



CONWAY MEDICAL CENTER

POLICY

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

POLICY TITLE:	CONWAY MEDICAL CENTER FINANCIAL ASSISTANCE POLICY		
ISSUED BY:	Patient Financial Services	REFERENCE #:	PFS-001-POL
APPROVED BY:	Director of Patient Financial Services and CFO	EFFECTIVE DATE:	11/14/95 Last Revision 9/28/16

SCOPE: Conway Medical Center and Conway Medical Center- Owned Physician Practices

DEFINITIONS:

Affiliate: includes Conway Medical Center and any wholly-owned entity or an entity operated under the Conway Medical Center name.

Application Period: the period that begins on the date the care is provided to an individual and ends on the 240th day after the individual is provided with the first billing statement for the care.

Conway Medical Center: In the policy, references to “Conway Medical Center” include physician practices owned by Conway Medical Center.

Financial Assistance: Services needed to treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine, which, if not promptly treated, would lead to an adverse change in the health status.

Entitlement Program: a government program guaranteeing certain health care benefits to a segment of the population. This does not include the healthcare exchange established by the Affordable Care Act.

Family: Includes husband, wife, and any children (including stepchildren) that live in the home and are qualifying dependents for tax purposes.

Income: Annual family earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

Medically Necessary Services: Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of a patient.

Plain Language Summary: A written statement that notifies an individual that the Conway Medical Center offers Financial Assistance under this Policy and provides the following additional information in language that is clear, concise, and easy to understand:

- brief description of the eligibility requirements and assistance offered under this Policy;
- a brief summary of how to apply for assistance under this Policy;
- the direct website address (or URL) and physical locations where the individual can obtain copies of this Policy and application form;
- instructions on how the individual can obtain a free copy of this Policy and application form;
- the contact information, including telephone number and physical location, of the facility office or department that can provide information about this Policy and either the office or department that can provide assistance with the application or a nonprofit or governmental agency that can provide assistance;
- a statement of the availability of translations of this Policy, application and Plain Language



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Summary in other languages, if applicable, and

- a statement that a Financial Assistance eligible individual may not be charged more than the amount generally billed to individuals with insurance covering the same emergency care or other medically necessary care.

Service Area – Defined and consistently applied by Conway Medical Center and includes 80-90% of their patients. Area includes Horry and surrounding and neighboring counties.

POLICY STATEMENT:

The Conway Medical Center's mission is to improve the overall health of our communities. This reflects Conway Medical Center's not-for-profit heritage and social accountability to the communities in which we are located. Conway Medical Center and affiliates will provide charity care (free care) for qualified low-income patients. This service, along with other community benefit services, is essential to Conway Medical Center's mission fulfillment.

The purpose of this policy is to establish the criteria and conditions for providing charity care to patients whose financial status makes it impractical or impossible to pay for emergency or medically necessary services. This policy does not cover elective services. Individuals who meet the eligibility criteria established in this policy qualify to receive free care for emergency or medically necessary services. Confidentiality of information and individual dignity will be maintained for all who seek assistance under this Policy.

The Conway Medical Center's Executive Leadership and/or the Conway Medical Center Board of Directors must approve any modification of this policy.

POLICY REQUIREMENTS:

I) Eligibility for Charity Care

A) Service Area

- 1) Hospital patients: residents within the Conway Medical Center service area are eligible to apply for Charity Care, as defined in this Policy.
- 2) Hospital-Owned Physician Practices patients: patients must live in the Conway Medical Center service area.
- 3) Hospital Patients and Hospital-Owned Physician Practice Patients: patients outside the applicable Conway Medical Center service area will be reviewed and approved by the Patient Financial Services Director and/or designees.

B) Income: The patient must be uninsured, be unable to access Entitlement Programs, have annual family income less than or equal to 200% of the available current year Federal Poverty Guidelines and must be without substantial liquid assets (i.e. cash-on-hand). Coverage of insured parties shall only be granted in limited circumstances upon management's review and approval of all Charity Care documents.

