



FINANCIAL ASSISTANCE POLICY AND PROCEDURE

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1 Purpose.

To promulgate the policy and procedures for the administration of Financial Assistance by this hospital.

2 Definitions.

2.1 "Financial Assistance" services means inpatient and outpatient medical treatment, physician services, and diagnostic services for uninsured or underinsured patients who can not afford to pay for their care. Such treatment is provided by this facility without expectation of payment. Financial Assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments or deductibles, or both.

2.2 "Bad Debt is defined as expenses resulting from treatment for services provided to a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by their actions an unwillingness to comply with contractual arrangements to resolve a bill.

3 Policy.

3.1 Non- discrimination

This hospital shall render services to all members of the community who Are in need of medical care regardless of the ability of the patient to pay For services. The determination will not be based on age, sex, race, Creed, disability, sexual orientation or national origin.

3.2 Determination of eligibility

Every effort will be made to determine eligibility prior to services being rendered. If complete information and documentation is unavailable at the time of service, the designation of Financial Assistance may be made after rendering services.

3.3 Confidentiality

Confidentiality of information and preservation of individual dignity shall be maintained for all who seek Financial Assistance services. Orientation of staff and the selection of personnel who will implement this policy and procedure will be guided by these values. Information contained within the Financial Assistance application shall be kept confidential and will not be released without express permission from the patient.

3.4 Financial Assistance Representative

The hospital shall designate an individual to approve Financial Assistance applications, coordinate outreach efforts, and oversee Financial Assistance practices. The Financial Assistance Representative may write-off up to \$1,000 per account. These write-offs must be communicated to the Business Office Manager and Chief Financial Officer. The business manager may write off accounts up to 2,000, Any accounts greater than said amount will require approval from the Chief Financial Officer. A Financial Assistance committee will be established by the hospital to review ongoing issues with the program, and in some cases to review individual accounts. The committee will meet on an as needed basis, and at least a minimum of four times per year. The committee shall consist of the Chief financial Officer, business office Manager, Financial Assistance Representative, Care Manager, and the compliance officer, and Patient Management Representative.

3.5 Staff Training.

All staff with public and patient contact are trained to understand the basics of the Financial Assistance Program and will have applications and printed materials available.

3.6 Uniformity

All off-site hospital owned clinics will have identical Financial Assistance policies. The hospital will encourage physicians who have admitting privileges to provide a certain amount of Financial Assistance.

4 Application Process.

4.1 Application.

The attached financial statement application (Appendix A) will be used by patients to apply for Financial Assistance from the hospital. Patients who do not have health insurance may qualify for Financial Assistance based on their monthly or annual income and their family size. Patients who have insurance may also be eligible for Financial Assistance for the portion of their bill that is not covered by insurance, including deductibles, coinsurance, and non-covered services.

4.2 Application Assistance.

The hospital's Financial Assistance Representative will provide application assistance to patients. Translation services and assistance will be offered to all patients.

4.3 Requests for Information.

The hospital shall send anyone who requests information on the hospital's Financial Assistance Program a letter and an application. (Appendix A & B)

4.4 Additional Requestors.

Financial Assistance requests may be proposed by other sources other than the patient, such as family members, a patient's physician, religious or community groups, social service organizations, or hospital personnel.

5 Application Review Process.

5.1 Eligibility Criteria.

5.1.1 Medical Necessity.

Treatment must be medically necessary and/or emergent. Financial Assistance will not normally be provided for non-emergent care. A written statement from the patient's physician must be provided if applications are prior to services being rendered. Medical necessity is defined as "the absence of immediate medical attention could reasonably be expected to place a person's health at risk resulting in death, impairment or dysfunction of bodily functions or organs."

5.1.2 Financial Statement.

The applicant must fill out a financial statement and include all supporting documentation.

