Adventist HealthCare
Home Care Services

PUBLIC DISCLOSURE OF FINANCIAL ASSISTANCE

Adventist Home Health, Inc. ("AHH") will make available to all patients home health care regardless of race, creed, gender, age, sexual orientation, national origin, or financial statuses that are uninsured, underinsured, or have experienced a catastrophic event and lack adequate resources to pay for services. If there is no medical insurance for reimbursement, the patient (or the patient's guarantor, if any) is responsible for payments. However, if the patient or guarantor does not have the ability to pay AHH for services, they may apply for charity care, based on a sliding fee scale, or attain a time payment plan. Probable eligibility will be decided within two business days of the initial request for these services or an application for Medical Assistance ("Medicaid").

(Full Financial Assistance Policy Continues Below)

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ADVENTIST HOME HEALTH
FINANCE POLICY

Effective Date: 2/92 Policy No: 3.1040
Comments: Section:
Reviewed: Approval:
Revised: 2/00, 5/01, 2/02, 9/02, 10/02, 5/04, 5/06, 6/10, 8/10, 6/11, 6/15, 4/17, 6/17

CHARITY CARE ASSESSMENT AND MEDICAID DETERMINATION POLICY

PURPOSE

To provide a systematic and equitable mechanism and to define guidelines for accepting charity patients who do not have medical insurance or the ability to pay.

POLICY

Adventist Home Health, Inc. ("AHH") will make available to all patients home health care regardless of race, creed, gender, age, sexual orientation, national origin, or financial status who are uninsured, underinsured, or have experienced a catastrophic event and lack adequate resources to pay for services. If there is no medical insurance for reimbursement, the patient (or the patient's guarantor) is responsible for payment. However, cases arise whereby the patient or guarantor does not have the ability to pay AHH for services rendered and may apply for charity care, a sliding fee scale or time payments.

Printed public notification regarding the AHH charity care and sliding fee scale policies will be made annually in newspapers in AHH service areas. The notification will also be posted in the AHH business offices and website.

Within two business days following a client's initial request for charity care services, application for medical assistance, or both, AHH shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.

Patients who are not eligible for insurance, Medicaid, or Charity are expected to pay for AHH services. Current AHH practice is that patients owing any financial balance to AHHS are sent an invoice over three months informing them of the balance. They receive a call after the second letter. They are provided the option on their billing statement to pay their balance by credit card or by monthly payments. AHH provides patients with a time payment plan in which they pay a minimum payment of as little as $10.00 monthly and allow up to 18 months to pay off the balance.

AHH will supply the patient and the patient's family with the AHH charity care policy and review the arrangements for payment and/or the provision of charity care for services at the initial meeting with the patient.

Probable Eligibility Determination Process

1. Either from the referral source or during the first meeting with the patient or the patient's family (whichever comes first), AHH will discuss the family size, insurance status, and income of the patient, which will be used to make a determination of probable eligibility for medical assistance, charity care and/or reduced fees within two business days.
    a. If the patient has applied for medical assistance, AHH will consider the patient to be

insured by medical assistance, unless a denial is issued.

b. If the patient (1) does not have insurance, (2) is not eligible for medical assistance, and (3) does not have the resources to pay based on the information obtained from the referral source or patient, the patient will be deemed to have probable eligibility for charity care and/or reduced fees.

2. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, AHH shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client within that timeframe.

Final Eligibility Determination Process

1. The patient's charity eligibility must be determined by AHH, not by the patient or referral source. A patient's signed declaration of his inability to pay his medical bills cannot be considered final proof of indigence.

2. If the patient already filed for Community Medicaid while in an AHC hospital and has completed the charity care process, AHH will accept the patient as Medicaid pending. The Reimbursement Department will track the patient's progress in obtaining Medicaid. No AHH charity form will be required.

3. AHH will take into account a patient's total resources which can include, but are not limited to, an analysis of disposable income and current expenses.

