

FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY

Columbus Regional Hospital promises to provide you the best care possible regardless of ability to pay.

We can help – please tell us if you cannot pay your bill.

Patient Financial Services at Columbus Regional Hospital has representatives available to assist you with questions regarding your bill. We have staff dedicated to helping you apply for government sponsored programs, arrange interest free payment plans or describe our financial assistance program and help with the application process.

Interest Free Payment Plans:

Interest free payment plans are available to any patient that wishes to establish one. Payment plans may extend up to 60 months and can be as low as \$25.00 per month.

Financial Assistance:

Financial assistance is available to help with out of pocket expenses from medically necessary services.

To apply you will be required to provide financial information and verifications. (See instruction sheet for list of required/requested items). Not all services are eligible for assistance. Cosmetic services, hearing aids, bariatric surgery along with 3 months of pre-op and 3 months of post-op services, fertility services and motor vehicle or other injury accidents, in some circumstance, are excluded.

Financial Assistance Applications:

Applications for assistance can be found on the Columbus Regional Hospital web site at www.crh.org, in our Billing and Financial Assistance Guides found in multiple patient waiting areas around the hospital, by calling our Customer Services representatives at 812-376-5315 or 1-800-841-4954 (hours 8:00 am to 4:45 pm, Monday through Friday) .

Completed applications can be returned via mail to Columbus Regional Hospital 2400 E 17th Street Columbus Indiana 47201.

Applications are available in both English and Spanish.

Qualification:

Qualification is based on yearly gross household income and number of dependents in the home (dependents must be claimed on 1040 tax filing form). See attached grid below. Guidelines are derived using the Federal Poverty Guidelines from the Federal Register.

Columbus Regional Hospital Financial Assistance Guidelines 2017

Family Size	% Above Poverty Guidelines		
	0-200%	200% to 300%	300% to 350%
	% of Write Off		
	100%	80%	60%
1	\$12,060.00 to \$24,120.00	\$24,121.00 to \$36,180.00	\$36,181.00 to \$42,210.00
2	\$16,240.00 to \$32,480.00	\$32,481.00 to \$48,720.00	\$48,721.00 to \$56,840.00
3	\$20,420.00 to \$40,840.00	\$40,841.00 to \$60,720.00	\$60,721.00 to \$71,470.00
4	\$24,600.00 to \$49,200.00	\$49,201.00 to \$73,800.00	\$73,801.00 to \$86,100.00
5	\$28,780.00 to \$57,560.00	\$57,561.00 to \$86,340.00	\$86,341.00 to \$100,730.00
6	\$32,960.00 to \$65,920.00	\$65,921.00 to \$98,880.00	\$98,881.00 to \$115,360.00
7	\$37,140.00 to \$72,280.00	\$72,281.00 to \$111,420.00	\$111,421.00 to \$129,990.00
8	\$41,320.00 to \$82,640.00	\$82,641.00 to \$123,960.00	\$123,961.00 to \$144,620.00

For each additional person add \$4180.00

2017 poverty Guidelines from the Federal Register

Family Size	
1	\$12,060.00
2	\$16,240.00
3	\$20,420.00
4	\$24,600.00
5	\$28,780.00
6	\$32,960.00
7	\$37,140.00
8	\$41,320.00

We encourage you to contact us with any questions you may have concerning your bill, establishing a payment plan or applying for financial assistance.

We can be reached by phone at 812-376-5315 or 1-800-841-4954, Monday to Friday between the hours of 8:00 am and 4:45 pm.

Columbus Regional Hospital

Patient Financial Services



COLUMBUS REGIONAL HOSPITAL

Instructions for completing the Financial Application

Please complete all lines on the application.

Return the completed application to Columbus Regional Hospital with the following:

1. Income tax return for the last years filing (1040) and current pay check stub. If you are self-employed a copy of the self-employment tax return is also needed.
2. If you did not file taxes last year but received a monthly benefit from Social Security, Disability or Unemployment, a copy of the award letter showing the monthly payment amount is needed. If you do not have an award letter, a copy of the bank statement showing the deposited amount is acceptable.

The application must be signed.

Failure to return the needed information may result in your request being denied.

Please feel free to contact us at 812-376-5315 or toll free 1-800-841-4954 if you have any questions or concerns.

Thank You
Patient Financial Services

2400 EAST 17TH STREET
COLUMBUS, INDIANA 47201
TELEPHONE 812.379.4441

Financial Application

Columbus Regional Hospital offers patients many different financial arrangements. This financial Application helps us make special arrangements and is completed by individuals who are in need of assistance with medical bills. Please complete the information completely. You may receive a call from a Financial Counselor within 2 business days or you can contact a Financial Counselor for follow-up at (812) 376-5315 or 1-800-841-4954.