5.1.3 Financial Information.

Verifications of financial information shall be requested by the hospital. Those may include but are not limited to paycheck stubs, W-2 forms, Tax returns, and unemployment or disability statements. If those items are unavailable a letter of support from individuals providing basic needs will be accepted.

5.1.4 Asset Exemption.

The residence where a patient and/or a patient's family resides, automobiles, savings accounts with less than two months of income, and retirement accounts less than 50,000 are exempted from consideration as assets in considering whether a patient meets Financial Assistance financial criteria. A Patient's monthly or annual income must be 250% or less than the federal poverty guidelines (Appendix D). Guidelines will be updated annually.

5.1.5 Other Coverage.

The applicant must be ineligible for but not limited to Medicaid, Medicare, Branch- Hillsdale-St Joseph County Health Plans, workman's compensation, auto insurance, homeowners insurance, and crime victims compensation. A Medicaid denial letter is required as part of the application process. All possible third party liability resources will be exhausted before Financial Assistance consideration.

5.2 Approval.

5.2.1 Approval Notification.

The eligibility determinations will begin once all appropriate documents are submitted, completed, and verified. The Chief financial Officer or a designee in his absence will make the final decision. The patient shall receive orally or in writing (Appendix E) a determination within fifteen (15) working days after receipt of all supporting materials. Once approved eligibility shall extend for 1 year, barring any change in the financial circumstances. No new application will be required if within the one (1) year time frame. Special cases may be exempt from any and all criteria.

5.2.2 Expired Patients.

Patients who have died and have no estate are deemed to have no income for the Financial Assistance purpose of determining eligibility.

5.3 Denial.

If a patient is denied Financial Assistance, the patient shall be informed within fifteen (15) business days. All reasons for denial shall be provided at that time. Incomplete and fraudulent applications will be denied.

6 Publications.

6.1 Publication Inside Hospital.

- 6.1.1 Signage will be available in all patient access areas in both English and Spanish.
- 6.1.2 Brochures and business cards outlining the Financial Assistance program and flexible payment schedules will be available in all patient access areas (Appendix H) including all off-site hospital owned clinics.
- 6.1.3 Information and applications on Financial Assistance will be available on the hospital website.

6.2 Publication Outside Hospital.

- 6.2.1 Public Health Department.
Information regarding the hospital's Financial Assistance Program, policy and application forms shall be provided to the local Department of Public Health.

7 Notification.

- 7.1 The hospital shall provide all patients with oral and written notice of the hospital's Financial Assistance Program in the language spoken by the patient during any preadmission, admission, and discharge process (Appendix I). This information will be available at or below a sixth grade level.

8 Alternative Payment Arrangements.

8.1 Reduced-cost care.

Upon denial of a patient's Financial Assistance application and where the hospital determines that a reduced fee payment is appropriate patients will be afforded the opportunity to pay over a reasonable period of time. (Refer to Discount Policy)

8.2 Restrictions on Actions Relating to Alternative Payment Arrangements.

In cases in which the patient is eligible for an alternative payment arrangement, the hospital will administer the account and the individual's note does not accrue interest, neither is it sold to a second party. Accounts of alternative payment patients are not sent to a collection agency until no payment has been received for three (3) months and the applicant has made no effort to apply for Financial Assistance.

9 Collection Activity.

9.1 Restriction on Referral.

Patients are not sent to collections without having an opportunity and adequate time to develop an alternative payment arrangement.

9.2 Equitable Payment Schedule.

In all instances, the hospital will make all efforts to work with the patient to determine an equitable payment schedule considering the patient's financial and medical circumstances.

9.3 Financial Assistance Notification.

People are not sent to collections before receiving advance notice about the availability of Financial Assistance and adequate time in which to apply for Financial Assistance.

9.4 Prohibition on Medical Record Notation.

No notations will be made in the patient's medical record regarding financial matters, including whether the patient paid all or part of any medical bill.

