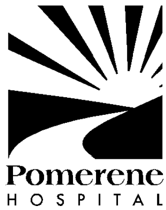

981 Wooster Road
Millersburg, OH 44654
(330) 674-1015, extension 1163

POMERENE HOSPITAL CARE ASSURANCE &
CHARITY CARE PROGRAM

REQUIREMENT LIST

Name of Patient: _________________ Date of Service: __________________

Account Number: ________________ Date of Application ________________

Dear Applicant,

Enclosed is the application for the HCAP and Pomerene Hospital Charity Care programs. Please complete all items as they pertained to your financial situation **3 months prior** to date of service. In addition to the application, you must include all of the following documentation in order for your application to be processed. Holmes County residents will be screened for the Charity Care Program as well.

EMPLOYED APPLICANT

- Proof of income (and spouse's if applicable): three months pay stubs prior to the date of service
- Letter from employer verifying gross income
- Income tax return, only if the patient cannot produce the above documentation

SELF EMPLOYED APPLICANT

- Cash receipts before taxes and reasonable deductions
- Statement from a certified public accountant verifying gross income
- Income tax return if the patient cannot produce the above documentation

UNEMPLOYED APPLICANT

- unemployment stubs or the unemployment letter showing weekly benefits
- "Statement of support/No Income" form, if no income, How patient is supporting themselves (included in packet)
- Workmen's compensation stubs
- Social Security and/or employment Disability income and/or Supplemental Security Income (SSI) income and/or Disability Financial Assistance Income (DA)

RETIRED APPLICANT

- Social security benefits yearly statement or letter from social security office indicating monthly payment
- Pension or veteran's benefits
- Copy of current bank statement showing automatic monthly income deposit.

OTHER TYPES OF INCOME

- Child support (if the patient is the child), and alimony: may provide divorce papers or court order statement indicating amount received
- VA income

ASSETS

- Copies of bank statements showing balance as of date of service. This includes checking account, savings account, CD's, IRA, retirement funds, stocks and bonds.

AMISH CHURCH FUND/AMISH AID

- Authorization for release of billing information needs signed
  - church district, church number, name of deacon

PROOF OF RESIDENCY (May use any one of the following documents) PO BOX **not** acceptable-must see physical address.

- Copy of driver's license
- Utility bill with your name and address
- Lease/deed

PROOF OF MEDICAID DENIAL

- If we determine that you may be eligible for Medicaid, or other assistance, you will be expected to apply for Medicaid before we can process the PHCC application. If you were denied Medicaid coverage, the denial letter is required.

Please be advised that any incomplete documentation will delay the application process and require us to deny your application until the appropriate documentation is received. Please only send us copies of documents NOT originals,

Financial assistance and charity care are secondary to ALL other financial resources available to patient. This may include:

- Health Insurance
- Health savings Accounts
- Health Flexible Spending Accounts
- Worker's Compensation
- Third Party Liability situations (auto accidents, personal injury)
- Victim's Assistance
- Other State, federal, and military programs
- Church Fund
- Amish Aid

POMERENE HOSPITAL HCAP AND CHARITY CARE PROGRAMS

Hospital Care Assurance Program (HCAP). The government of the State of Ohio, in collaboration with the United States federal government, has sponsored, funded, and implemented an Expanded Hospital Care Assurance Program, which was effective May 22, 1992. According to this program, "hospitals that receive payments under the provision of Chapter 51212 of the Ohio Revised Code shall provide, **without charge** to the individual patient, basic, medically necessary, hospital-level services to the individuals who are residents of this State, are not recipients of the Medicaid program, and whose income is at or below the federal poverty line." Current recipients of the disability financial assistance (DA) program as defined in Chapter 5115. Of the revised code or its successor program, qualify for services under the provisions of this rule. Pomerene Hospital, which receives funds under this federal/state government program, is required by law to participate in the *Care Assurance Program*.

Pomerene Hospital Charity Care Program (PHCC) Pomerene Hospital is also concerned with the health of our community and will provide emergency and other medically necessary care either at no charge or at a reduced charge to individuals who are residents of Holmes County and eligible under the Pomerene Hospital *Charity Care Program*.

