FINANCIAL ASSISTANCE/CHARITY CARE
INFORMATION

POLICY STATEMENT:

In order to serve the health care needs of our community, Lancaster Regional Medical Center will provide financial assistance/charity care to patients without financial means to pay for Inpatient, Observation and Emergency Room hospital services.

Financial Assistance/Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent according to the hospital’s eligibility criteria.

If there are state specific laws that conflict with any portion of this policy, those sections have been identified and edited to comply with said law. In addition, attached to this policy are copies of each law as verification of requirements.

PURPOSE:

To properly identify those patients who are financially indigent, who do not qualify for state and/or government assistance, and to provide assistance with their Inpatient and Emergency Room medical expenses under the guidelines for Financial Assistance/Charity Care.

ELIGIBILITY FOR FINANCIAL ASSISTANCE/CHARITY CARE

1. FINANCIALLY INDIGENT:

   A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital’s eligibility criteria as set forth in this Policy.

   B. To be eligible for charity care as a financially indigent patient, the patient’s total household income shall be at or below 100% of the current Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities for the person when determining eligibility.

   C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual’s eligibility for charity care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or
February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 100% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

E. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for charity upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. No other documents will be required in order to approve the charity application. The patient will not be required to make a formal financial assistance/charity application. The hospital may submit the application and verification of Medicaid coverage as proof of qualification.

2. **MEDICALLY INDIGENT:**

   A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person’s annual gross income and who is unable to pay the remaining bill.

   B. Patients covered under state Medical Assistance programs that owe copayments or have a ‘spend down’ amount are excluded from being considered for financial assistance/charity care. Payment of copayments and spend down amounts are a condition of coverage and should not be written off or discounted.

   C. Medically indigent patients are not eligible for charity care due to having third party coverage for their medical bills.

1. **FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION**

   A. The following factors are to be considered in determining the eligibility of the patient for charity care:

   1. Gross Income
   2. Family Size
   3. Employment status and future earning capacity
   4. Other financial resources
   5. Other financial obligations
   6. The amount and frequency of hospital and other medical bills
B. The income guidelines necessary to determine the eligibility for charity are attached on Exhibit “B”. The current Federal Poverty Guidelines are attached as Exhibit “C” and they include the definition of the following:

1. Family
2. Income

2. FAILURE TO PROVIDE APPROPRIATE INFORMATION

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.
B. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

3. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.
Exhibit A
Financial Assistance Form
Lancaster Regional Medical Center
Charity Care/Financial Assistance Program Application
Page 1 of 2

Patient Account Number: ___________________________ Date of Application ____________

PATIENT INFORMATION

Name___________________________________________
Address________________________________________
City____________________________________________
State/Zip________________________________________
SS#____________________________________________
Employer________________________________________
Address________________________________________
City____________________________________________
State/Zip________________________________________
Work Phone______________________________
Length of Employment_____________________
Supervisor______________________________

PARENT/GUARANTOR/SPOUSE

Name___________________________________________
Address________________________________________
City____________________________________________
State/Zip________________________________________
SS#____________________________________________
Employer________________________________________
Address________________________________________
City____________________________________________
State/Zip________________________________________
Work Phone______________________________
Length of Employment_____________________
Supervisor______________________________

RESOURCES

Checking: yes___ no___ Vehicle 1: Yr______ Make________ Model________
Savings: yes___ no___ Vehicle 2: Yr______ Make________ Model________
Cash on hand: $_____________
Vehicle 3: Yr______ Make________ Model________
INCOME

<table>
<thead>
<tr>
<th>Patient/Guarantor:</th>
<th>Spouse/Second Parent:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages (monthly):</td>
<td>Wages (monthly):</td>
</tr>
<tr>
<td>Other Income:</td>
<td>Other Income:</td>
</tr>
<tr>
<td>Child Support:</td>
<td>Child Support:</td>
</tr>
<tr>
<td>VA Benefits:</td>
<td>VA Benefits:</td>
</tr>
<tr>
<td>Workers’ Comp:</td>
<td>Workers’ Comp:</td>
</tr>
<tr>
<td>SSI:</td>
<td>SSI:</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

LIVING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Rent</th>
<th>Own</th>
<th>Other (explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Landlord/Mortgage Holder:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Monthly payment $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

- **Proof of Income:** Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

- **Proof of Expenses:** Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

**The Hospital reserves the right to pull a copy of your credit report.**

Signature of Applicant

________________________________________

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Exhibit B  
Income Guidelines For Determining % of Charity Care Discount  
(For Financially Indigent Patients)  

Based on Current Year's Federal Poverty Income Guidelines  

<table>
<thead>
<tr>
<th>% of Poverty Income</th>
<th>Discount from charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal to or Below Poverty</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Exhibit C

**Federal Poverty Income Guidelines 2016**

Reference: Federal Register: January 25, 2016, Volume 81, Number 15 pp. 4036-4037

#### The 2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,880</td>
</tr>
<tr>
<td>2</td>
<td>16,020</td>
</tr>
<tr>
<td>3</td>
<td>20,160</td>
</tr>
<tr>
<td>4</td>
<td>24,300</td>
</tr>
<tr>
<td>5</td>
<td>28,440</td>
</tr>
<tr>
<td>6</td>
<td>32,580</td>
</tr>
<tr>
<td>7</td>
<td>36,730</td>
</tr>
<tr>
<td>8</td>
<td>40,890</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $4,160 for each additional person.

#### 2016 Poverty Guidelines for Alaska

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$14,840</td>
</tr>
<tr>
<td>2</td>
<td>20,020</td>
</tr>
<tr>
<td>3</td>
<td>25,200</td>
</tr>
<tr>
<td>4</td>
<td>30,380</td>
</tr>
<tr>
<td>5</td>
<td>35,560</td>
</tr>
<tr>
<td>6</td>
<td>40,740</td>
</tr>
<tr>
<td>7</td>
<td>45,920</td>
</tr>
<tr>
<td>8</td>
<td>51,120</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $5,200 for each additional person.

Charity Care Policies to use the new income guidelines effective February 1st, as well as any other polices that use the Federal Poverty Income Guidelines (FPI). As noted in the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the Federal poverty income guidelines (FPI). The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program. To find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.