10 Recordkeeping.

10.1 Internal Recordkeeping.

All Financial Assistance applications will be logged in the Financial Assistance control log and will be given a sequential control number (Appendix K). The completed applications will be kept on file for five (5)

years. A copy of the patient's Financial Assistance application and all correspondence with the patient regarding the Financial Assistance application, approval, denial and appeal will be maintained in the patient's file.

10.2 Accounting.

Financial Assistance shall be recorded using the direct write-off method and shall comply with all accounting regulations by the American Institute for Certified Public Accounting. The Business Office Manager will provide a year-to-date list of write-offs to the Chief Financial officer and the Chief Executive Officer at the end of each quarter.

10 Reporting.

11.1 External Reporting.

The hospital shall provide a copy of the hospital's Financial Assistance Program and report the amount of Financial Assistance provided in cost and charges in its annual financial statements. The hospital shall file a copy of the hospital's Financial Assistance Program with all appropriate local and state agencies.

11.2 Financial Assistance Provision.

The hospital shall aggregate and make anonymous information regarding the provision of Financial Assistance including:

- a) The total number of Financial Assistance applications granted and denied by zip code and ethnicity.
- b) The percentage of emergency or scheduled services provided as Financial Assistance compared to the total amount.
- c) The percentage of care provided as inpatient, outpatient, or ancillary Financial Assistance compared to the total amount.
- d) The total number of Financial Assistance patient days.
- e) A listing of all diagnoses for Financial Assistance patients.
- f) The total number of referrals made to other facilities, their names, and a list of reasons for referrals.
- g) The total cost of Financial Assistance delivered for the hospital's fiscal year.

11.2 Public Access.

The hospital shall make this information available to the public upon request. (Appendix L)

12 Corporate Responsibility.

The chief executive officer or officers and the chief financial officer or officers, or persons performing similar functions, shall certify in each annual financial report and report filed with the state and local agencies that includes information about Financial Assistance, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statement of material fact or omit to state a material fact necessary in order to make the statements.

By: _____
(CFO/Chief Financial Officer)

By: _____
(CEO/President)

Reviewed: Annually

Revision: February 2009, June 2010, October 2011, November 2012

Three Rivers Health Financial Assistance Policy & Program
Table of Appendices

Financial Assistance Application Form/Translated.....	A
Letter to Patient Regarding Financial Assistance Availability/Translated.....	B
Medical Hardship Criteria/Translated.....	C
Financial Assistance Eligibility Based on 2012 Federal Poverty Guidelines.....	D
Notification Letter for Patients Eligible for Financial Assistance	E
Denial Letter.....	F
Posters Located Throughout Hospital/Service Area.....	G
Information Sheet Describing Financial Assistance Program and Application.....	H
Statements for Oral Notification and Written Notification.....	I
Statement Included in All Medical Bills.....	J
Financial Assistance Patient Log.....	K
Financial Assistance Public Report Form.....	L
Self Pay ER/URC Flow Sheet.....	M
Self Pay Unscheduled Flow Sheet.....	N

Appendix A
Financial Assistance Application

1. Applicant information.

Last Name	First Name	Mi	Financial Assistance Sequential Control Number
Street Address			Telephone Numbers Home Work Cell
City	State	Zip Code	Mailing Address (if different from Street Address)
Date of Birth	SSI#		<input type="checkbox"/> Male <input type="checkbox"/> Female—Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are you: **homeless?** Yes No
unemployed? Yes No
uninsured? Yes No

2. If you are applying for someone else, complete this section.

Last Name	First Name	Mi	Relationship to Applicant:
Street Address			Telephone Numbers Home Work Cell
City	State	Zip Code	Mailing Address (if different from Street Address)

3. Family Information. List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parents or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___

4. List Earned Income before taxes and deductions for each family member who works.

Name of Working Family Member	Employer Name & Address	Amount Earned	How Often? Weekly/Monthly/Annually

5. Other Income not from an Employer – Asset Verification

Type of Income	Family Member Receiving Income	Amount	How Often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veteran's Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
County General Relief			
Refugee Resettlement Program			
Dividend Income			
Bank Account Income			
Other Income, Please specify			

6. Other Expenses. Fill in this section if you or anyone in Section 3 are required to make payments for any of the below expenses along with proof of those expenses.

