JEWELL COUNTY HOSPITAL
100 CRESTVUE
MANKATO, KS

FINANCIAL ASSISTANCE PROGRAM

Purpose: To provide financial assistance for medically necessary healthcare services received as an inpatient or outpatient from the hospital in a fair, consistent, respectful and objective manner to indigent, medically indigent, uninsured or underinsured patients. This policy contains GPHA recommendations.

A. Eligibility Criteria:
   1. The financial assistance program employs a sliding scale discount that takes into consideration a patient's household income and qualifying assets.
   2. Eligible patients are people who have received medically necessary services, and are medically indigent, uninsured, or underinsured. The patient's household income must be less than 300% of the federal poverty level to qualify for financial assistance discounts. Financial assistance discounts are subject to the limitations on Qualified Assets described in section C6 and C7.
   3. Financial Assistance determination will be consistent among patients, regardless of sex, race, creed, disability, sexual orientation, national origin, immigration status or religious preference.
   4. The hospital's financial assistance program is generally intended to aid the residents of the community served by the hospital. A community resident is someone who resides within the primary service area of the hospital. Generally, to be considered a community resident, the patient has resided within the primary service area for at least six months preceding the date when services are rendered. The requirement of six months residency shall not apply to individuals who reside outside the primary service area of the hospital, but who require emergency treatment while traveling or visiting within the primary service area of the hospital, but who requite emergency treatment while traveling or visiting with the primary service area.
   5. Financial assistance is secondary to all other financial resources available to the patient, including employer-based insurance coverage, commercial insurance government programs, third-party liability and household qualified assets.

6. Patients with financial resources that have access to health insurance, third-party reimbursement for health services or government assistance, and elect not to enroll rail to take advantage of, or fail to maintain eligibility for such coverage, are excluded from the financial assistance program.
7. The financial assistance appli9cation process is generally initiated prior to an account being classified as bad debt. Account balances residing with a collection agency generally do not qualify for financial assistance program.

B. Application Process:
   1. All qualifying applicants will be granted financial assistance for medically necessary services in accordance with the qualifications and guidelines herein set forth.
   2. The financial Assistance process should be initiated when it is evident that a patient or the person having financial responsibility for the medically necessary services provided does not have financial resources to settle patient responsibility balance.
   3. The financial assistance process begins at the time of service (during pre admission, admission, or at time of discharge). If the patient fails to initiate the financial assistance process during registration, and the hospital has knowledge of the patients financial hardship, the business office may request the patient initiate the financial assistance process.
   4. Patients wishing to apply for financial assistance are responsible to initiate the process by seeking and completing the personal financial statement for financial assistance within 30 days of discharge.
   5. If it becomes evident that a patient or guarantor is having difficulty making payments in a timely and/or systematic manner, the process can be started at a later date (within 120 days of discharge).
   6. The application process includes completion of a personal financial statement for financial assistance and providing verification documents. Verifiable information may include, but is not limited to the following:
      a. Individual or family income (income tax return with copies of earnings statements-W-2 forms, 1099 forms, etc for past 2 years)
      b. Copies of most recent 90 days of payroll stubs, social security checks or unemployment checks.
      c. Copies of most recent 60 days of bank statements
      d. Current trust fund statements
      e. Mortgage statements
      f. Annual property tax statements
      g. In the absence of income, a letter of support from individuals providing for the patients basic living needs.

h. County tax appraisal statement
i. Documentation of employment status
j. Household family size
k. Credit history reports
l. Denial letter from Medicaid
m. Precious or current returns from collection agencies with documentation regarding inability to pay
n. Business office knowledge of individual or family background

Note: The object is to document the need for financial assistance. If a patient or the person who has financial responsibility for medically necessary services is unwilling or unale to provide all necessary and pertinent information to make a conscientious and fair determination of their financial net worth generally a financial assistance will not be granted.

7. After the application for financial assistance has been complete, accounts being considered for financial assistance will be put in a hold status while the application is being reviewed (no longer than 30 days). The hold status will prevent accounts from proceeding through the collection process, including assignment to a collection agency. Once the financial assistance application has been processed and approved/denied, the hospital will send written notice to the patient and/or person having financial responsibility.
8. The hospital business office will continue to work with the patient or guarantor to resolve remaining account balances. Patients or guarantors are responsible to make mutually acceptable payment plan arrangements with the hospital with 30 days of receiving a written notice of determination regarding their financial assistance application.
9. If the patient or guarantor fails to initiate or complete the financial assistance process, the hospital may elect to begin collection activity, including possible transfer of account to a collection agency.

C. Financial Assistance Determination:
   1. Financial assistance discounts are in addition to the uninsured and underinsured discounts. The qualifying level of assistance is applied to charges after the uninsured and underinsured discounts have been applied.
   2. Financial assistance discounts are determined based on a sliding fee scale and are subject to income and assets. To obtain financial assistance, the patient or guarantor must establish that the household income is below 300% of the most recent federal poverty level at the date of service. Discounts provided per FPL income are identified in the poverty sliding scale 2011 document.

Jewell County Hospital/Rural Health Clinic
100 Crestvue/PO Box 327
Mankato, Ks 66956
Phone 785-378-3137/785-378-3511
Fax 785-378-3450/785-378-3919

Jewell County Hospital/Rural Health Clinic offers a Financial Assistance/Sliding Fee Discount Program for patients who are unable to pay for Medical care. If approved, care may be provided at no cost or at a reduced rate. Please complete the application: Personal Financial Statement for Financial Assistant and attach the following information:

1. **Copies of two months of paystubs**
2. **A copy of your most recent Federal Income tax return**
3. **Copies of two months of bank statements**
4. **Social Security Benefit Letter**
5. **Proof of income from everyone in your household**
6. **Determination letter from Medicaid**
7. **All sources of income such as child support, alimony, rental, business etc.**

If all of these items listed above are not provided your application will be denied

Do not send anything that needs returned.

You must apply for Medicaid if no insurance.

Please return the application within the next **30 days** to the address above. Once your application is received, your situation will be evaluated and you will be notified as to whether your application has been approved and if you qualify for the Sliding Fee Discount Program.

Thank you for allowing Jewell County Hospital/Rural Health Clinic the opportunity to provide your healthcare needs.

If you have any questions regarding financial assistance, do not hesitate to call us.

JEWELL COUNTY HOSPITAL/RURAL HEATLH CLINIC

Personal Financial Statement for Financial Assistance

Patient Name	Age	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Please Return By:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Date Returned:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $

Patient		Person Responsible for Bill (if not patient)	Relationship
Street:		Name:	
		Street	
City, ST, Zip		City, ST Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed?	How Long Unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes_____ No_____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

JEWELL COUNTY HOSPITAL/RURAL HEATLH CLINIC

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (Print)			
Signature		Date	

Office Use Only

Patient Name: _____

Approved Discount: _____

Approved by: _____

Date Approved: _____

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, ~~two~~ most recent pay stubs, or other		
Insurance: Insurance Cards		