Thank you for choosing Columbus Regional Hospital for your care.

Today's Date: _____/_____/_____ Hospital Account Number: _____ Amount of Bill \$ _____

Patient Name: _____

Please Return By: _____

Individual Responsible for Hospital Charges

Name _____ SS# x x x - x x - _____ Date of Birth _____/_____/_____

Spouse/Partner _____ SS# x x x - x x - _____ Date of Birth _____/_____/_____

Present Address _____

City _____ State _____ Zip Code _____

Phone (Home) (_____) _____ (Work)(_____) _____ (Cell)(_____) _____

Present Employer _____ Hours/Week&Rate _____

Spouse Employer _____ Hours/Week&Rate _____

Dependent Information

Number of Individuals in Household who are claimed as dependents on taxes.

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

Name _____ DOB _____ Name _____ DOB _____

DOB - Date of Birth

Continued on Back



ADM-179 (03/30/17) 2/s Terra Green

COLUMBUS REGIONAL HOSPITAL
 2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
 1-800-841-4938 812-379-4441
 www.crh.org

Financial Application

PATIENT LABEL
OR

Patient Name: _____

DOB: _____/_____/_____

MR #: _____

Income Information

Last Year's Annual Household Income \$ _____

Changes in income since last year? _____

If unemployed and not receiving any type of income, how are you meeting daily needs: _____

Other Income

Social Security \$ _____

SSI \$ _____

Retirement / Pension Income \$ _____

Unemployment \$ _____

Other (please specify) \$ _____

I am requesting financial assistance for the services I have received from Columbus Regional Hospital. I certify that the information I have submitted to Columbus Regional Hospital is true and accurate. I authorize Columbus Regional Hospital to verify the information contained herein, including the Credit Rating Bureau and employment. I understand that any information found to be misleading or untrue by Columbus Regional Hospital or its representative could result in immediate denial of financial assistance. I understand that I am responsible for account balances not covered by financial assistance.

Signature _____

Date ____/____/____

Spouse Signature _____

Date ____/____/____

Note: Financial assistance is granted using the information provided by the applicant with the understanding there is no insurance to cover the out of pocket expense for you. If there is insurance payment made at a later date (by insurance or through a legal settlement) payment will be accepted and applied to this adjustment as recovery.

Office Use Only Total Income _____
Total Expenditure _____
Balance _____

Financial Counselor _____

Date Approved _____



COLUMBUS
REGIONAL
HOSPITAL

**POLICY OF PATIENT
FINANCIAL
SERVICES
DEPARTMENT**

Policy Code:
Effective Date: **4-1-17**

Subject: Financial Assistance Policy

Purpose: To ensure that guidelines exist to determine eligibility and outline the application process. Financial Assistance is offered to uninsured, underinsured and medically indigent patients who indicate an inability to pay for emergency and other medically necessary services received at Columbus Regional Hospital.

RESPONSIBILITY: Financial Counselor/Team Leader

Policy:

Columbus Regional Hospital is committed to providing health care services regardless of a patient's ability to pay. Patients who express an inability to pay and who meet the policy's financial criteria will be covered under the Financial Assistance Policy.

Information concerning the Financial Assistance Policy at Columbus Regional Hospital can be found on the back of each patient statement, on the Columbus Regional Hospital web site at www.crh.org, in the Billing and Financial Assistance Guide found in multiple patient waiting areas around the hospital, by calling Patient Financial Services customer service representatives as 812-376-5315 or 1-800-841-4954, (Hours 8:00am to 4:45 pm, Monday through Friday). This policy is available in both English and Spanish. (1.501(r)(b)(3)(i)(A)).

- Qualification for Assistance is based on gross household income and the number of dependents claimed on tax filing for that household, whether filing jointly or individually. (1.501(r)(b)(1)(iii)(A)).
- Income is compared to the Columbus Regional Hospital guidelines. (See attached graph for income guidelines.)

Columbus Regional Hospital Financial Assistance Guidelines 2017

% Above Poverty Guidelines			
	0-200%	200% to 300%	300% to 350%
% of Write Off			
	100%	80%	60%
Family Size			
1	\$12,060.00 to \$24,120.00	\$24,121.00 to \$36,180.00	\$36,181.00 to \$42,210.00
2	\$16,240.00 to \$32,480.00	\$32,481.00 to \$48,720.00	\$48,721.00 to \$56,840.00
3	\$20,420.00 to \$40,840.00	\$40,841.00 to \$60,720.00	\$60,721.00 to \$71,470.00
4	\$24,600.00 to \$49,200.00	\$49,201.00 to \$73,800.00	\$73,801.00 to \$86,100.00
5	\$28,780.00 to \$57,560.00	\$57,561.00 to \$86,340.00	\$86,341.00 to \$100,730.00
6	\$32,960.00 to \$65,920.00	\$65,921.00 to \$98,880.00	\$98,881.00 to \$115,360.00
7	\$37,140.00 to \$72,280.00	\$72,281.00 to \$111,420.00	\$111,421.00 to \$129,990.00
8	\$41,320.00 to \$82,640.00	\$82,641.00 to \$123,960.00	\$123,961.00 to \$144,620.00
For each additional person add \$4180.00			