Payment Type	Recipient Name/Relationship	Amount Paid	How Often? Weekly/Monthly/Annually
Alimony			
Child Support			
Car Payment			
Mortgage/Rent			
Utilities			
Credit Cards			
Other			

7. Other Insurance. Financial Assistance can pay for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any other health insurance program, including Medicare? Y ___ N ___ if yes:

Policy Holder (Name)	Insurance Company	Policy Number

b. Are you seeking Financial Assistance because of a work-related accident or injury? Y ___ N ___

c. Are you seeking Financial Assistance because of a car accident? Y ___ N ___

- d. Are you a student? Y ___ N___ If yes, are you full time? ___ Part time? ___
- e. Do you have an application pending for any of these programs? (Check all that apply)
 Medicaid ___ Medicare ___
- f. Are you currently approved for Financial Assistance at another hospital or community health center?
 Y ___ N ___ If yes, where? _____

8. Medical Bills. Total medical bills _____

Why can't you pay your medical expenses? Why do you need Financial Assistance?

9. Ethnicity/Race. Ethnicity/Race will not be used to determine eligibility.

- Asian or Pacific Islander
- African American, not Latin
- Latino
- American Indian or Alaskan Native
- Caucasian, not Latino
- Other _____
- I do not wish to answer

This is for data collection and analysis purposes only.

10. Assignment of Rights. Read this section carefully and sign.

I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Financial Assistance.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

I understand that this hospital cannot share confidential information with any state or federal agency without my prior approval.

 Signature of Applicant Date

 Signature of authorized representative Date

If you have questions about this application, contact the Financial Assistance Representative at 269-273-9769.

Mail the completed application to:

Three Rivers Health
 701 S. Health Parkway
 Three Rivers, Mi 49093

Appendix A (translated)
Financial Assistance Application

1. Informacion de Solicitante.

Apellido	Nombre	Financial Assistance Sequential Control Number
Direccion De La Calle		Numeros De Telefono Casa Trabajo Celular
Ciudad	Estado	Codigo Postal
Fecha De Nacimiento		SSI#
		Masculino Feminino/Esta Usted Embarazada? Si___ No___

¿Es usted? sin hacer? Si__ No__
 desempleado? Si__ No__
 sin seguro? Si__ No__

2. Si usted esta aplicando por alguien, complete esta seccion.

Apellido	Nombre	Relacion al solicitante
Direccion De La Calle		Numeros de Telefono Casa Trabajo Celular
Ciudad	Estado	Codigo Postal
		Direccion Que Envia

3. información de la familia. Apunte la gente en su familia que vive con usted y usted apoya con sus ingresos. Incluya a su esposo, niños dependientes bajo edad 18 y ancianos dependientes que vivan con usted. Si esta aplicacion es para un niño bajo edad de 18, incluya a los hermanos y las hermanas debajo de 18 y el padre o los padres del niño viven con usted,

4. Renta Ganada De La Lista. Cada Cuandi?

Nombre Del Miembro De Trabajo De La Familia	Nombre Y Direccion Del Patron	La Cantidad Gano	Semanal/Mensual?Anualmente

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5. Miembro De La Familia Que Recibe Ingresos.

