MARQUETTE GENERAL HEALTH SYSTEM
MARQUETTE, MICHIGAN

SUBJECT: Financial Assistance for Uninsured Patients

POLICY NO: 100-087

EFFECTIVE DATE: 7/24/2000

REVISION DATE: 11/01/08, 6/22/11

DISTRIBUTION: All Departments

Authorized By
A. Gary Muller, FACHE
President & CEO

POLICY: MGHS shall fulfill its charitable mission by providing medically necessary healthcare services to all individuals without regard to their ability to pay. MGHS shall provide fair discounts and financial protection to low income uninsured U.S. citizens.

SCOPE: This policy applies to services rendered at MGHS Hospital campus.

PROCEDURE: MGHS is committed to meeting the needs of everyone in their communities, including those who cannot pay for their care and are uninsured. Similarly, patients who are able to pay have an obligation to pay and providers have a duty to seek payment from these individuals.

1. Financial assistance will be available for medically necessary services provided to persons who meet the financial and documentation criteria defined in this policy. This policy does not apply to payment arrangements for cosmetic, bariatric or special package pricing procedures.

   1.1 Patient Access personnel will attempt to identify uninsured patients prior to or at time of Admission and will refer those patients to a Financial Counselor or other MGHS designee.

   1.2 Full financial assistance shall be provided to uninsured patients earning 200% or less of the Federal Poverty Income Guideline (FPIG).

   1.3 For financially needy uninsured patients earning 200% and above of the FPIG financial assistance discount shall be provided based on the below table.

FPI Level	Less than 200%	Greater than or equal to 200% but less than 225%	Greater than or equal to 225% but less than 250%	Greater than or equal to 250% but less than 275%	Greater than or equal to 275% but less than 300%	300% and above
Financial Discount	100%	85%	60%	45%	25%	10%

PUBLIC ASSISTANCE PROGRAMS

1. Any patient seeking financial assistance must complete applications for all eligible public assistance programs including but not limited to Medicaid and Local County care Programs. Patients must complete and follow through with all of the application requirements. If MGHS refers patient to an outside agency for the purpose of obtaining assistance the patient must fully cooperate with the Agency.

2. Documented responses from all public assistance programs applied for must be on file in order for a final financial assistance determination to be made.
    - 2.1 MGHS staff or designee will evaluate all uninsured inpatients and outpatients to determine if they may be eligible for Medicaid or other county care programs
    - 2.2 If the patient is a resident of Michigan and meets MGHS criteria for referral, MGHS Social Work staff or designee will help the patient complete and submit the application for Medicaid.

FINANCIAL ASSISTANCE APPLICATION GUIDELINES

1. All inpatient and hospital based facility outpatient accounts exceeding $1000 are eligible for financial assistance.

2. A patient must complete or attempt to complete a financial assistance application to be considered eligible for financial assistance including the following patient populations, any exception to this requirement must be approved by the Chief Financial Officer (CFO):
    - Homeless
    - Non-English Speaking
    - Nursing Home, Assistant Living, Living with a Care Giver
    - Patients unable to read or write

3. Patients who are uninsured U.S. citizens, not eligible for public assistance, and have no other means to pay for medically necessary services, should be offered a financial assistance application prior to service or at the time of service.

4. Elective services such as Cosmetic, Bariatric, or special packaging procedures are not eligible for financial assistance.

5. Deductibles and coinsurance amounts are not eligible for financial assistance.

6. Financial assistance will not be considered on accounts that have been sent to a collection agency.

7. A financial assistance application must be submitted within 60 days of discharge to be considered for financial assistance. Exception will be made for any agency referral made by MGHS.

8. Eligibility for financial assistance may be determined at any point in the revenue cycle.

9. Falsification of application or refusal to cooperate with the application process will result, in denial of financial assistance.

10. Marquette General Health System reserves the right to change benefit determinations if the patient's financial circumstances change.

11. Financial assistance applications will expire after six months. After six months a new financial assistance application will need to be completed by the patient.