2017 poverty Guidelines from the Federal Register

Family Size	
1	\$12,060.00
2	\$16,240.00
3	\$20,420.00
4	\$24,600.00
5	\$28,780.00
6	\$32,960.00
7	\$37,140.00
8	\$41,320.00

- Columbus Regional Hospital guidelines are derived by using the Federal Poverty Guidelines. Income can be up to 350% over the Federal Poverty Guidelines and qualify. Columbus Regional Hospital Financial Assistance Policy is in compliance with Federal Regulations 1.501(r). Amounts Generally Billed is calculated using the look back method. (42%)
- Columbus Regional Hospital patients with out of pocket expense will be billed for a term of 120 days before listing with an outside collection agency. Exceptions are: establishing a payment plan or receipt of return mail that we are unable to obtain correct address information for.
- Patients may apply for assistance at any time within 240 days of the date of service.
- Listing an account balance with an outside collection agency may result in the outstanding debt being reported to credit bureaus. This will affect your credit rating.
- Once application is made Columbus Regional Hospital allows 30 days for the return of all information requested.
- Patients are provided with complete instructions on how to complete the application and what information is required to be returned with the application. (See below for list of required items).
- The financial application must be completed, signed and returned for review before approval can be made. Financial applications may still be considered if proof of extenuating circumstances exist that make returning the application unlikely.

- Patients are provided with the name and direct telephone number for their financial counselor for any questions or concerns they may have during the application process.
- The financial assistance policy applies to medically necessary services. Medical Necessity is determined by the examining physician determination.
- Not all services qualify for assistance. Excluded are: cosmetic services, bariatric surgery as well as 3 months pre-op and 3 month post-op bariatric services, hearing aids, and fertility services. Also excluded is motor vehicle accident pending lawsuits, or if CRH becomes aware that a settlement was paid direct to the patient and the patient has not paid CRH, those services will not be eligible for assistance.
- Information from Trans Union may be used to assist in the determination/approval process.
- If an applicant has been uncooperative anytime during the insurance billing or financial application/eligibility process, or knowingly provides incorrect/false information, the assistance may be limited or denied.
- Balances that have already been referred to an outside collection agency or established payment plan that are within 240 days of the application date will be considered for adjustment of current balance. Adjustment will be the same percentage as the financial application approval and will be taken against the current balance of the bad debt encounter or remaining amount of the payment plan. (Refunds will not be made on encounters already placed at a collection agency or established payment plan.)
- Encounters that have a current balance in AR (not bad debt) will be reviewed for possible refund of patient payment. The approved percent will be applied to the patient out of pocket expense. Depending on the percent of approval, the patient may or may not have a remaining balance. Any payment the patient has previously made will be applied towards any remaining balance (If not approved for 100%) thus any overage that may be created after approval adjustment will be refunded to the patient.
- Medicaid patients with coverage lapses or copays may be referred for financial assistance or may qualify for assistance adjustment on current AR balances, as they meet financial guidelines for government assistance.
- Patients that are currently Medicaid approved (includes PE approval) and have past encounters that are not eligible may be considered for assistance. Balances in AR must be within 240 days of the date of Medicaid approval. Balances in BD (already placed with a collection agency) are not eligible for adjustment.
- Patients that qualify for HIP (Healthy Indiana Plan) may be considered for financial assistance on current AR balances, for services not covered by HIP or for co-pay/out of pocket balances left for the patient by the HIP program. Balances already placed in BD are not eligible.
- In some cases, the Hospital may have established before discharge, or within a reasonable time before or after current admission, that the patient is either indigent or medically indigent. The Hospital can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals respectively. Otherwise, the Hospital should apply its customary methods of determining eligibility for assistance.
- Patients that are found to be incarcerated may be considered eligible for financial assistance.
- Patients that indicate they are homeless may be considered eligible for financial assistance.
- Patients that file for bankruptcy may be considered eligible for financial assistance once notice of filing has been received from bankruptcy court/attorney.
- Financial assistance approvals are valid for 12 calendar months from date of application. (There are some exceptions for case by case reviews).
- If financial assistance is denied a patient may reapply at any time.
- Every attempt will be made to get uninsured patients signed up for coverage (Medicaid/HIP/Market Place coverage)
- Patients that cannot provide a valid U.S. social security number will be considered for approval on out of pocket expenses only for medically necessary or emergency services received at Columbus Regional Hospital. It is also required to complete a financial statement and provide any household size and income information possible.