Tipo De Ingresos	Miembro De La Familia Que Recibe Ingresos	Cantidad	Semanal/Mensual?Anualmente
Seguridad Social			
Retiro Del Ferrocarril			
Ventajas Del Veterano			
Fondos De Retiros			
Anualidades			
Pensiones			
Ayuda De Nino			
Alimentos			
Desempleo			
Remuneracion De Los Trabajadores			
Renta			
Renta De La Confianza			
Alivio General Del Condado			
Programa Del Restablecimiento Del Refugiado			
Renta De Divendo			
Cuenta Bancaria			
Otros Ingresos, Especifique Por Favor			

6. Otros Gastos. Complete esta seccion si usted o cualquier persona en la seccion 3 requiere hacer pagos para los gastos abajo junto con laprueba de estos costos.

Tipo Del Pago	Recipiente Nombre/Relacion	Cantidad Pagada	Semanal/Mensual?Anualmente
Alimentos			
Ayuda De Nino			
Pago De Coche			
Hipoteca/Renta			
Utilidades			
Tarjetas De Credito			
Otros Gastos			

7. Otro Seguro. Puede pagar las cosas tales como sus co-pagos y deductibles incluso si usted tiene otro seguro medicaos.

a. Es usted cubrio bajo cualquier programa del seguro medico, incluyendo seguro de enfermedad.

Nombre Del Asegurado	Compania De Seguros	Numero De La Polizade Seguro

b. ¿Usted esta buscando "Financial Assistance" debido a un accidente o lesion trabajar relacionado? Si ___ No ___

c. ¿Usted está buscando cuidado de la caridad debido a un accidente de tráfico? Si ___ No ___

d. ¿Es usted un estudiante? Si ___ No ___ ¿Si sí, es usted a tiempo completo? Si ___ No ___

e. ¿Usted tiene un uso para ninguno de estos programas?

Medicaid ____ Medicare ____

f. ¿Le aprueban actualmente para el cuidado de la caridad en otro centro de salud del hospital o de la comunidad? Y__ N__
¿Si sí, dónde? _____.

8. Cuentas Medicas. Cuentas medicas totales _____.

¿Porque no puede usted pagas sus costos medicos? ¿Porque necessita
"Financial Assistance"? _____

9. Pertenencia Etnica/Raza. No sera utilizado para determinar elegibilidad.

- Asiatico
- Africano-Americano
- Latino
- Indio Americano
- Caucasico
- Otro
- No Deseo Contestar

Esto esta para los propositos de la coleccion y del analisis de datos solamente.

10. Asignacion De Los Derechos. Lea esta seccion cuidadosamente y firme.

Yo estoy en acuerdo de informar al hospital sobre cambios por el estado de familia incluyendo: cobertura del tamano, de la renta y de seguro de la familia para la cual podria cambiar mi elegibilidad para el programa "Financial Assistance".

Toda esta informacion en este uso es verdad al mayor de mi conocimiento. Acuerdo proporcionar la documentacion por requerimiento.

Entiendo que este hospital no puede compartir la informacion confidencial con ningun estado o la agencia federal sin mi aprobacion anterior.

Firma del solicitante

Fecha

Firma del representante autorizado

Fecha

Si usted tiene preguntas sobre esta aplicacion, entre en contacto con el representante del programa "Financial Assistance" at 269-273-9769.

Envies u aplicacion completa a:

Three Rivers Health
701 S Health Parkway
Three Rivers, Mi 49093

Appendix B
Letter to Patient Regarding Financial Assistance Availability

Dear Patient:

You may be eligible for medical care even if you cannot pay for it.

This hospital has a Financial Assistance Program for patients who cannot afford to pay for medical care. Eligibility for the program is based on the number of people in your family. It may also be based on whether your medical expenses would constitute a medical hardship.

In order to be considered for care you need but cannot pay for, please complete the attached application form. If you have any questions or need assistance in completing this application, please contact the Financial Assistance Representative at 269-273-9769. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please send your application to:

Three Rivers Health
Financial Assistance
701 S Health Parkway
Three Rivers, Mi 49093

We will notify you within (15) fifteen business days as to whether your Financial Assistance application has been approved.

