Financial

Policy: *340B Cost Savings*
Patient Financial Assistance

Policy: # *FIN284*

Prepared By: *Deven Langhorne*

Revision: November 29, 2018

Approved By: *Board of Directors*

Effective Date: *December 19, 2018*

Policy

It is the policy of Rural Health Medical Program, Inc. (RHMPI) to establish procedures and guidelines to provide financial assistance to patients who do not have the ability to pay for medically necessary services. RHMPI will utilize 340B Cost Savings to offer financial assistance through the completion of a standardize application process.

Procedure

Responsibility

- Authorizing Official-Chief Executive Officer
- Chief Financial Officer
- Social Worker

Financial Assistance Process

- RHMPI financial assistance process includes:
  - Identify patients who are unable to pay for medically necessary healthcare services
  - Completion of Financial assistance application
  - Collection all supporting documentation
  - Notification of the amount of financial assistance
- RHMPI provides the following types of financial assistance for Medically Necessary Services:
  - Universal Exams/Testing
  - Copay Assistance (Prescription Medications, Office Visits, Labs, Other Services)
- Financial assistance will be available on the basis of documented financial need when there are no additional forms of payment available. No patient will be denied Financial Assistance on the basis of age, sex, or sexual orientation, race, religion or national origin.
- RHMPI will provide a copy of the financial assistance application to all patients at time of registration and will be kept on file in the event there is a need for assistance with patient treatment cost/share. This form will be reviewed once the patient requests financial assistance with the request of additional supporting documentation.
- RHMPI will utilize the standardized financial assistance application to review the applicable patient's account balance, medication adherence, and appointment compliance.
- RHMPI requires each patient applying for financial assistance to cooperate with the standardized application process by providing the required documents as proof there is a reasonable basis for financial assistance such as proof of income, id, and household size.

- RHMPI will also screen uninsured patients for Presumptive Eligibility for financial assistance upon request by the patient. However, if there is a reasonable basis to believe the patient may be eligible for insurance coverage under public programs, or if RHMPI requires documentation to establish a presumptive eligibility category, RHMPI shall allow the patient 30 days to respond to RHMPI and apply for insurance coverage or to produce requested documents.
- RHMPI will approve or deny each application based on all qualifying factors and the patient will be notified regarding.
- RHMPI shall determine approval or denial as soon as possible prior to providing services and prior to the issuance of any bill for such services.
- Each approved patient financial assistance amount will be based on the services being provided.
- All information and completed financial assistance forms will be maintained at RHMPI.

Definitions:

Applicant
An individual who has submitted a completed Financial Assistance Application, including all information and documents requested on the Application form.

Family Income
The adjusted gross income and cash benefits from all sources before taxes of all persons legally obligated to pay the charges incurred, less payment of child support.

Family Size
The aggregate number of personal exemptions allowed under federal tax law on a federal income tax return which was filed or could have been filed for the most recent calendar year and on which the Patient or Guarantor is one of the persons for whom a personal exemption is allowed, unless a Patient can establish a civil union pursuant to state law.

Patient
The person who receives care from RHMPI and the person who is the Guarantor of the payment for services received from RHMPI.

Uninsured Patient
A patient not covered under a policy of health insurance and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability insurance.

This policy and procedure shall be periodically reviewed and updated consistent with the requirements and standards established by the Board of Directors and the RHMPI CEO, as well as federal and state laws and regulations.

RURAL HEALTH
MEDICAL PROGRAM, INC.
Providing Quality Healthcare Services Since 1977.

Patient Financial Assistance Application

Patient Information

Last Name:_____ **First Name:**_____ **Middle Initial:**___

Date of Birth:_____ **Social Security#:**_____-_____-_____ **Street Address**_____

City_____ **State**_____ **Zip**_____

Phone:_____ **E-mail Address:**_____

Employer:_____ **Employer's Phone Number:**_____

Employer's Address: _____

□ **Single** □ **Married** □ **Civil Union** □ **Divorced** □ **Widowed**

Spouse/Partner/Parent/Guardian Name: _____

Street Address_____

City_____ **State**_____ **Zip** _____

Phone: _____

Employer:_____ **Employer's Phone Number:**_____

Employer's Address: _____

# of Persons in the Patient's Family/Household:_____

# of Persons who are Dependents of the Patient:_____ **Ages of Patient's Dependents:** _____

Monthly Household Income

Source	Patient Amount/Frequency	Spouse/Partner/Parent/Guardian Amount/Frequency
Wages	$_____/_____	$_____/_____
Unemployment	$_____/_____	$_____/_____
Work Comp	$_____/_____	$_____/_____
SS/SSI/SSD	$_____/_____	$_____/_____

Child Support/Alimony	$_____/_____	$_____/_____
VA Benefits	$_____/_____	$_____/_____
Private Disability	$_____/_____	$_____/_____
Pension/Retirement	$_____/_____	$_____/_____
Interest/Dividend	$_____/_____	$_____/_____
Trust	$_____/_____	$_____/_____
Rental	$_____/_____	$_____/_____
Other Income	$_____/_____	$_____/_____

Assets: Please identify your assets and estimated asset value

Financial Accounts	**Name of Financial Institution/Administrator**	**Estimated Value**
Checking Account		
Savings Account		
Certificates of Deposit		
Health Savings/Flex Spend		
Investments	**Name of Stock/Fund**	**Estimated Value**
Stocks		
Mutual Funds		
Vehicles	**Make and Model**	**Estimated Value**
Automobile		
Automobile		
Other		
Real Property	**Address**	**Estimate Value**

Monthly Household Expenses

Rent/Mortgage_____ Gas/Electric_____ Food_____

Telephone _____ Water/Sewer_____ ChildCare _____

Description of other expenses and dollar amount _____

Certification:

I certify that the information in this Application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this cost of healthcare services. I understand that the information provided may be verified by Rural Health Medical Program, Inc., and I authorize Rural Health Medical Program, Inc. to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Date of Request:_____Patient or Applicant's Signature:_____

MARENGO
DALLAS
MONROE
RURAL HEALTH
MEDICAL PROGRAM, INC.
Providing Quality Healthcare Services Since 1977.