OLYMPIA MEDICAL CENTER

Title:	Discount Program Policy	File Under:	Admit
Manual:	Admitting/ Business Office Policy and Procedure	Page:	1of 8
Scope:	Admitting	Eff. Date:	1/08
Written By:	Lori Casillas	Updated:	4/11
Admin. Team		CEO	

I. PURPOSE

To provide discounted healthcare to patients treated at Olympia Medical Center (OMC) that have a limited ability to pay for their care.

II. POLICY

Olympia Medical Center is committed to providing high quality, comprehensive health care services, regardless of a patient's ability to pay. OMC strives to ensure the financial situation of people who need health care services and does not prevent them from seeking or receiving care. Discount care is not considered to be a substitute for personal responsibility and patients are expected to cooperate with OMC's procedures for obtaining financial assistance and to contribute to the cost of their care based on individual ability to pay.

The determination of discount care generally should be made at the time of admission, or shortly thereafter. However, events after discharge could change the patient's ability to pay.

Discount Rate Program
The discount amount is based on household income compared to the Federal Poverty Limit (FPL) for the current year. Uninsured or Under-insured patients with household income between 201%- 350% FPL will be eligible for care at a sliding scale discount (see Attachment C). Uninsured patients whose family income exceeds 350% FPL will receive a discount flat rate.

Charity Care Program
Patients with family income under 200% FPL will be eligible for free care for the dates of service for which an application is completed. Refer to the Charity Care Policy for additional information.

III. DEFINITION

A. Under-insured Patients
An "under-insured patient" is an insured patient with "high medical costs". These are insured patients whose family income does not exceed 350% of the FPL and has either (1) incurred or whose family has incurred annual out-of-pocket costs at the hospital that exceed 10% of the patient's family income in the prior 12 months or (2) incurred or whose family has incurred annual out-of-pocket costs with other

providers that exceed 10% of the patient's family income in the prior 12 months. Patients must provide documentation of out-of-pocket costs incurred at providers.

IV. PROCEDURE

A. Factors to be Considered

Factors to be considered in determining eligibility for discounted care must include comparing the patient's gross income to the annually published Federal Poverty Guideline (FPG), or an equivalent thereof. This information may be obtained through verbal means from the patient/guarantor and documented by a specifically designated OMC employee (i.e. Financial Counselor).

Other factors may include, but not limited to, the following:

1. Validate means of support if unemployed and no earned or unearned income have been provided on the Confidential Financial Assistance Application.
2. Validate activity on current accounts reported on credit bureau to determine how payments are being made if household expenses exceed income reported on the Confidential Financial Assistance Application.
3. Expired Patients- Expired patients may be deemed to have no income for purposes of the OMC calculation of income if there is no surviving spouse or no other guarantor appears on the patient's account. Although no documentation of income and no Confidential Financial Assistance Application are required for expired patients, the patient's financial status will be reviewed at the time of death by OMC to ensure that a discount care adjustment is appropriate and an estate or probate do not show liquid assets in excess of $10,000. If the estate or probate exceeds $10,001, the patient will not qualify for discount care. The estate will be pursued for reimbursement on debts owed.
4. International patients are considered on a case-by-case basis for ER treatment and or ER admission only.
5. Catastrophic illness and documented hardship within the hospital may also be considered for Charity Care or discounted care.

B. Documentation

1. Confidential Financial Assistance Application
   a) A Confidential Financial Assistance Application completed by the patient may not be required for patients who are deemed to be already eligible for other federal, state and county assistance programs (i.e. Medi-Cal, VOVC).

   b) In order to qualify for discounted care, OMC requires each patient or family to complete the application. The application allows the collection of information about income and the documentation of other requirements as defined below:
      (i) **Family Members**- OMC will require patients to provide the number of family members in their household.

a) Adults- To calculate the number of family members in an adult patient's household, include the patient, the spouse and or legal guardian, all of their dependent children under 21 years of age, whether living at home or not.

b) Minors- To calculate the number of family members in a minor patient's household, include the patient, the patient's mother/father, legal guardian and or caretaker relative, and all of their other dependents under 21 years of age.

(ii) **Income Calculation**- OMC requires patients to provide their household annual gross income.

a) Patient's household income includes all funds received by all members of the patient's household that support the household.

b) Household is defined as patient, patient's spouse or domestic partner, and all dependents living in the same residence as the patient and/or guarantor.

c) A dependent is defined as a person who can be claimed by the guarantor and/or patient as a dependent on their federal tax return.

c) The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching any one or more of the following:

(i) IRS tax returns

(ii) Payroll Stubs

(iii) Declarations

(iv) Verbal Attestation

(v) Other forms used to substantiate the need for Charity Care consideration

(vi) Credit bureau report (including the lack thereof)

In cases where the patient is unable to complete the written application, verbal attestation is acceptable if it is not disallowed by state law/regulation.