If you are denied Financial Assistance you may: 1) re-apply for Financial Assistance at any time your financial situation changes; 2) work out a payment plan with our patients account office, considering your existing financial obligations.

Thank You,

Appendix B (translated)

Estimado (Patient Name)

Usted podra ser eligible para recibir cuidado medico aun cuando no pueda pagar por los servicios.

El hospital tiene un programa llamado "Financial Assistance" para pacientes que no pueden hacer el gasto por su cuidado medico.

El programa esta basado en la entrada de ingresos y el numero de personas que viven en su casa. Usted tambien puede ser selecionado para recibir cuidado medico si sus gastos constituyen afliccion.

Para recibir estos servicios, por favor de llenar esta aplicacion. Si usted tiene preguntas o necessita asistencia en llenando su aplicacion, por favor llame con un representante de "Financial Assistance" al 269-273-9769 Si usted no puede terminar la aplicacion, puede autorizar a un representante personal.

Por favor de enviar su aplicacion a:

Financial Assistance Processing
Contact Name
Department
Address

Nosotros le notificaremos durante 15 dias de negocio si su aplicacion fue aprobada.

Si en caso que su aplicacion llege ser rechazada, usted podra volver a aplicar cuando sus gastos financieros cambien or cuando usted pueda hacer un plan de pago con la representante de cuentas al respeto de su obligacion financiero.

Gracias,

Appendix C Medical Hardship Criteria

In some instances there may be extenuating circumstances that arise requiring special consideration in approving Financial Assistance for patients who do not meet the established financial criteria for Financial Assistance but qualify for “medical hardship” depending on financial and medical circumstances. While it is not possible to provide a complete list of all extenuating circumstances that may arise, some important factors to consider include:

- The medical status of the patient or of his/her family’s provider.
- The employment potential of the patient in light of his/her medical condition and/or skills in the job market.
- The likely emotional or medical impact of financial indebtedness upon the patient and the family.
- Whether the patient lives on a fixed income.
- Existing liabilities such as a mortgage, school tuition, or automobile or college loan.
- The effect a catastrophic illness has on the ability of the patient to work.

Appendix C (translated)
(Criterios Medicos De La Dificultad)

En algunos casos puede haber las circunstancias raras que se presentan requiriendo la consideracion espcecial en el programa "Financial Assistance" para los pacientes que no resuelven el criterio financiero establecido para el programa "Financial Assistance" pueden calificar para la dificultad medica dependiendo de sus circunstancias financieras y medicas. Mientras que no es posible proporcionar una lista completa de todas las circunstancias raras que puedan presentarse, algunos factores importantes que considerer incluyen:

- La cantidad debida por el paciente en lo referente a su total significa.
- El estado medico del paciente o del abastecedor de su familia.
- El potencial del empleo del paciente en luz de su condicion medica y/o habilidades en el Mercado de trabajo.
- El probale impacto emocional y medico el endeudamiento financiero sobre el paciente y la familia.
- Si el paciente vive en una renta fija
- Responsabilidades existents tales como una hipoteca, una cuota del la escuela o un automovil o un prestamo de la Universidad.
- El efecto que una enfermedad catastrofica tiene en la capacidad del paciente de trabajar.

Appendix D
Federal Poverty Guidelines 2012

Family Size	250% of the Federal Poverty Guidelines Yearly Income
1	\$27,925
2	\$37,825
3	\$47,725
4	\$57,625
5	\$67,525
6	\$77,425
7	\$87,325
8	\$97,225

Each additional family member add \$9,900.00

Appendix E
Notification Letter for Patients Eligible for Financial Assistance

Dear Patient,

We are pleased to notify you that your Financial Assistance application has been approved. Please notify the hospital immediately if your situation changes and you can afford to pay for your medical care.

If you have any questions, call the Financial Assistance Representative at 269-273-9769.

