

MORRISON COMMUNITY HOSPITAL DISTRICT  
MORRISON, ILLINOIS

SUBJECT: Financial Need Program

RESPONSIBLE  
DEPARTMENT: Patient Accounts

DATE: November 9, 2004

EFFECTIVE: January 1, 2005

REVISION DATES: September 2009

## POLICY

Morrison Community Hospital will provide discounts on a sliding-fee scale basis under the Financial Need Program; hereinafter known as “The Program”, to individuals who have demonstrated an inability to pay for the services received. Inability to pay will be determined on a case-by-case basis.

## PURPOSE

To provide guidelines for sliding-fee scale discounts to individuals who have demonstrated an inability to pay for hospital/clinic services rendered.

## PROCEDURE

1. Eligibility – Determination of eligibility for The Program will occur when there is an incident and will cover the 6-month time period following the incident. Patient/Guarantors who meet one of the following criteria are eligible to apply for The Program:
  - a. Uninsured patient/guarantors who do not have the ability to pay based on criteria set by the Hospital in this policy
  - b. Patients/Guarantors who demonstrate ability to pay part but not all of their liability
  - c. Deceased patients with no estate
2. Ineligibility – Patient/Guarantors are not eligible for sliding-fee scale discounts under The Program when:
  - a. They refuse alternate sources of payment from third parties (i.e. Medicaid). Patient/Guarantors must show they have applied for public aid assistance and have been denied by bringing in a copy of the denial.
  - b. They refuse to provide information necessary to make a determination within the required amount of time
  - c. They do not pay balance owing in accordance with agreed upon terms for graduated income level discounts
3. Applications
  - a. Morrison Community Hospital will make information and applications for assistance available at each registration site or at the Business Office.
  - b. Patient/Guarantors may also call the Billing Director and an application will be mailed with instructions.
  - c. Requests for sliding-fee scale discounts may be made at any time before, during, or after services are rendered but before the account is sent to collections.
4. Application Receipt – If the application is received within 30 days of the request, the Billing Director will review the application to verify it has been adequately completed and all required documentation has been supplied.
  - a. If documentation is complete, the Billing Director will note the system indicating the account is under review.
  - b. If documentation is incomplete, the Billing Director will note the system indicating what information is missing and generate a system letter to the patient/guarantor requesting the required information. The Billing Director will add a follow-up date for one week. If the application is still incomplete after one week or there has been no response, the application is denied. The Billing Director will proceed with standard collection policy.

- c. If the application is not received within the 30 days, the Billing Director will review the account. One call will be placed to the patient/guarantor inquiring on the status of the application.
- If the patient/guarantor plans to complete the application, they will be given a one-week extension. The Billing Director will note the system and add a follow-up date for one week. If the application is not received within one week, the Billing Director will proceed with standard collection policy.
  - If the patient/guarantor is not planning on completing the application, the Billing Director will proceed with standard collections policy.

Morrison Community Hospital

List of items to be returned to Morrison Community Hospital for Financial Need Program application:

- \_\_\_\_\_ Completed application
- \_\_\_\_\_ W-2 Withholding Statements for all employed household members
- \_\_\_\_\_ Most recent Federal/State income tax returns for all household members
- \_\_\_\_\_ Paycheck/Unemployment check stubs (Past 3 months) or written statement of earnings from employer(s)
- \_\_\_\_\_ Denial received from Illinois or Iowa Medicaid program
- \_\_\_\_\_ Date all papers completed

I, \_\_\_\_\_, on \_\_\_\_\_  
Patient/Guarantor Signature Today's date

believe the information provided for this application is true to the best of my knowledge. I furthermore agree the hospital has taken steps to assist me/and or my family following policy and Federal Poverty Guidelines.

APPLICATION FOR FINANCIAL NEED

Mail this completed form to:  
 Morrison Community Hospital  
 Attn: Billing Director  
 303 North Jackson Street  
 Morrison, IL 61270

Name of Patient/Guarantor \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Spouse \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Household Members:

	Name	Age	Relationship to Patient	Employer
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

INCOME: List Gross Income of Total Household for: \_\_\_\_\_ Last Twelve Months

Patient/Guarantor's Gross Monthly Income\*..... \_\_\_\_\_  
 Spouse's Gross Monthly Income\*..... \_\_\_\_\_  
 Other Wages\*..... \_\_\_\_\_  
 Farm/Self Employed..... \_\_\_\_\_  
 Food Stamps..... \_\_\_\_\_  
 Social Security..... \_\_\_\_\_  
 Unemployment..... \_\_\_\_\_  
 Workers Compensation..... \_\_\_\_\_  
 Alimony/Child Support..... \_\_\_\_\_  
 Military Family Allotments..... \_\_\_\_\_  
 Pensions..... \_\_\_\_\_  
 Income from Dividends, Interest, Rent Etc..... \_\_\_\_\_  
 Other..... \_\_\_\_\_

\*These amounts are before taxes or any deductions.

Signature of Applicant:  
 By signing my name to this form I am saying that the answers I have given are true and complete to the best of my knowledge. I have been advised and understand that if I knowingly give wrong information, I am liable for prosecution under state law. I also understand that this application shall remain in the confidential property of Morrison Community Hospital. I hereby give my consent to Morrison Community Hospital to make inquiry concerning information in this application.

\_\_\_\_\_  
 Applicant's Signature Date