C) Covered Services: Covered Services include emergency and Medically Necessary Services received at Conway Medical Center or Conway Medical Center-Owned Physician Practices



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- For patients of Conway Medical Center-Owned Physician Practices, Covered Services are determined by physician evaluation. Covered Services do not include cosmetic, elective, non-urgent tests, services or procedures, fertility services or experimental treatments. In the case of Conway Medical Center Physician-Owned practices, prescription medication.
- D) Other Health Coverage: Patients, who are known to have chosen not to participate in employer sponsored health plans and / or not eligible for government sponsored health coverage due to non-compliance with program requirements, are not eligible for Financial Assistance under this Policy.
- E) Special Circumstances. Deceased patients without an estate or third party coverage may be considered for Financial Assistance eligibility. Patients who are in bankruptcy may also be eligible for Financial Assistance.
- II) Application: An application (see attached application) providing all supporting data required to verify Financial Assistance eligibility will be completed by the patient and returned to a financial counselor at the hospital. Patients without an income source should supply a letter of support stating their need for Financial Assistance consideration based on their current financial situation. Letters should at a minimum state that the patient has no supporting financial documentation to supply. (See Section VI below.) Applications will be maintained in the hospital and provided to individuals requesting Financial Assistance or identified as potential candidates for Financial Assistance. Applications are available in English and Spanish. Assistance may be provided in completing the application by contacting a financial counselor at one of the following phone numbers: 843-347-8072 or 843-234-6726.
- III) Determination Based Upon Application: Once complete documents are received and an eligibility determination has been made, a notification letter will be sent to each applicant advising them of the hospital's decision. If the patient meets eligibility requirements, they will be designated as eligible to receive Financial Assistance. Patients who submit incomplete applications and/or do not provide supporting documentation will be contacted via phone or mail.
- IV) Providers Delivering Emergency and Medically Necessary Care: Conway Medical Center maintains a list of providers that deliver emergency or other medically necessary care in the facility, which identifies which providers are covered under this Policy ("List of Providers"). This list may be updated on a regular basis without approval by the facility governing board. A List of Providers may be obtained through Conway Medical Center's website <http://www.conwaymedicalcenter.com> or by contacting a financial counselor at one of the following phone numbers: 843-347-8072 or 843-234-6726.
- V) Eligibility Period: The Financial Assistance application and documentation must be updated every six months, or at any time during that six month period the patient's family income or insurance status changes to such an extent that the patient becomes ineligible. Each visit within the six month period will be reviewed for potential access to other Entitlement Programs.
- VI) No Supporting Financial Documentation: Patients without an income source may be eligible if they do not have a job, mailing address, residence or insurance. Consideration must also be given to patients who do not provide adequate information as to their financial status. Patients



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without an income source should supply a letter of support stating their need for Financial Assistance consideration based on their current financial situation. Letters should at a minimum state that the patient has no supporting financial documentation to supply. Financial Assistance may not be denied under this Policy based on an applicant's failure to provide information or documentation that this Policy or application form does not require an individual to submit.

- VII) Billing and Collection Actions:** For information regarding Conway Medical Center's billing and collection activities please see the Conway Medical Center Billing and Collections Policy. A copy of the policy may be obtained through Conway Medical Center's website, <http://www.conwaymedicalcenter.com> or by contacting a financial counselor at one of the following phone numbers: 843-347-8072 or 843-234-6726
- VIII) Effective Date of Financial Assistance:** While it is desirable to determine a patient's eligibility for Financial Assistance as close to the time of service as possible, so long as the patient submits the required documentation within the Application Period, Financial Assistance will be provided.
- IX) Record Keeping:** Records relating to potential Financial Assistance patients must be readily obtained for use. Document images related to Financial Assistance are accessible at the account or medical record level of the patient for retrieval.
- X) Conway Medical Center Revenue Cycle:** Application documentation is scanned to the Patient's E.H.R. (Electronic Health Record).
- XI) Charges:** No Financial Assistance-eligible individual will be charged for emergency or other medically necessary care under this Policy. If Conway Medical Center were to charge for emergency or other medically necessary care under this Policy, it would use the look-back method and would include Medicaid fee for service and all private health insurers to determine amounts generally billed ("AGB") and would not charge a Financial Assistance-eligible individual more than AGB.
- XII) Financial Assistance Budget:** The availability of Financial Assistance may be limited based upon Conway Medical Center's budget or other financial constraints, which would impact the ability of Conway Medical Center to remain financially viable.
- XIII) Public Notice and Posting:** Conway Medical Center will make available to the public information about the assistance provided in this Policy as follows:
- A) This Policy, the application and a Plain Language Summary shall be available on Conway Medical Center's website;
 - B) Paper copies of this Policy, the application and a Plain Language Summary shall be available upon request and without charge, both by mail and in public locations throughout Conway Medical Center, including at a minimum the ER and admissions areas;
 - C) Financial Assistance brochures, which inform the reader about the Financial Assistance available under this Policy, how to obtain more information about this Policy and the application process, and how to obtain copies of this Policy, the application and a Plain Language Summary, will be available at Conway Medical Center-Owned Physician Practices.
 - D) Patients shall be offered a paper copy of the Plain Language Summary as part of the intake or discharge process;
 - E) Billing statements will have a conspicuous notice on them to inform the reader of this Policy,