12. If a patient or immediate family member disagrees with the financial assistance determination an appeal can be made.

    a. The appeal must be in writing.
    b. The appeal must be made within 30 days of receiving notification of the determination.
    c. MGHS will consider the appeal.

d. MGHS will respond within 30 days of receiving an appeal.

FINANCIAL ASSISTANCE ELIGBILITY
Patient eligibility for financial assistance will be based on the following information:

1. All third party resources and non-hospital financial aid programs, including public assistance available through Medicaid, in which the patient is enrolled.
   Note: As stated above, all public assistance programs must be exhausted before financial assistance can be provided.

2. Components on the financial assistance application:
   - Income from all sources living within the patient's household. Gross income for the most recent pay periods needs to be provided. Pay stubs for the past three months should be provided as proof of gross income.
   - Self–employed applicants, company's most recent Income Statement.
   - Resources from savings and checking accounts, certificates of deposit, stocks, bonds, real estate, trusts, etc.
   - Retirement income.
   - 50% of Pension/Retirement fund will be considered an asset.
   - Assets including home, cars, boats, and any other vehicles.
   - Monthly expenses.
   - Number of dependents.
   - Copy of last filed federal tax return.

FINANCIAL ASSISTANCE PROGRAM ADMINISTRATION
Marquette General Health System's financial assistance benefits will be administered according to the following guidelines:

1. Upon receiving a financial assistance application a Financial Counselor or Hospital designee will review the patient's accounts to identify all unresolved balances.

2. The patient's application, federal income tax forms, supporting financial documentation, and remaining account balances will be reviewed and verified by the Financial Counselor or Hospital designee to determine the patient's annual household income and total outstanding account balances.

3. To determine if the patient/guarantor qualifies for financial assistance, the Financial Counselor, Hospital designee or Business Office Manager will consider the following:

   - Poverty Level
   - Income versus Necessary Expenses
   - Medicaid eligibility will always be run, unless the patient is not a resident of Michigan
   - A credit report will be obtained.
   - Living arrangements / Home Life situation
   - Difference between poverty level and total annual income
   - Conversations with patient or patient's family

4. The patient's annual household income and number of dependents will be used to identify if the patient is eligible for financial assistance based on the FPIG Level.

   - If the patient has a household income less than or equal to 200% of the Federal Poverty Level ("FPL"), he/she will be eligible for a 100% write off for services that have been provided at the Hospital main campus.

   - If the patient has a household income level above 200% of the FPL the patient will receive a discount on the services provided to them based on a sliding scale.

   - Assets above $5,000 will be recognized as potential income.

5. All decisions and recommendations for financial assistance should be documented on the financial assistance application.

6. The financial assistance application is maintained confidentially by the Financial Counselor whether approved or denied, and retained in the Financial Counselor's Office.

7. Financial assistance applications will randomly be pulled by the Financial Counselor Supervisor to be reviewed for accuracy, information, etc.

8. Financial assistance applications verifying eligibility will be kept on file for at least 1 year for auditing purposes.

9. Anyone who applies for financial assistance consideration shall receive a written reply by the Financial Counselor or Hospital designee indicating approval, or non-approval of the request.

10. Depending upon the Financial Assistance adjustment amount approval maybe necessary before handling the completion of the adjustment. For authorization write off amounts see attachment.

Attachments: Write-off Authorization
Financial Assistance Application

WRITE OFF AUTHORIZATION

Write Off Amount	Write-off Authority	Responsibility
Under $10,000	Business Office Director	Financial Counselor or Hospital Designee: Gathers data, assures completion of form. Follows time guidelines. Ensure all necessary follow-up steps are completed prior to writing off an account. Business Office Supervisor: Secondary review will be completed via a spot-checking. Ensures all necessary follow-up steps were completed prior to writing off an account, account notes are clear and the appropriate transaction code is used. Business Office Director: Director approval via documented system notes and sign off on the Adjustment Request Form.
Above $10,000	CFO	Financial Counselor or Hospital Designee: Gathers data, assures completion of Form. Follows time guidelines. Ensure all necessary follow-up steps are completed prior to writing off an account. Business Office Director: Director approval via documented system notes and sign off on the Adjustment Request Form. If approved for write-off, all account documentation will be printed out and delivered to the CFO. If CFO approves, ensure all necessary follow-up steps are completed prior to writing off an account, account notes are clear and the appropriate transaction code is used. CFO: CFO approval and Business Office Director will document the system notes, and sign off on the Adjustment Request Form.