- Any patient receiving assistance approval will have the right to appeal the decision if they disagree with the determination. Patients will need to notify their financial counselor with their disagreement & request additional review/consideration. The patient may be asked to provide additional information to support their request.

Deceased Patients

- Patients that are deceased may be eligible for financial assistance adjustment. Consideration will be made if family members do not accept financial responsibility or state there are not sufficient funds to pay. The financial counselor will attempt to verify if an estate is intended to be opened. If the family of the deceased advises they do not intend to open an estate the financial application and instructions will be provided. The deceased family will be given instructions in writing that the application will be reviewed as usual, and if approved will adjust the balance accordingly. However if it is found that an estate is opened at a later time CRH will file the balance against the estate and recover funds if possible. A copy of the death certificate should be obtained and scanned to the encounter. (Note- if an estate opened a claim will be filed to that estate and funds recovered).
- NOTE – the surviving spouse may apply for assistance. If it is found that they are over income to be approved for assistance, it may be deemed that payment can be made for the deceased patient balances also.

Presumptive Eligibility

Columbus Regional Hospital may presume patients eligible for financial assistance under certain circumstances. For patients that express a financial need that are unable to provide completed application, other information may be used to make an assessment of financial need. (Trans Union, history of encounter balances at Columbus Regional Hospital, qualified for other programs such as WIC, Food Stamps or subsidized housing, etc.). In these cases CRH representatives may presume a patient eligible for assistance without other documentation. This presumptive eligibility may be used in the following type cases: A patient that will not or cannot provide any/all information and has outstanding balances in bad debt that cannot be/are not being paid. A patient that cannot return any/all documentation due to medical condition and has no family to aide them with the process. When return mail is received and it is discovered that the patient has moved/or returned to an out of country residence. A patient that has out of pocket expense that is equal to or exceeds \$20,000.00 may be considered for assistance due to extreme hardship. These patients may or may not have a history of BD accounts (accounts places with a collection agency). A parent/responsible party that do not have Medicaid/HIP coverage but their dependents do have Medicaid/HIP coverage may be considered. (1.501(r)(b)(1)(iii)(E)).

Trans Union Medical Credit Scoring Grid:

Score of 500 or below	100% assistance
Score of 501 to 600	80% assistance
Score of 601 to 800	60% assistance

Patients that are granted presumptive assistance will be notify of the presumed need and the percentage approved for. Patients will be advised in this notification that if they disagree with the amount approved they can make an appeal for additional review for additional approval. Patient may be asked to provide additional information to support their request.

Catastrophic Event

Patients may also qualify for assistance for services resulting from a catastrophic event. The catastrophic event would be for services of an un-expected nature that leave the patient with out of pocket

expenses that exceed 20% of their annual income. Approval would be for the catastrophic event services only. Other services not related to the catastrophic event would not qualify under this clause.

Patients that have out of pocket of 20% or more of their annual income will be assessed as followed:

Annual income of up to \$50,000.00:	pay 10% of the out of pocket expense.
Annual income of \$50,001.00 to \$75,000.00:	pay 15% of the out of pocket expense.
Annual income of \$75,000.01 or more:	pay 20% of the out of pocket expense.

Examples of catastrophic events: Cardiac event resulting in cardiac/open heart surgery and rehab, Cancer diagnosis resulting in long term chemo/radiation therapy and medications, accidents that require long term rehab/therapy that it has been determined there is no insurance to pay or insurance has exhausted benefits and there are no law suit settlements pending currently or in the future.

****Assistance granted within this policy applies to services at Columbus Regional Hospital and Physicians in the Columbus Regional Health system. (1.501(r)(b)(1)(iii)(F)).**

Information and documentation required for application:

- Copy of previous year's income tax return. (1040 form)
- Current pay check stubs.
- If the patient did not file taxes due to income level and receives a monthly benefit (social security, disability or unemployment) a copy of the awarded amount must be obtained. Acceptable proof of benefit is, letter showing the amount awarded or a bank statement showing the monthly deposited amount.
- If the patient did not file taxes for any other reason, this must be documented on the patient file as to why this information cannot be obtained.
- As determination is based on household income both spouse's/partner's must sign the financial statement
- Completed Financial Statement signed by all applicants. (Excludes underage dependents).
- Documentation of household size & income.
- Additional information of W2's or pay check stubs may be requested. (1.501(r)(b)(3)).

****Note:** Financial assistance is granted using the information provided by the applicant with the understanding there is no insurance to cover the out of pocket expense for you. If there is insurance payment made at a later date (by insurance or through a legal settlement) payment will be accepted and applied to this adjustment as recovery.

Author: W Moore