SYSTEM POLICY

Section: Finance

Subject: Financial Assistance – Nursing Home

Executive Owner: Vice President, Finance

Approval Date: 4/1/2012
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Last Review:
Revised Date:
Supersedes:

I. POLICY STATEMENT

In order to promote the health and well-being of the community served, individuals who have no health insurance, with limited financial resources, and who are unable to access entitlement programs shall be considered for free or discounted health care services for nursing home charges.

II. PURPOSE

Resources are limited and it is necessary to set limits and guidelines. These limits are not designed to turn away or discourage those in need from seeking treatment. They are in place to assure that the resources the ministry can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' financial information are intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances.

III. MISSION / VALUES RATIONALE

Our Mission and Values call us to serve those in need and maintain fiscal viability. Provena Health – Resurrection Health Care has a long tradition of serving the poor and the needy. However, our Ministries alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. We also continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations. This policy applies only to Nursing Home ministry charges.

IV. SPECIAL INSTRUCTIONS

This Policy applies to Presence Health Nursing Home

V. DEFINITIONS

A. **Charity Care**: Health care services that were never expected to result in cash. Charity care results from providing health care services free or at a discount to individuals who do not have the ability to pay based upon a review of the resident's financial means.

B. **Financial Assistance:** Services provided without charge to the resident, or at a reduced rate to the resident, based upon the resident's inability to pay the full rate for such services.

C. Financial Assistance Review Committee: Include as members, the Administrator or Executive Director in which the financial assistance request resides, Vice President of Operations (for appropriate service line), Vice President Mission Services, CFO, and Director of Patient Financial Services. This committee will determine if the resident qualifies for financial assistance and if the ministry can reasonably afford to provide such care.

VI. PROCEDURE

A. Each nursing home ministry will seek to provide financial assistance when appropriate, and within the resource constraints of the ministry to eligible residents/clients (hereafter referred to as "residents").

B. Signage will be visible in all ministries to create awareness of the financial assistance program and encourage residents and resident family members to receive assistance from our local staff in the Medicaid application process (in Medicaid certified ministries). Ministry business office managers will receive appropriate training to be proficient in providing assistance to residents in completion of the Medicaid application process. Each ministry will either have bi-lingual staff on site or provide residents access to language line assistance when necessary. This policy will be translated to and made available in Spanish.

C. Those nursing homes that participate in the Medicaid program routinely accept payment from this program for residents who exhaust their personal funds and are accepted by the government as eligible for Medicaid coverage, and for whom a Medicaid certified bed is available. At some of our nursing home facilities there is a limitation on the number of beds certified for Medicaid. When a Medicaid bed is not available, thus limiting a resident from being retained as a Medicaid-funded resident, that resident may be afforded the opportunity to request continued care through financial assistance funding. When the ministry cannot retain additional Medicaid residents, the resident affected will be assisted in relocating to another long-term care ministry that will accept them under this funding program. Financial assistance status will be considered where significant hardship might occur should the resident be forced to relocate from our nursing home ministry. The determination Of: significant hardship" will be made solely by the Financial Assistance Review Committee.

D. Nursing home entities that have a specific endowment fund designed to provide funding to the ministry for those on "charity care" should consider financial assistance as a means of providing appropriate charity care. Facilities that do not have such an endowment fund should consider the severity of the resident's need to remain for care against the financial hardship that such financial assistance will cause to the ministry. Good stewardship consideration may preclude the provision of financial assistance when such action would have a significant adverse financial impact upon the ministry operation and thus adversely affect the quality or quantity of care provided to other residents.

E. Residents requesting financial assistance will be asked to complete an Application for Financial Assistance:

1. The resident/family member must include copies of the last three years of the resident's Federal Income Tax Returns with the Application for Financial Assistance.
2. A family member may submit an application on behalf of a resident. Application may be made to appeal for financial assistance at any time in the collection process.
3. Residents' are encouraged to make such request as far in advance of need as possible so that should the request not be favorably considered, sufficient time is available for the relocation of the resident.
4. Residents will be informed at the time of application that no guarantee of approval exists.
5. The patient must cooperate with the ministry to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid.
6. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

F. The resident applying for financial assistance, and their family, must represent that no gift of real or personal property has been made or will be made in contemplation of receipt of financial assistance. The resident also agrees to make no such gift subsequent to receipt of financial assistance which may impair the resident's own ability or the ability of his/her estate to satisfy his/her financial obligations to the ministry.

G. A resident, who, while in a self-pay status, resides in a private room, may be asked to relocate to a semi-private room if their care is to be covered in full or part by financial assistance.

H. Once approved for financial assistance, the ministry has the right to request for financial assistance to be revoked at any time, for any reason deemed appropriate by the ministry Administrator. This request must be approved by the Financial Assistance Review Committee.

I. All income of the resident will be used toward the cost of the care provided by the ministry. Financial assistance will only be used to supplement such income when such income is inadequate to pay for continued care at the normal fee rates of the ministry.

J. If a patient disagrees with the decision, the patient may request an appeal process in writing within 45 days of the denial. The Financial Assistance Review Committee will review the application. Decisions reached will normally be communicated to the patient within 45 days, and reflect the Committee's final and executive review.