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as set forth in more detail in Conway Medical Center’s Billing and Collections Policy; and

F) Conspicuous public displays that notify and inform patients of this Policy will be displayed in public locations throughout Conway Medical Center, including at a minimum the ER and admissions areas.

XIV) Accessibility to LEP Individuals: Conway Medical Center shall make this Policy, the application form and the Plain Language Summary available to all significant populations that have limited English proficiency (“LEP”). To determine whether a population is significant, Conway Medical Center will use a reasonable method to determine LEP language groups within a Conway Medical Center Service Area.

XV) Availability of Policy and Related Documents: For hospital patients, a copy of this Policy, Plain Language Summary, an application, the List of Providers and the Billing and Collections Policy may be obtained by:

- A) Visiting the Conway Medical Center website at <http://www.conwaymedicalcenter.com>
- B) Visiting the Financial Counseling office at Conway Medical Center.
- C) Calling Financial Counselors at: 843-347-8072 and 843-234-6726

XVI) EXCLUSIONS: This policy only applies to services rendered at Conway Medical Center and Affiliates and does not apply to services rendered by any independent physicians or practitioners. This policy also does not apply to services provided within or outside the hospital/facility by physicians or other healthcare providers including but not limited to Anesthesiologists, Radiologists, Pathologists, Psychiatrists and/or Teleconsultants who are not employed by Conway Medical Center.

RECORDS: Financial Assistance Application (see application below)

REFERENCE STANDARDS:

- I) 501(r)
- II) Plain Language Summary
- III) Billing and Collection Policy

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
09/28/16	All	Reviewed, completely revised in accordance with 501(r), new format
11/07/02	All	Reviewed
05/11/01	All	Reviewed
09/14/00	All	Reviewed
01/22/97	All	Reviewed
08/21/96	All	Reviewed
03/12/96	All	Reviewed
11/14/95	All	Reviewed



Financial Assistance Application

INSTRUCTIONS

- ❖ Complete copy of Federal Tax Return Form 1040 including W-2's. If you are self-employed, a Schedule "C" must be included. Please provide all schedules which are applicable.
- ❖ If married, two (2) current paystubs for patient and spouse. If separated from spouse, please provide notarized letter.
- ❖ Submit copies of your last two (2) bank statements.
- ❖ Proof of Alimony or Child Support.
- ❖ Proof of Monthly amount of Food Stamps.
- ❖ Proof of Unemployment Income.
- ❖ If you are a full time student, proof of financial aid and/or student loans. If your parents claim you as a dependent on their tax return, we will need a copy of your parents' current tax return, paystubs and current bank statements.
- ❖ If receiving Social Security, a letter showing monthly amount for each person receiving it.
- ❖ If another person is helping with your expenses such as rent or food, we will require detailed documentation.
- ❖ You must be screened for Medicaid and provide us with an approval or a denial. This can be done with the on-site hospital eligibility workers at 843-234-6958 or 843-347-8183. You may also contact the Conway DHHS at 1201 Creel Street, Conway, SC. or by phone at 1-888-549-0820.
- ❖ If your accounts are the result of a motor vehicle accident, and there is a possible settlement, no financial assistance will be available.
- ❖ Please complete, sign and date the application and attach all supporting documentation requested. All information will be verified. An incomplete application will be denied.

