THE DETROIT MEDICAL CENTER
PATIENT FINANCIAL SERVICES
OPERATIONAL POLICY

SUBJECT: Uncompensated Care Program **REF#: PFS00.1001**

EFFECTIVE DATE: 11/01/04 **Page: 1 of 2**
REPLACES: Policy #PFS00.1120
REVISED: 06/03/2010

I. Objective: To assign responsibilities and identify patients eligible for uncompensated care and to determine the portion of charges if any to be designated as such**.**

II. Scope: All operating units of the Detroit Medical Center. Applies to facility charges only. Professional charges are excluded. All services must be medically necessary as determined by the patient's physician.

III. Policy

The Detroit Medical Center (DMC) will provide medically necessary services without payment or at reduced payment to those unable to pay or underinsured without regard to race, religion, age, or gender.

Patient Financial Services will apply uniform guidelines to all patients to determine the portion of charges to be forgiven and designated as uncompensated care.

The Detroit Medical Center reserves the right at any time, in its discretion, to revise or modify this policy.

IV. Provisions

A). **Financial Responsibility Guidelines** – The Corporate Chief Financial Officer in conjunction with the Corporate Vice President, Patient Financial Services, are responsible for preparation and revision of financial responsibility guidelines and any policy or procedure necessary for the implementation of this policy.

B). Registration – Individuals responsible for registration should refer all patients without insurance or underinsured and unable to pay (financially indigent) to a financial counselor to determine eligibility for uncompensated care.

C). Application of Guidelines - The guidelines attached as **Appendix I** should be applied to determine what portion, if any, of a patients' account should be designated as uncompensated care. Questions or situations not covered by the guidelines should be referred to the Vice President, Patient Financial Services. Amounts previously designated as uncompensated care may be revised if third-party resources are identified or if the financial circumstances of the responsible party change at any time prior to payment of the current balance of an outstanding account.

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D). Uncompensated Care Transaction Allowance Codes - The Patient Financial Services Department will use the Uncompensated Care transaction code to ensure all accounts forgiven through the guidelines defined by **Appendix I** are appropriately written off from accounts receivable.

E). Medicare Coinsurance/Deductibles – Medicare coinsurance and/or deductibles amounts maybe waived in consideration of a patient's financial hardship. A good faith determination must be made to determine the individual is in financial need and reasonable collection efforts have failed. Hospitals must take reasonable measures to document their determination of Medicare beneficiaries financial need. Refer to Policy PFS.1050. Medicare patients will be assessed using the same criteria as all other patients outlined in Appendix I

F). Patient Accounting - In the event a State of Michigan Family Independence Assistance application (FIA-1171) was NOT taken prior to bill production, Patient Accounting Customer Service will ensure all patients requesting uncompensated care retrospectively are provided with an Uncompensated Care application. **(Exhibit I)**

Approved by: _____
Corporate Senior Vice President/Chief Financial Officer

Approved by: _____
Vice President, Patient Financial Services

APPENDIX I

Uncompensated Care Discount - Category I

- Uncompensated Care category I discounts are based on 2009 Poverty Guidelines. The applicant must be a United States resident to qualify for uncompensated care at the Detroit Medical Center.

Uninsured – Financially Indigent
Poverty Guidelines From
Federal Register

Monthly Gross Income

					Column I		Column II	
Family Size		Yearly	Monthly		Income 200% Poverty Guidelines		Income 300% Poverty Guidelines	
					Monthly	Annual	Monthly	Annual
1		10,830	903		1,805	21,660	2,708	32,490
2		14,570	1,214		2,428	29,140	3,688	44,250
3		18,310	1,526		3,052	36,620	4,576	54,930
4		22,050	1,838		3,675	44,100	5,513	66,150
5		25,790	2,149		4,298	51,580	6,448	77,370
6		29,530	2,461		4,922	59,060	7,383	88,590
7		33,270	2,773		5,545	66,540	8,318	99,810
8		37,010	3,084		6,168	74,020	9,253	111,030
9		40,750	3,396		6,792	81,500	10,188	122,250
10		44,490	3,708		7,415	88,980	11,123	133,470

Column I – Guarantor Annual Income within 200% of Poverty Guidelines

Refer to financial counselor for Medicaid Application. The patient's account will be screened for Medicaid Eligibility. If it is determined that a Medicaid application will not be completed, because the patient is not eligible for Medicaid the financial counselor will complete an Uncompensated Care Application. If it is determined that a Medicaid Application should be completed and the patient is denied, 100% Uncompensated care discount will be issued. No statements will be sent to the guarantor or subsequent collection agency referral.

Column II – Guarantor Annual Income Between 200% - 300% of Poverty Guidelines

Refer to financial counselor for Medicaid application. If denied, the following discounts will be issued based upon 2003 BC cost to charge ratio.

	Discount Charges	Patient Responsibility Charges
▪ **Children's Hospital of Michigan**	**60%**	**40%**
▪ **Detroit Receiving Hospital**	**60%**	**40%**
▪ **Harper/Hutzel/Karmanos/MIOSHI**	**55%**	**45%**
▪ **Huron Valley Sinai Hospital**	**60%**	**40%**
▪ **RIM**	**40%**	**60%**
▪ **Sinai/Grace Hospital**	**55%**	**45%**

Statements will be mailed to the patients at the reduced rates. Every attempt will be made to establish a payment arrangement in keeping with policy PFS.1490. Collection activity will be initiated if the terms of the payment arrangements are breeched.

