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, 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") or both.

(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, 3/18

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
2018 Poverty Guidelines / Sliding Scale Table

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	100%	$ 12,060	100%	0%
2	$ 16,240	100%	$ 16,240	100%	0%
3	$ 20,420	100%	$ 20,420	100%	0%
4	$ 24,600	100%	$ 24,600	100%	0%
5	$ 28,780	100%	$ 28,780	100%	0%
6	$ 32,960	100%	$ 32,960	100%	0%
7	$ 37,147	100%	$ 37,147	100%	0%
8	$ 41,320	100%	$ 41,320	100%	0%

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	200%	$ 24,120	100%	0%
2	$ 16,240	200%	$ 32,480	100%	0%
3	$ 20,420	200%	$ 40,840	100%	0%
4	$ 24,600	200%	$ 49,200	100%	0%
5	$ 28,780	200%	$ 57,560	100%	0%
6	$ 32,960	200%	$ 65,920	100%	0%
7	$ 37,147	200%	$ 74,294	100%	0%
8	$ 41,320	200%	$ 82,640	100%	0%

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	225%	$ 27,135	80%	20%
2	$ 16,240	225%	$ 36,540	80%	20%
3	$ 20,420	225%	$ 45,945	80%	20%
4	$ 24,600	225%	$ 55,350	80%	20%
5	$ 28,780	225%	$ 64,755	80%	20%
6	$ 32,960	225%	$ 74,160	80%	20%
7	$ 37,147	225%	$ 83,581	80%	20%
8	$ 41,320	225%	$ 92,970	80%	20%

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	250%	$ 30,150	60%	40%
2	$ 16,240	250%	$ 40,600	60%	40%
3	$ 20,420	250%	$ 51,050	60%	40%
4	$ 24,600	250%	$ 61,500	60%	40%
5	$ 28,780	250%	$ 71,950	60%	40%
6	$ 32,960	250%	$ 82,400	60%	40%
7	$ 37,147	250%	$ 92,868	60%	40%
8	$ 41,320	250%	$ 103,300	60%	40%

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Addendum 1 (Cont.)
2018 Poverty Guidelines / Sliding Scale Table

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	275%	$ 33,165	40%	60%
2	$ 16,240	275%	$ 44,660	40%	60%
3	$ 20,420	275%	$ 56,155	40%	60%
4	$ 24,600	275%	$ 67,650	40%	60%
5	$ 28,780	275%	$ 79,145	40%	60%
6	$ 32,960	275%	$ 90,640	40%	60%
7	$ 37,147	275%	$ 102,154	40%	60%
8	$ 41,320	275%	$ 113,630	40%	60%

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	300%	$ 36,180	20%	80%
2	$ 16,240	300%	$ 48,720	20%	80%
3	$ 20,420	300%	$ 61,260	20%	80%
4	$ 24,600	300%	$ 73,800	20%	80%
5	$ 28,780	300%	$ 86,340	20%	80%
6	$ 32,960	300%	$ 98,880	20%	80%
7	$ 37,147	300%	$ 111,441	20%	80%
8	$ 41,320	300%	$ 123,960	20%	80%

Family Size	2018 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,060	325%	$ 39,195	0%	100%
2	$ 16,240	325%	$ 52,780	0%	100%
3	$ 20,420	325%	$ 66,365	0%	100%
4	$ 24,600	325%	$ 79,950	0%	100%
5	$ 28,780	325%	$ 93,535	0%	100%
6	$ 32,960	325%	$ 107,120	0%	100%
7	$ 37,147	325%	$ 120,728	0%	100%
8	$ 41,320	325%	$ 134,290	0%	100%

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Addendum 2
2018 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