4. AHH must determine that no source other than the patient would be legally responsible for the patient's medical bill (guarantor).

5. Charity Care will be provided according to the Federal Poverty Guidelines as described in this policy (see Addendum 1).

6. If a patient does not qualify for Charity Care under the Federal Poverty Guidelines, but has extraordinary expenses, such as high medical bills, Charity Care may be approved. Director of Finance must approve Charity Care in these cases.

7. If the patient qualifies for Medicaid, but has not completed all documentation, the patient will be deemed provisionally eligible for charity and the Social Worker will track and follow up with the patient. The progress of the Medicaid application will be communicated to the Reimbursement Department.

8. If the patient is deemed not eligible for Medicaid or charity care because their household income exceeds the charity care threshold, they may be eligible for a sliding scale fee or a time payment schedule. (See Sliding Fees Schedule, Addendum 1)

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CHARITY FINANCIAL HARDSHIP APPLICATION

I have requested Charity Care for services I will receive or have received from Adventist Home Health. I understand that if I do not fill this form out truthfully, this request will automatically be denied. If my request for Charity Care is approved based on incorrect information, I will be responsible for paying for all services provided by Adventist Home Health.

Please describe why charity services should be granted. (to be completed by Medical Social Worker)

_____

_____

_____

_____

Patient Name: _____ DOB: _____ SS# _____
Spouse Name: _____ DOB: _____ SS# _____

MONTHLY INCOME

Monthly Household Income: Gross $ _____ Net $ _____
Other Monthly Income: Gross $ _____ Net $ _____

Total Monthly Income: Gross $ _____ Net $ _____

MONTHLY EXPENSES

Rent/Mortgage:		Cable:	
Other Medical Expenses:		Furniture/Appliance Payment:	
Medical Insurance:		Clothing Expenses:	
Life Insurance:		Educational Expenses:	
Car Payment:		Charitable Donations (church, etc):	
Car Insurance:		Subscriptions/Magazines:	
Groceries:		Other Expenses:	
Utilities:		Telephone:	
Other Assets:			

Credit Card 1 Name _____ Balance _____ Number _____

Credit Card 2 Name _____ Balance _____ Number _____

Credit Card 3 Name _____ Balance _____ Number _____

(Please use the back of this form if you need additional space to list other expenses)

Total Monthly Expenses: $

Please attach W2s, tax returns, and returns, recent pay stubs, and/or bank statements, etc.
If you have additional information that may be helpful in our decision, please attach to this form.

Recommendation: _____

_____

MSW Signature:_____ Date:_____

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CHARITY CARE AGREEMENT

Patient Name _____ Discharge Date _____

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Our short-term goal is to provide services to educate you about your health care needs and how best for you to manage those needs in a home setting. If you are unable to manage your treatment plan alone, you will be required to authorize someone to do this on your behalf.

Patient Acknowledgement:

I understand and agree that in order for AHH to provide home health services, I am responsible for:

1. Learning to manage my care independently or authorizing someone to learn on my behalf.

2. Providing accurate financial information (on an on-going basis) to assist in determining my eligibility for community resources and Charity Care. **Should my financial information prove inaccurate, my care will be billed retroactive for all services provided and for future care.**

3. Completing initial application processes for available community resources.

4. Continuing to follow up with community resources in a timely manner.

5. Agreeing to release information on Medicaid application to AHH.

6. Charity Care will not cover third party liability cases. If litigation is involved, I will be billed retroactive for the services that were provided for free and will be billed for all future services.

I accept responsibility for compliance with the above stated requirements and acknowledge that failure to comply could result in discharge from AHH. If I do not comply and AHH continues to support my care, this in no way affects the right of AHH to discharge me in the event of a subsequent failure on my part to comply with the terms of this agreement.