Uncompensated Care Discount – Category II

Under Insured – Medically Indigent

1) Underinsured patients are eligible for uncompensated care discount if the remaining account balance after all Third Party payments is greater than 20% of guarantor's annual gross income plus any liquid assets. The uncompensated care discount is not to exceed individual operating units cost.

Liquid Assets: cash, life insurance, saving account, checking account, stocks or bonds, saving certificate, trust funds, and money held by another person in a nursing home.

2). Guidelines apply to balances remaining after consideration of all insurances, third party liability and other available resources.

ELIGIBILITY DETERMINATION

Forms and instructions to complete the final determination will be furnished to the guarantor when uncompensated care is being requested; when need is indicated; or when financial screening indicates potential need. The Department of Human Services application (FIA-1171) MAY be given to all patients who demonstrate the potential of non-payment due to lack of insurance. A DMC Uncompensated Care application (Exhibit A) will be taken for under-insured patients requesting financial assistance.

Income documentation to verify information indicated on the application form will be requested. The verification documentation requested shall include payroll checks (last six months). Responsible parties may be requested to submit one or more of the following items in lieu of or in addition to payroll information.

1). IRS tax return (most recent year)
2). W-2 withholding statement
3). Form approving or denying eligibility for medical and/or state funded assistance.
4). Form approving or denying eligibility for unemployment compensation.
5). Written statements from employers or welfare agencies.
6). In the event the responsibility party is unable to provide any of the documentation listed above, a written and signed attestation of absence of income from the responsible party may be used.

The responsible party will be required to provide written verification of ineligibility for all other potentially pertinent sources of funding.

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept on file. Determination of eligibility will be made by the DMC Admitting – financial counselors or the Patient Accounting customer services representative.

- Families NOT providing all requested financial information are NOT eligible for uncompensated care discounts.
- Determination is subject to change if the DMC discovers that information was withheld, if additional information is received, at any time, or if circumstances change at any time prior to payment of current account.
- Family size refers to patient's household, including parents (natural and adoptive or step) or guardians and their dependents. Incomes refer to income of all persons in household legally responsible for patient's medical care, together with income of adoptive or step parents. Other persons may be considered in determining family size and income if warranted by special circumstances.

Hospital Name:_____

APPLICATION FORM FOR UNCOMPENSATED CARE

In order for us to assist you financially, it is important that you provide us with the following information regarding your income and assets. This questionnaire is designed to assess your needs and remains confidential. If you have any questions with this form, please contact us at _____ _____.

PATIENT NAME _____**DATE** _____

RESPONSIBLE PARTY_____ **SSN/ACCOUNT#**_____

DATE OF BIRTH_____

DATE OF SERVICE_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. Are you a U.S. Resident? _____
2. What is the total number of members in your family?_____.
3. Is anyone in the family currently employed or has been employed in the last 12 months?

   Yes _____ or No _____. If yes, please list below (list the most recent job first).

Employee Name	Name & City of Employment	Monthly Earned Income (before taxes)	Dates Employed From – To

If employed, please verify income by sending copies of paycheck stubs or obtain a signed statement from your employer regarding earnings. If you are self-employed, please verify business income and expenses from last 6 months.

4. Total monthly child support/guardian fees paid: $_____ (if child support is paid, include proof of support payment).
5. Have you ever applied for social security? Yes _____ No_____. If yes, when? _____

   What was outcome?_____.
6. Does any family member receive any other income listed below? (If yes, please send a copy of the check stub, award letter and or statement, etc).

TYPE OF INCOME	**CIRCLE ONE**	**AMOUNT**
Social Security	Yes or No	$_____
Veteran's Benefits	Yes or No	$_____
Supplemental Social Security	Yes or No	$_____
Railroad Benefits	Yes or No	$_____
Retirement/Pension Benefits	Yes or No	$_____
Child Support or Alimony	Yes or No	$_____
Unemployment Compensation	Yes or No	$_____
Income from Rent	Yes or No	$_____
Income from Roomers or Boarders	Yes or No	$_____
Income from Land Contract	Yes or No	$_____
Income from Relatives or Friends	Yes or No	$_____
Crops or other Farm Income	Yes or No	$_____
Worker's Compensation	Yes or No	$_____

7. If you have no source or income, who is supporting you?_____. How do you pay your bills?_____.

8. Does any family member have any assets listed below:

ASSETS:	**CIRCLE ONE**	**VALUE**
Cash	Yes or No	$_____
Life Insurance	Yes or No	$_____
Savings Accounts	Yes or No	$_____
Checking Account	Yes or No	$_____
Stocks or Bonds	Yes or No	$_____
Savings Certificate	Yes or No	$_____
Trust Fund	Yes or No	$_____
Money held by another person or nursing home	Yes or No	$_____

9. Does any family member have one or more vehicles, motorcycle or recreational vehicles? Yes or No, if yes please list below.

Name or Owner Year & Model Amount Owed Re-sale Value

_____

_____

10. Are you currently paying for any health insurance coverage? Yes or No.

If yes, $_____ per month. Begin Date: _____

11. When was the last time you had health insurance? _____.

12. Do you feel you are disabled, unable to work for the next 12 months? Yes or No.

If yes, explain why:

_____

_____

COMMENTS: (PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS REGARDING YOUR FINANCIAL SITUATION).

_____

_____

_____

_____

I certify that to the best of my knowledge, all answers on this form are true and complete.

Signature_____ Date_____