**PLEASE RETURN TO: CONWAY MEDICAL CENTER
INTERNAL MAIL BOX #59
PO BOX 829,
CONWAY, S.C. 29528-0829**



Financial Assistance Application

Date: _____

Patient Information

Account Number(s) _____

Patient Name: _____ Date of Birth: _____ SS#: _____

Spouse or Guarantor Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____ Years/months at residence: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Household Information

Member Name	Age	Relationship	Employer	Annual Gross Income
		SELF		\$
				\$
				\$
				\$
				\$

Total Family Size: _____ Total Dependents: _____ Total Household Income: \$ _____

Screening Information:

- ❖ Do you currently have health insurance? (Y/N) _____ If yes, please provide insurance info below:
 - Insurance Name: _____ Policy # _____
 - Group Name/Number: _____
- ❖ Have you had health insurance that has been terminated in the past 3 months? (Y/N) _____ If yes, complete the following:
 - What type of insurance? (i.e. Medicaid, BCBS, Tricare, etc.) _____
 - Reason for insurance termination? _____
 - Did you apply for COBRA coverage? (Y/N) _____
 - If so, when? _____
 - Former Employer Name: _____
- ❖ Are you active duty or retired military? (Y/N) _____ ❖ If so, are you eligible for VA Benefits? (Y/N) _____
- ❖ Have you applied for Medicaid or SSI Disability? (Y/N) _____ If yes, complete the following:
 - When? _____ ❖ Where? _____
 - Caseworker? _____
 - Has your household or income status changed since you last applied? (Y/N) _____
- ❖ Were you a victim of a crime? (Y/N) _____ If yes, complete the following.
 - Have you filed a Police Report? (Y/N) _____ (Must be filed within 72 hrs of incident)
 - Completed Victim of Crime application? (Y/N) _____
- ❖ If you have any other special circumstances which you would like us to consider when reviewing your application, please explain below:



Financial Assistance Application

Financial Assessment

Account Number(s) _____
 Patients Name _____ Date: _____

Monthly Expenses

Rent/Mortgage \$ _____
 Utilities \$ _____
 Food \$ _____
 Cell Phone/Pager \$ _____

 Cable \$ _____
 Auto Loan \$ _____
 Auto Insurance \$ _____
 Loans \$ _____
 Child Support \$ _____
 Credit Cards (Min.Payment) \$ _____
 Other \$ _____
 \$ _____
 \$ _____

Assets

Checking Account(s) \$ _____
 Savings Account(s) \$ _____
 Other Cash Assets \$ _____
 Credit Cards (Available Credit) \$ _____

Monthly Gross Income

Employment Income \$ _____
 Spouse Income \$ _____
 Retirement Income \$ _____
 Food Stamps \$ _____
 Government Benefits \$ _____
 Child Support \$ _____
 Other \$ _____

Total Expenses \$ _____

Total Income \$ _____

TOTAL MONTHLY INCOME \$ _____

TOTAL MONTHLY EXPENSES \$ _____

AMOUNT AVAILABLE \$ _____

Patient/Guarantor Certification

I, _____, CERTIFY the information I have provided is true and accurate to the best of knowledge. I understand that if I do not cooperate with the hospital in supplying ANY additional requested information; my application may be denied for possible financial assistance. I understand that the information which I submit is subject to verification by the HOSPITAL, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I understand that this application pertains to hospital charges and not physician's charges. I understand that if any information I have given proves to be untrue, the HOSPITAL will re-evaluate my financial status and take whatever action becomes appropriate. I am also aware that I am only applying for the accounts specified above, and that my financial status will have to be reevaluated and may require a new application for any/all future treatment I receive at Conway Medical Center, Inc.

 Patient/Guarantor Signature

 Date

For Office Use Only	
Reviewed by: _____ Date _____ Recommendation: Percentage Approved: _____% D Indigent D Denied: Reason _____	Approved : _____ _____ Date _____ _____ Date _____ _____ Date _____



Financial Assistance Application

Additional Financial Documentation

(Only complete when applicable)

Account Number(s) _____

Patients Name _____ Date: _____

_____ **Support Statement:**

My signature will certify that I, _____, do provide all necessary essentials for living for the patient's behalf, and have done so for a period of _____ years / months.

Signature of Patient's Supporter

Relation to Patient

Date

_____ **Homeless Affidavit**

I, (PRINT NAME) _____ hereby certify that I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.

Signature

Date

_____ **No Changes to Financial Status since Previous Application for Assistance**

I, (PRINT NAME) _____ hereby certify there have been no changes to my (nor my spouse's) financial status since my previous application for financial assistance from Conway Medical Center which was completed on _____. Please select of the following options:

- D I am still being supported by another. They do provide all necessary essentials for living for my behalf, and have done so for a period of _____ years/months.
- D I am still homeless. I am homeless, have no permanent address, no job, savings, or assets and no income other than donations from others.
- D There are no changes to my (or my spouse's) income or household size since my previous application.

Signature

Date