Date of Authorization	Signature of Patient
Witness/Relationship	Legal Representative if patient is unable to sign/Relationship to Patient
If patient signs by making an "X"	Witness/Relationship

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Addendum 1
2019 Poverty Guidelines / Sliding Scale Table

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	100%	$ 12,490	100%	0%
2	$ 16,910	100%	$ 16,910	100%	0%
3	$ 21,330	100%	$ 21,330	100%	0%
4	$ 25,750	100%	$ 25,750	100%	0%
5	$ 30,170	100%	$ 30,170	100%	0%
6	$ 34,590	100%	$ 34,590	100%	0%
7	$ 39,010	100%	$ 39,010	100%	0%
8	$ 43,430	100%	$ 43,430	100%	0%

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	200%	$ 24,980	100%	0%
2	$ 16,910	200%	$ 33,820	100%	0%
3	$ 21,330	200%	$ 42,660	100%	0%
4	$ 25,750	200%	$ 51,500	100%	0%
5	$ 30,170	200%	$ 60,340	100%	0%
6	$ 34,590	200%	$ 69,180	100%	0%
7	$ 39,010	200%	$ 78,020	100%	0%
8	$ 43,430	200%	$ 86,860	100%	0%

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	225%	$ 28,103	80%	20%
2	$ 16,910	225%	$ 38,048	80%	20%
3	$ 21,330	225%	$ 47,993	80%	20%
4	$ 25,750	225%	$ 57,938	80%	20%
5	$ 30,170	225%	$ 67,883	80%	20%
6	$ 34,590	225%	$ 77,828	80%	20%
7	$ 39,010	225%	$ 87,773	80%	20%
8	$ 43,430	225%	$ 97,718	80%	20%

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	250%	$ 31,225	60%	40%
2	$ 16,910	250%	$ 42,275	60%	40%
3	$ 21,330	250%	$ 53,325	60%	40%
4	$ 25,750	250%	$ 64,375	60%	40%
5	$ 30,170	250%	$ 75,425	60%	40%
6	$ 34,590	250%	$ 86,475	60%	40%
7	$ 39,010	250%	$ 97,525	60%	40%
8	$ 43,430	250%	$ 108,575	60%	40%

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Addendum 1 (Cont.)
2019 Poverty Guidelines / Sliding Scale Table

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	275%	$ 34,348	40%	60%
2	$ 16,910	275%	$ 46,503	40%	60%
3	$ 21,330	275%	$ 58,658	40%	60%
4	$ 25,750	275%	$ 70,813	40%	60%
5	$ 30,170	275%	$ 82,968	40%	60%
6	$ 34,590	275%	$ 95,123	40%	60%
7	$ 39,010	275%	$ 107,278	40%	60%
8	$ 43,430	275%	$ 119,433	40%	60%

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	300%	$ 37,470	20%	80%
2	$ 16,910	300%	$ 50,730	20%	80%
3	$ 21,330	300%	$ 63,990	20%	80%
4	$ 25,750	300%	$ 77,250	20%	80%
5	$ 30,170	300%	$ 90,510	20%	80%
6	$ 34,590	300%	$ 103,770	20%	80%
7	$ 39,010	300%	$ 117,030	20%	80%
8	$ 43,430	300%	$ 130,290	20%	80%

Family Size	2019 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,490	325%	$ 40,593	0%	100%
2	$ 16,910	325%	$ 54,958	0%	100%
3	$ 21,330	325%	$ 69,323	0%	100%
4	$ 25,750	325%	$ 83,688	0%	100%
5	$ 30,170	325%	$ 98,053	0%	100%
6	$ 34,590	325%	$ 112,418	0%	100%
7	$ 39,010	325%	$ 126,783	0%	100%
8	$ 43,430	325%	$ 141,148	0%	100%

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Addendum 2
2019 Per Visit Fee Schedule

Discipline	Per Visit Fee
Skilled Nursing	$ 200
Physical Therapy	$ 220
Occupational Therapy	$ 220
Speech Therapy	$ 220
Medical Social Worker	$ 360
Home Health Aide	$ 100