_\_\_

Наличные средства \$ \_\_\_\_\_

# Mat-Su Regional Medical Center

Региональный медицинский центр Mat-Su  
Заявление на участие в Программе благотворительной поддержки/финансовой помощи

Стр. 2 из 2

## ДОХОД

Пациент/поручитель  
Заработная плата (в месяц): \_\_\_\_\_

Супруг(а)/второй родитель:  
Заработная плата (в месяц): \_\_\_\_\_

Иной доход: Алименты \$ \_\_\_\_\_

Иной доход: Алименты \$ \_\_\_\_\_

Пособие ветеранам: \$ \_\_\_\_\_

Пособие ветеранам: \$ \_\_\_\_\_

Компенсация за вред,  
причиненный  
здоровью работника: \$ \_\_\_\_\_

Компенсация за вред,  
причиненный  
здоровью работника: \$ \_\_\_\_\_

Дополнительная  
социальная помощь (SSI): \$ \_\_\_\_\_

Дополнительная  
социальная помощь (SSI): \$ \_\_\_\_\_

Другое: \$ \_\_\_\_\_

Другое: \$ \_\_\_\_\_

## ЖИЛЬЕ

Аренда \_\_\_\_\_ Собственное \_\_\_\_\_ Другое (пожалуйста) \_\_\_\_\_  
Арендодатель/налогодержатель: \_\_\_\_\_  
Номер телефона \_\_\_\_\_ Ежемесячная плата \$ \_\_\_\_\_

## НЕОБХОДИМЫЕ ДОКУМЕНТЫ

К вашему заявлению на получение благотворительной поддержки/финансовой помощи необходимо приложить следующие документы:

Подтверждение дохода: декларация по подоходному налогу за прошлый год, корешки последних 4 чеков на выплату заработной платы, письмо от работодателя, органа социального обеспечения и т. д., выписки по банковскому счету за последние 3 месяца. Другие документы по требованию.

Подтверждение расходов: копия договора залога или аренды, копии всех ежемесячных счетов (включая кредитные карты, банковские займы, займы на приобретение автомобиля, страховые платежи, счета за коммунальные услуги, стационарный и мобильный телефон). Другие документы по требованию.

Информация, изложенная в настоящем заявлении, подлежит проверке сотрудниками больницы и была предоставлена с целью определить мою способность погасить задолженность. Я понимаю, что в случае указания мною неадекватной информации больница откажет мне в предоставлении какой-либо финансовой помощи.

Больница оставляет за собой право получить копию вашей кредитной истории.

Подпись заявителя \_\_\_\_\_

Сотрудник больницы, оформивший заявление: \_\_\_\_\_

Подписи указывают на то, что вы рассмотрели заявление и сопроводительную документацию и находите информацию соответствующей установленным правилам.

Одобрение/разрешение на предоставление благотворительной поддержки \_\_\_\_\_ Одобренная сумма \$ \_\_\_\_\_

Руководитель подразделения \_\_\_\_\_ Генеральный директор \_\_\_\_\_

Финансовый директор \_\_\_\_\_