Thank You,

Appendix E (translated)
Notification Letter for Patients Eligible for Financial Assistance

Estimado paciente,

Estamos satisfechos notificarle que se ha aprobado su uso del cuidado de la caridad. Notifique por favor el hospital inmediatamente si su situación cambia y usted puede permitirse pagar su asistencia médica.

Appendix F
Denial Letter

Dear Patient:

This hospital cannot provide you coverage with Financial Assistance at this time because:

If your financial circumstances change, you may be eligible for Financial Assistance. Please reapply if your income or expenses change.

You may be eligible for a reduced payment plan. Please contact Patient financial services at 269-273-9769 to discuss this.

You are allowed by law to get Emergency Medical Care from the hospital.

If you have further questions please call,

Sincerely,

Name

Appendix F (translated)
Letra De La Negacion

Estimado Paciente:

El hospital no puede proporcionarle cobertura con el programa "Financial Assistance" en este proque:

Si us circustances financieros cambian, usted puede ser elegible para el programa Financial Assistance. Porfavor reaplique sis u renta o gastos cambian.

Usted puede ser elegible para el plan reducido del pago. Entre en contacto con la oficina paciente de las cuentas al 269-273-9769.

Sinceramente,

Nombre

Appendix G
Posters Located Throughout Hospital

Financial Assistance

**We believe all people should get
medical care**

whether or not they can pay.

**If you cannot pay
your medical expenses,**

you may qualify for the

Hospital's Financial Assistance Program.

For more information, contact us at:

269-273-9769

Appendix G (translated)
Posters Located Throughout Hospital

Financial Assistance

**Creemos que toda la gente debe
conseguir asistencia medica si o
no ellos pueden pagar.**

Si usted no puede pagar sus costos medicos,

usted puede calificar para el programa

“Financial Assistance”

ofrecido por el hospital. Para mas

information, pongase en contacto con

nosotros en

269-273-9769

Appendix H
Information Sheet Describing Financial Assistance Program and Application Process
Can't pay your hospital bill?

What if I can't pay my hospital bills?

If you don't have health insurance or if your insurance doesn't cover all your medical expenses, let us know. We believe all people should get medical care whether or not they can pay.

How do I apply for Financial Assistance?

Call and ask for an application.

269-273-9769

We can answer your questions and help you fill out your application.

And, we can help you apply for public health care programs.

How does the hospital decide if I qualify?

We look at your family's income and how many people in your family. We will not look at your age, sex, sexual orientation, race, beliefs or disabilities.

What happens if I qualify?

If you qualify, you can get Financial Assistance for one year, and you won't have to pay the hospital back (unless your financial situation changes).

How do I know if I qualify?

We will mail you a letter within (15) fifteen business days of getting your application. Or we may ask you for more information.

What if I don't qualify?

You can:

- Apply again—if your income has changed.
- Ask the hospital to let you make payments.

For more information, contact us at:
269-273-9769

Three Rivers Health
701 S. Health Parkway
Three Rivers, Mi 49093

Appendix H (translated)

Informacion del programa “Financial Assistance” y el proceso de uso

No Puede Pagar Su Cuenta Del Hospital?

Qué si no puedo pagar mi cuenta del hospital ?

Si usted no tiene seguro médico o si su seguro no cubre todos sus gastos médicos, déjenos saber. Creemos que la gente debe conseguir asistencia médica si o no ellos pueden pagar.

Cómo solicito cuidado de la caridad ?

Llame y pida un aplicacion.
269-273-9630

Podemos contestar sus preguntas y ayudarle a completar su aplicacion.
Y, podemos ayudarle a solicitar programas del cuidado médico público

¿Cómo el hospital decide si yo califico?

Miramos los ingresos y cuánta gente está en su familia. No discriminamos sobre su edad, sexo, orientación sexual, raza, creencia o inhabilidades

¿Qué sucede si califico?

Si usted califica, puede recibir la ayuda del programa “Financial Assistance” por un año, y usted no tiene que restituir el hospital (a menos que su situación financiera cambie).