K. Information to be used by the Financial Assistance Review Committee in making this determination will include, but not be limited to:

1. Date of admission to the ministry
2. Degree of financial need
3. Availability of ministry resources for the provision of financial assistance support.
4. Degree of ability to pay by the resident and their family
5. Severity of impact upon the resident if relocation is required to another long-term care ministry
6. Other factors as deemed appropriate by the Committee.

L. When an Administrator or Executive Director receives a complete application from a resident it will be sent directly to the Financial Assistance Review Committee. The Administrator or Executive Director will date, sign and send the completed application to the committee.

M. Applicants for financial assistance will receive written correspondence from the administrator communicating the disposition of their application within 45 days of receipt of application.

N. Retention Log. A log will be maintained at the Continuum of Care Corporate Office. The Director Patient Financial Services will record the financial assistance activity. The log will record Date Application Received, Resident Name, Disposition, date Disposition was communicated to applicant, and Assistance Provided (if applicable), The Continuum of Care Corporate Office will be accountable for retention of data to support all applications listed on log.

O. Application Approval. The application will be approved for a specified amount monthly (or a statement that all charges will be covered) and the date effective for this approval; be approved with specified (on the application form) limitations or stipulations; or be disapproved.

P. Final Application Approval. Following final action on the application, the Administrator or Executive director and VP of Operations (for appropriate service line) will enter his/her name, signature and date in the indicated part of the form. The date of notification of the resident (or other applicant) of the outcome of the application will also be noted on the application form. Ministry leader will notify applicant.

Q. Facilities will include in their operating budget a specific expense amount to be used to cover the cost of financial assistance during that calendar year. This budget item is subject to the same review and approval as all other aspects of the ministry budget.

R. Cancellation of Financial Assistance. Should a circumstance arise that appears to warrant the cancellation of financial assistance status for a resident, the Administrator will notify the resident, and their responsible party if any, in writing stating that information has come to the Administrator's attention which warrants prudent consideration of whether or not the financial assistance status of said resident should be continued, modified, or cancelled. The letter will provide a date and time for the resident and/or responsible party to meet with the Administrator to review the circumstances and issues that gave rise to the letter being sent. The resident and/or responsible party will be given a full opportunity at this meeting to present information, to refute information that the Administrator has made reference to, and any other pertinent information regarding the financial assistance status for that specific resident. The resident and/or responsible party will be informed that they will receive written notice of the decision reached for this resident, and that such notice will be mailed no later than five working days following the scheduled meeting. If the financial assistance status is to be cancelled, the effective date of that cancellation will be no earlier than 14 days following the mailing of the decision letter to allow sufficient time for the appropriate relocation of the resident to another setting. The financial assistance committee will be involved in all decisions related to the cancellation of financial assistance.

FORMS AND OTHER DOCUMENTS
Application for Financial Assistance

REFERENCES
Other - Ethical and Religious Directives, section 1.2

Continuum of Care – Nursing Home
Application for Financial Assistance

MINISTRY: _____

1. **Resident's Name:**_____

2. **Responsible party for financial affairs**:
   Name: _____ Relationship: _____
   Address: _____
   Phone: _____

3. **Resident's Current Financial Assets:**

Checking Account(s)	$_____
Saving Account(s)	$_____
Other Assets:	
_____	$_____
_____	$_____
Total Assets	$==========

4. **Resident's Monthly Income:**

Social Security	$_____
Annuities &/or Pensions	$_____
Other Income	$_____
Total Monthly Income	$==========

5. **Resident's <u>Estimated</u> Monthly Expenses:**

Ministry Room & Board	$_____
Supplies (charged by Ministry)	$_____
Pharmacy Charges	$_____
Medical Expenses	$_____
Personal Expenses	$_____
Other Expenses	
_____	$_____
_____	$_____
Total Estimated Expenses	**$**==========

Amount of financial assistance requested:

This is a onetime request: Yes___ No_____

This amount is requested monthly: Yes____No___

No gift, of real or personal property has been made, or will be made in contemplation of receipt of financial assistance. I also agree to make no gift subsequent to receipt of financial assistance, if this application is approved, which may impair the Resident's own ability, or the ability of his/her estate to satisfy his/her financial obligations to the ministry. I understand that financial assistance, if granted, can be revoked or reduced at any time. I understand that should my financial circumstances listed above improve during the time period I am receiving financial assistance, I must notify the ministry immediately.

I certify that the above information is correct and complete to the best of my knowledge.

I have attached copies of the most recent three years of Federal Income Tax Returns filed by the resident for whom financial assistance is being requested.

_____	_____
Signature of Person Filling out Application	Signature of Resident
_____	_____
Relationship to Resident	Requested Financial Assistance Amount
_____	_____
Date	Date

Submitted to Financial Assistance Review Committee on _____ (date).

_____	_____	_____
Name of Administrator Or Executive Director	**Signature**	**Date**

Amount approved by the FARC:

This amount approved is approved for one time only. Yes___No___
This amount approved is monthly until ended by the Ministry. Yes___ No___

_____	_____	_____
Name of Vice President	**Signature**	**Date**

Notification of Patient _____ (date)

_____	_____	_____
Name of Administrator Or Executive Director	**Signature**	**Date**