C. Appeal of Denied Discounted Care Applications
The patient may appeal the charity denial by submitting additional documentation to substantiate the application and qualification to:

Attention: Director of Patient Financial Services
Olympia Medical Center
5900 West Olympic Blvd
Los Angeles, CA 90036-4671
(323) 932-5080

D. Reservation of Rights
It is the policy of OMC to reserve the right to limit or deny financial assistance at our sole discretion, consistent with the hospital policy and all applicable laws.

1. Non-Covered Services- It is the policy of OMC to reserve the right to designate certain services as not subject to the hospital's Charity Care policy.

VI. Attachments

Attachment A- Federal Poverty Guidelines
2011FPG is as follows:

2011 Annual Federal Poverty Guidelines

48 Contiguous States and DC

PERCENTAGE OF FEDERAL POVERTY LEVEL (2011) Annual Income									
Size	100%	150%	200%	250%	300%	350%	400%	450%	500%
1	$10,890	$16,335	$21,780	$27,225	$32,670	$38,115	$43,560	$49,005	$54,450
2	$14,710	$22,065	$29,420	$36,775	$44,130	$51,485	$58,840	$66,195	$73,550
3	$18,530	$27,795	$37,060	$46,325	$55,590	$64,855	$74,120	$83,385	$92,650
4	$22,350	$33,525	$44,700	$55,875	$67,050	$78,225	$89,400	$100,575	$111,750
5	$26,170	$39,255	$52,340	$65,425	$78,510	$91,595	$104,680	$117,765	$130,850
6	$29,990	$44,985	$59,980	$74,975	$89,970	$104,965	$119,960	$134,955	$149,950
7	$33,810	$50,715	$67,620	$84,525	$101,430	$118,335	$135,240	$152,145	$169,050
8	$37,630	$56,445	$75,260	$94,075	$112,890	$131,705	$150,520	$169,335	$188,150

Attachment B- Discount Flat Rate- Sliding Scale

Percentage based on established Cash Flat Rates

201% -250%	=	75% discount
251% -300%	=	50% discount
301% -350%	=	25% discount

OLYMPIA MEDICAL CENTER

Confidential Medical and Financial Assistance Application

Acct. #:	Patient Name:	SSN:	DOB:
Patient Address:		Patient Home Phone:	Patient Work Phone:
Type of Service: (circle one) **ER OP IP** **Co-Pay Amount: $ _____**		Service Date: _____/_____/_____ to _____/_____/_____	

SECTION A: MEDICAL ASSISTANCE SCREENING

	Yes	No
1. Is the patient under age 21?	☐	☐
2. Is the patient over the age of 65?	☐	☐
3 Is the patient a married parent of a minor child?	☐	☐
If **yes**, answer the following questions:		
a) Does the child(ren) live full time in the home?	☐	☐
c) Is the patient the primary wage earner for the household?	☐	☐
4. Is the patient a single parent of a child under age 21?	☐	☐
5. Is the patient a caretaker or guardian of a child Under 21?	☐	☐
6, Is the patient pregnant, or was the admission policy pregnancy related?	☐	☐
7. Will the patient potentially be disabled for 12 months?	☐	☐
Answer these questions if the patient answered **NO** to question 1-5.		
a. When did the patient last work? _____		
b. Is the patient planning to return to work?		☐
c. Does the patient have any additional medical problems?		
If **yes**, please list all medical conditions. _____		
8. Is the patient a Victim of Crime?		☐
If **yes**, was a police report filed?		☐
9. Does the patient have a "COBRA" or insurance policy that the premium has lapsed?		☐

SECTION B: MEDICAL ASSISTANCE SCREENING

Responsibility Party:	Relationship to Patient:
SSN:	DOB:
Home Address:	Phone #:
Gross Income: $	Circle One: ☐ Hourly ☐ Daily ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly
Name of Employer:	Hours Per Week:
If income is $0/unemployed, what is your means of support?	☐ Living on Savings/Annuity ☐ Live with parent/family/friends ☐ Homeless ☐ Shelter
Total Number of Dependent Family Members in Household: _____ (*Include patient, patient's spouse, legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)*	

SPOUSE

Responsibility Party:	SSN:	DOB:
Home Address:		Phone #:
Work Address:		Phone #:
Gross Income: $	Circle One: ☐ Hourly ☐Daily ☐ Weekly ☐ Monthly ☐ Yearly	

SECTION C: MEDICAL ASSISTANCE SCREENING

I, _____, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. _____
Patient/Guarantor Initials

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services maybe considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that the Charity Care program(s) is a "Payor of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which Olympia Medical Center or it's subsidiaries provided care.

_____ _____

PATIENT/GUARANTOR SIGNATURE DATE