¿Cómo sé si califico?

Le enviaremos una carta dentro de 15 días laborales de conseguir su aplicacion o podemos pedirle más información.

¿Qué si no califico?

Usted puede:

- .. Aplíquese otra vez - si sus ingresos han cambiado, usted puede calificar; o
- .. Pida el hospital para que dejen que usted haga pagos.

Appendix L
Statement for Oral Notification

If you cannot pay for your medical services, you may be eligible for care through the hospital's Financial Assistance Program. This is an application or you can call 269-273-9769.

Statement of Written Notification

If you cannot pay for your medical services, you may be eligible for care through the hospital's Financial Assistance program. For more information about if you qualify, call 269-273-9769.

Appendix L (translated)
Statement for Oral Notification

Si usted no puede pagar usted servicios médicos, usted puede ser elegible para el cuidado con el programa del cuidado de la caridad del hospital. Esto es un uso o usted puede llamar 269-273-9769

Statement for Written Notification

Si usted no puede pagar sus servicios médicos, usted puede ser elegible para el cuidado con el programa del cuidado de la caridad del hospital. Para más información sobre si usted califica, llame 269-273-9769.

Appendix J
Statement Included in All Medical Bills

We believe all people should get medical care whether or not they can pay. If you do not have health insurance or if your insurance doesn't cover all your medical expenses, you may qualify for help through the hospital's Financial Assistance Program.

Please contact the Financial Assistance Representative at 269-273-9769. We can discuss whether you qualify for state and federal assistance programs including Medicare and Medicaid. You may also request a Financial Assistance application if you will have trouble paying your medical bills.

Appendix J (translated)

Declaracion incluida entodas las cuentas medicas

Nosotros creemos que todas las personas deben recibir cuidado medico tomando en cuenta si usted puede pagar o no. Si usted no tiene seguro medico o su seguro no cubre todos los gastos medicos, usted puede calificar para asistencia a traves de un programa llamado "Financial Assistance Program" ofrecido por el hospital.

Por favor llama con un representante del programa "Financial Assistance" al 269-273-9769. Podememos determinar si usted califica para un programa del estado o federal incluyendo Medicare y Medicaid. Usted tambien teniendo problemas pagando su cuenta medica.

Appendix K
Financial Assistance Patient Log

- 1 Financial Assistance Sequential Control Number.
- 2 Demographic Data.
 - 2.1 Patient identification number
 - 2.2 Sex
 - 2.3 Zip code of residence
 - 2.4 Ethnicity
 - 2.5 Household size
 - 2.6 Primary Language
- 3 Service Data.
 - 3.1 Date of service / admit date
 - 3.2 Type of service (including whether it was emergency or scheduled)
 - 3.3 Type of care delivered (i.e. inpatient, outpatient, or ancillary)
 - 3.4 Number of inpatient days
 - 3.5 Diagnosis
 - 3.6 Cost of care delivered
 - 3.7 The name of the facilities to which an individual requesting or applying for Financial Assistance was referred and reason for referral.
- 4 Financial Data.
 - 4.1 Household monthly income
 - 4.2 Household principal income source
- 5 Financial Assistance Program Data.
 - 5.1 Timing of determination with care.
 - 5.2 Timing of determination.

Appendix L
Financial Assistance Report Form

- 1 The total number of Financial Assistance applications granted and denied by zip code and ethnicity.
- 2 The percentage of emergency or scheduled services provided as Financial Assistance compared to the total amount provided.
- 3 The percentage amount of care provided as inpatient, outpatient, or ancillary Financial Assistance compared to the total amount provided.
- 4 The total number of Financial Assistance patient days.
- 5 A compilation of all diagnoses for Financial Assistance patients.
- 6 The total number of referrals made to other facilities, their names, and a list of reasons for referrals.
- 7 The total cost of care delivered for the hospital's fiscal year.