MARQUETTE GENERAL HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

Name:_____ **Visit ID#:**_____

Social Security #: _____ Date of Birth: _____ Home Ph#:_____

Work # :_____ Cell #: _____

Address: _____
(City) (State) (Zip)

Mailing address:_____
(City) (State) (Zip)

Check Employment Status: [] Retired [] Disabled [] Unemployed [] Student [] Dependent [] Self

Patient's Employer: _____ How Long Employed?_____

Employer's Address: _____

Employer's Phone # :_____ Occupation: _____

Total Monthly Income $: _____ Other Household Income $: _____

Indicate Source of other Income: ☐ Alimony ☐ Child Support ☐ Spouse ☐ Other:_____

GENERAL INFORMATION:

List all people living in the household, their relation to applicant and date of birth.

Name	Relationship	Date of birth

Medicaid Application Date:_____ Reason for denial:_____

_____(Attach copy of denial)

FINANCIAL INFORMATION:

Bank: _____ City, State, Zip:_____

Checking Acct. Balance $: _____ Savings Acct. Balance $: _____ (Attach 30 day Statement)

Do you own your home? [ ] Yes [ ] No If yes, balance owed $:_____

Approximate Value of the Home $: _____ Monthly Payment $:_____

Are you renting: [] Yes [] No How Long? _____ Monthly Rent $:_____

(Attach most recent assessed tax statement)

AUTOMOBILE/RECREATIONAL/ANY OTHER VEHICLES OWNED:

Make: _____ Model: _____ Year: _____ Monthly Payment: _____
Make: _____ Model: _____ Year: _____ Monthly Payment: _____
Make: _____ Model: _____ Year: _____ Monthly Payment: _____
Make: _____ Model: _____ Year: _____ Monthly Payment: _____

MONTHLY HOUSEHOLD EXPENSES:

Food	**$**	**Power**	**$**	**Water**	**$**
Gas	**$**	**Telephone**	**$**	**Sanitation**	**$**
Prescriptions	**$**	**Cable**	**$**		**$**

OTHER DEBTS: List all debts owed but not previously listed below. If needed, use third page. Please include all medical bills, credit cards, insurance premiums, etc.

OWED TO WHOM:	BALANCE OWED	MONTHLY PAYMENTS
	Total Owed:	

I hereby certify that the above information is true and correct. I authorized Marquette General Heath System to contact the employers and institutions listed on this application to verify its accuracy, if deemed necessary. I further authorize the employee/institutions to release such information to MGHS. **Falsification of application will result in denial of Financial Assistance.**

PATIENT: _____ DATE: _____

SPOUSE OR LEGAL GUARDIAN: _____ DATE: _____

IMPORTANT – PLEASE READ

Completed form must be returned within 30 business days to: MGHS Business Office 580 W. College Ave. Marquette, MI 49855. This form will remain active and on file for six months. The following information must be provided with the completed application for assistance to be determined.

- **Pay stubs for the past three months should be provided as proof of gross income**
- **Copy of last federal tax return (s) (schedule C if self-employed)**
- **Copy of all investments i.e.: IRA, stocks, bonds, mutual funds etc.**
- **Copy of life insurance policy (s)**
- **Financial Assistance Application form must be filled out completely with all information listed**
- **Spouse or legal guardian, if applicable must sign application form before processing**

Credit history will be obtained to assist in verification of information provided on this application.
If you are not able to provide the above information, please contact a Financial Counselor for alternative verification options.

MARQUETTE GENERAL HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION

ADDITIONAL WORK SHEET IF NECESSARY

OWED TO WHOM:	BALANCE OWED	MONTHLY PAYMENTS
	Total Owed:	

Additional Comments Supporting Financial Assistance Need:

_____

_____

_____

_____

_____

_____

_____

Please return completed application and supporting information to:

Marquette General Hospital
Attn: Business Office
580 W. College Ave.
Marquette, MI 49855