The 2019 federal poverty income guidelines for HCAP:	
Family Size	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

The 2019 Charity Care Guidelines for PHCC:		
Family Size		**TO:**
1	$12,491	$21,859
2	$16,911	$29,594
3	$21,331	$37,329
4	$25,751	$45,064
5	$30,171	$52,799
6	$34,591	$60,534
7	$39,011	$68,269
8	$43,431	$76,004

a. Add $4,420 for each additional person if the family unit has more than 8 members.

b. If the patient's total annual gross family income from all sources falls within or below the figures listed for their size family the "Federal Poverty Limit" ("FPL"), they may be eligible for free or reduced charges under one of these programs. In addition, to be eligible for the Hospital's charity care program, a patient's assets readily convertible into cash (i.e. retirement, savings or brokerage accounts) must have a value of less than $5,000).

Income Level	Percentage Discount off of the Hospital's Gross Charges
At or below 100% of FPL	100%
Greater than 100% of FPL but less than 125% of FPL	75%
At or above 125% of FPL but less than 150% of FPL	50%
At or above 150% of FPL but less than 175% of FPL	AGB Discount

Amounts Generally Billed (AGB). Pomerene Hospital will not charge an individual that is eligible for financial assistance under this policy more than the AGB to individuals who have insurance covering emergency or other medically necessary care. Pomerene Hospital uses the "look back" method for determining AGB. See Appendix B for the AGB calculation method.

Frequently asked questions

1. **What is included with "family size"?**
   a. Family size means, for a patient who is 18 years of age or older, (i) the patient's spouse, regardless of whether the spouse lives in the patient's home; and (ii) the patient's minor children (by birth or adoption-stepchildren are not included) who live in the patient's home. For a patient who is less than 18 years of age, family size means (i) the patient's birth or adopted parents; and (ii) the patient's minor siblings (by birth or adoption-stepbrothers and stepsisters are not included) who live in the patient's home. Notwithstanding the foregoing, if an individual who is a patient's spouse or parent cannot be located and his/her income cannot be verified, such individual shall not be included in the calculation of a patient's family size.

2. **What is considered "income"?**
   a Include all sources of a patient's (or the applicant's, if the patient is a minor) income including but not limited to wages, alimony, child support, social security income, SSI, VA and disability income and any distributions from a retirement account or other savings/bank account and interest and dividends on a non-retirement savings or brokerage account are all considered income. Child support can only be used as income if the applicant is the sole intended recipient designated to receive the support. Grants, scholarships or housing allowances that are paid directly to a student or patient, are considered income. If they are paid directly to the school or housing authority it is not considered income. Patients who are still married need to include the spouse's income into their income even if that spouse no longer lives in the home. If they are not able to obtain that figure, the reason needs to be documented on the application.

INCLUDE FOR UNEMPLOYED APPLICANT

3. **Who is eligible for PHCC?**
    a. Residents of Holmes county who:
        i. Meet the income criteria
        ii. Have been screened for HCAP
        iii. Have no health coverage or have coverage that only pays part of the bill.
        iv. Are ineligible for any private or government sponsored coverage (such as Medicaid)

4. **What services are covered under PHCC?**
    a. Only medically necessary and emergency health care services are covered.

If I receive a discount off my bill from PHCC, how do I set up payments for my balance?

- Once your application has been processed, you must **immediately** set up payments for the balance, no longer than 10 days after notification. You can do so by contacting the Patient Financial Services office at 330-674-1015 ext 1744 or the Financial Counselor at 330-674-1015 ext. 1163. You may only receive financial assistance one an account one time.

Other Important Information

- Patients are screened for Medicaid eligibility first, then HCAP, then PHCC, if the patient a resident of Holmes County.
- HCAP is applicable 3 years from the date of your first statement.
- PHCC is applicable 1 year from the date of your first statement
- A bill totaling less than $100 will not be eligible for PHCC.
- If the patient has Amish Church Fund or Amish Aid, an application will not be processed until an authorization for release has been signed, so that Pomerene Hospital may discuss your account with your church Deacon.
- Only the patient (if not a minor), patient's spouse, legal guardian, or financial POA can sign the application. If the patient/applicant is unable to sign the application, the Financial Counselor may sign the application and clearly document why the patient/applicant is unable to sign.
- If the applicant/patient is deceased, the application must be completed by someone who is legally able to speak for the patient, so an executor of their estate would be the first choice. If there is no executor of the estate-the patient's next of kin could sign and attest to the validity of the information on the application.
- An inpatient application can be used to cover related outpatient services for the patient in the 90-day period immediately following the first day of the inpatient admit. If a re-admission takes place within 45 days of discharge for the same underlying condition, it is not necessary to get a new application. All other inpatient admissions must be judged separately and require a new application.
- Our Financial Counselor is here to assist you with your application. Please call Mon-Fri 9a.m. - 5 p.m. 330-674-1015, ext. 1163 for an appointment. Appointments can be set up outside of office hours, if requested.

Pomerene HOSPITAL

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Millersburg, OH 44654
(330) 674-1015, extension 1163

POMERENE HOSPITAL HCAP AND CHARITY CARE PROGRAM

Patient Information

Date of Application: ________________________ Date of Service _____________________

Patient's Name: _________________________Patient's Date of Birth: __________________

Applicant name, if not the patient ___________________ Account Number: _____________
Please answer the following questions as they apply to the patient

I attest that I am: Single Married Legally Divorced Widowed

Physical Address: ____

Mailing Address: ____

Primary Phone Number: ___________________ Spouse Name / DOB: ________________

Guarantor of Account (if not patient) _____________

1. Were you an Ohio resident at the time of your hospital service? Yes No

2. Were you a resident of Holmes County at the time of hospital service? Yes No

3. Were you an active Medicaid recipient at the time of your hospital service? Yes No
If yes, Medicaid ID number: _____________________

4. Were you an active recipient of the Disability Financial Assistance Program Yes No
At the time of your hospital service? If yes, please provide proof of this income

5. Did you have health insurance (other than Medicaid) at the time of your Yes No
Hospital service?
Name of Health Insurance _________________________________

Family Information

Please provide the following information for all people in your immediate family who live in your home. For purposes of HCAP/PHCC, family is defined as the patient, the patient's spouse, and the patient's children (natural or adopted, under **age 18**) who reside in the patient's home. If the patient is a minor, the family should include the patient, the patient's natural or adoptive parents (whether they reside in the home or not), and the patient's siblings (natural or adopted and under 18) who live in the home. Grandparents, step-parents and legal guardians are not considered part of a minor patient's "family".

Name	Date of Birth	Age	Relationship to the Patient

Family Income

Please list ***income*** for yourself, your spouse, and any natural or adopted children under age 18

Name of the Recipient of Income				
Income Source job, disability, unemployment, social security, etc				
Income for 3 mo <u>prior to application</u>				
Income for 12 mo prior to hospital service*				
Type of income verification ** Please see guidelines previously listed				

INCLUDE FOR UNEMPLOYED APPLICANT

*Income verification must accompany this application
**Income verification may include: pay stubs, W-2's, tax returns or other documents containing income information for the appropriate time period (3 months prior to hospital service). Please refer to complete listing on pages 1-2 of this document, or call the Financial Counselor at 330-674-1015 ext 1163.

Do you have assets over $5,000 in a savings or checking account? If yes, how much? ________

Do you have a Health Savings Acct? _______ If yes, have you exhausted those funds? ______

If you reported $0 income, please provide a brief explanation of how you (or the patient) are meeting basic living needs: ____

____

______I attest that I have ______dependent children who reside with me. Only include children who are natural or adopted under the age of 18

AUTHORIZATION AND AGREEMENT

I hereby submit the above information for the purpose of allowing Pomerene Hospital to evaluate my financial status and determine my eligibility for various financial assistance programs, and do hereby authorize Pomerene Hospital to verify this information as necessary, which may include a credit bureau report, employment, and/or income verification, and appropriate supporting documents.

I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should, at any time, any of this information prove to be false, all Financial Assistance grants awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances. By applying for Financial Assistance, I also agree to accept payment responsibility for any amount due from me as a result of any partial discount, which may be awarded.

____ ________________________

Applicant Signature Date

For Hospital Use ONLY

_______A. Eligible for HCAP If No Denial Reason ______________________

_______B. Eligible for PHCC If No Denial Reason ______________________

_______C. Eligibility Dates ______________to _________________________

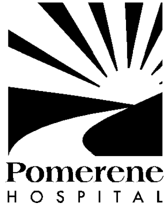
_______D. Patient contacted on __/___/___requesting ___________________

_______E. Patient contacted on __/__/____ advising of approval at 100%

_______F. Patient contacted on __/__/____ advising of approval at ___%
With or without physician fees/with or without remaining amount due

_______G. Patient contacted on __/__/____advising must apply for Medicaid

_______H. Patient contacted on __/__/____ advising of Denial and amount due



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POMERENE HOSPITAL CARE ASSURANCE & CHARITY CARE PROGRAM

NO INCOME VERIFICATON

I, ______________________________ have not had any income since ___________________.
(PATIENT NAME) (DATE LAST WORKED)

I am meeting basic living needs by: ____

____

Patient signature: ________________________________Date:_________________________

I may be reached at _________________________________ if you have any questions.
(Phone number)

Witness ____Date___________________________

INCLUDE FOR UNEMPLOYED APPLICANT