Ouachita County Medical Center
Financial Assistance Policy

OCMC is committed to ensuring access to high quality medical care to all members of our community. OCMC will provide emergency and medically necessary medical care to all acutely ill persons regardless of insurance status or ability to pay.

The need for financial assistance may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek charitable services. No information obtained in the patient's financial assistance application may be released without the patient's permission, except to bona fide governmental agencies requesting aggregate data.

This policy applies to all emergency and other medically necessary care provided by the hospital, including all such care provided in the hospital facility by a substantially related entity. This Policy is applicable to uninsured patients only. Patients deemed unable to pay will be eligible to receive available financial assistance. The patient is ultimately responsible to fulfill their financial obligation to OCMC and is not granted financial assistance until the application has been completed and approved. This policy will be reviewed annually to determine appropriateness to current community and financial conditions. Policy revisions must be approved by the OCMC Board of Directors.

Measures to Publicize the Financial Assistance Policy:

All patients will be made aware of the existence of this Financial Assistance Policy through the following means:

- Patients will be provided a copy of the Financial Assistance Policy Plain Language Summary upon admission (or discharge)
- Employees in the scheduling, patient access, and patient financial services departments will be fully versed in the Financial Assistance Policy, have access to financial assistance application forms, and be able to direct questions to the appropriate OCMC representatives.
- The Financial Assistance Policy, FAP Plain Language Summary, and Application will be posted on the OCMC Website (www.ouachitamedcenter.com) in a format downloadable without special software.
- Notices of the Financial Assistance Policy and FAP Plain Language Summary will be posted in several prominent locations within the Hospital including, but not limited to, the emergency department, billing office, and registrations areas. The notices will be clearly visible to the public.
- Availability of financial assistance will be printed on applicable letters and billing statements.
- Direct patient contact, in person, or over the phone. Financial assistance information can be obtained free of charge in the OCMC Business Office or by calling 870-836-1000.
- Outreach to community organizations and public and non –profit agencies
- Availability of financial assistance will be posted annually in the local newspaper

Patients will be provided with information about this Financial Assistance Policy upon request, including specific information as to how eligibility is determined and the means for applying for assistance.

A request for financial assistance may be made by any person who could reasonably be expected to act for the patient, has a reasonable basis to believe that the person may qualify for uncompensated services, and can provide the information required to establish the eligibility. Determining a patient's eligibility can be done through a variety of means to include but not limited to:

- Completing a written application
- Submission of documents for proof of financial indigence. Examples include, but are not limited to: W-2s, Income Tax forms, Check Stubs, etc.
- Credit Check or scoring criteria

- Other approved criteria/means to determine ability to pay. Examples include, but are not limited to: Proof of Food Stamps & HUD

Financial assistance may be granted prospectively or retrospectively. All overdue accounts will be reviewed internally to determine whether the patient is eligible for financial assistance prior to the initiation of any external collection efforts, legal proceedings, or other extraordinary collection efforts.

In the event a patient approved for financial assistance fails to comply with payment terms for a period of more than one hundred twenty (120) days, the account may be turned over to a collection agency or reported to a credit agency. Any collection agencies used by the Hospital will agree to refrain from abusive collection practices. Bench warrants and property foreclosures will not be a part of collection efforts.

Typically, patient billing statements are mailed one time per month. Guarantors are mailed a final notice letter notifying the guarantor of the intent to place the account with a bad debt agency if no payment is received within 10 days. Further information can be found in the Patient/Guarantor Billing & Follow-up Collection Policy.

Eligibility:

1. Eligibility for financial assistance does not exist where an individual has, or can qualify, for other third-party coverage. If an individual is not currently covered by a third-party, he must apply for Medicaid and show a Medicaid denial to be eligible for financial assistance services. OCMC personnel will assist individuals in applying for Medicaid. In the event that third-party coverage is discovered at a later date, any financial assistance write-off will be reversed and third-party insurance will be filed.
2. In order to be eligible for financial assistance, a Financial Assistance Application must be completed and submitted along with the required documentation. Eligibility for financial assistance and/or charity care will be determined by evaluating a variety of factors, including, but not limited to:
    a) Individual or family income. Examples include, but are not limited to: W-2s, Income Tax forms, Check Stubs, etc.
    b) Individual or family net worth. Examples include, but are not limited to: Checking Bank Statements, Savings Bank Statements, etc.
    c) Employment status and earning capacity
    d) Family size
    e) Amount and frequency of bills for healthcare services
    f) Other sources of payment for the services rendered
    g) Other financial obligations
    h) Proof of public assistance (Proof of Food Stamps & HUD)
3. A sliding scale, based on the Federal Poverty Guidelines, will be used as a guide to help determine the amount of financial assistance for which a patient qualifies; provided, however, that the annual household income shall not be the only factor considered when determining eligibility for financial assistance. The 2015 Federal Poverty Guidelines are attached to this policy as Exhibit A. The sliding scale is attached as Exhibit B. Financial Assistance includes free or discounted care.
4. For patients who owe an extraordinary balance that is catastrophic to the family income base, catastrophic protection may be provided by limiting payment liability to zero (0) percent of annual household income. Determinations to provide catastrophic financial assistance will be made by the President/CEO.
5. OCMC adopts the U.S. Census Bureau's definition of family for this policy:
    a. A family consists of two or more people (one of whom is the householder) related by birth, marriage, or adoption residing in the same housing unit.

6. Patients who qualify for financial assistance will not be charged for emergency or other medically necessary care at rates higher than the "amounts generally billed" to third-party payers. The use of gross charges to such patients is prohibited. For purposes of this policy, "amounts generally billed" will be determined by the "look back method." The historical payments (insurance payment and paid co-pays/deductibles) will be divided by the charges for Medicare, Medicaid, and other private insurance companies to arrive at an AGB percentage. The AGB percentage will be applied to the gross charges on the patient account to determine the highest dollar amount the patient may be responsible for the individual account. The AGB percentage is 31.7%. Further information regarding the calculation of the AGB percentage can be obtained by contacting the Revenue Cycle Management department at 870-836-1000.
7. This Financial Assistance Policy applies only to Hospital charges and does not include physician or professional charges that are not billed by the Hospital. Financial Assistance is limited to emergency and medically necessary services and is not available for elective procedures.
8. If an individual gives the facility a payment before applying for financial assistance, that amount may be refunded the patient if is determined they are eligible for 100% write-off of charges. Individuals can apply up to one (1) month prior to receiving service.
9. A letter will be sent to each applicant informing him of the eligibility determination, the amount of financial assistance given, any remaining balances owed by the patient, and the suggested repayment plan.
10. Patients denied Financial Assistance will be sent a letter informing them of the reason for denial.
11. OCMC's Business Office will keep a log of financial assistance provided each fiscal year, along with all applications, of those approved and denied. Account notes will be maintained as well.

Procedure:

1. Patients requesting financial assistance will be provided with an application for financial assistance. Application materials will include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine eligibility, the patient may disregard any bills from the Hospital until OCMC has rendered a decision on the application. Completed applications, along with supporting documentation, should be returned to the Financial Counselor in the OCMC Business Office at 638 California Ave. SW, Camden, AR.
2. Patients who do not provide the requested information necessary to completely and accurately assess their financial situation in a timely manner and/or who do not cooperate with efforts to secure governmental healthcare coverage may not be eligible for financial assistance care.
3. This policy will be applied equally to all patients regardless of payer. Applications that do not meet established criteria may be approved based upon extraordinary circumstances with the documented approval of the President/CEO.
4. Applications for financial assistance will be reviewed within thirty (30) days of receipt of a completed application. Patients will be notified of the Hospital's eligibility determination in a timely manner.
5. If a patient has applied for and received financial assistance within the past twelve (12) months, and the patient's financial circumstances have not changed, the patient will be deemed eligible for financial assistance without having to submit a new financial assistance application.
6. All applications for financial assistance will be maintained for a period of one (1) year.

OUACHITA COUNTY MEDICAL CENTER
Financial Assistance Application

Name of patient:	SSN:
Name of spouse:	SSN:
Number of dependents:	Phone number:
Address:	
Employer:	Phone number:
Employer's Address:	
Spouse's Employer:	Phone number:
Employer's Address:	

Monthly Household Income: _____
Please attach a copy of a recent pay stub, tax return, social security or disability statement, or other documentation of income.

Assets: Please include names of financial institutions and copies of recent bank statements.

Checking Account:	Savings
Other liquid assets:	Stocks/bonds
Real estate	
Other	

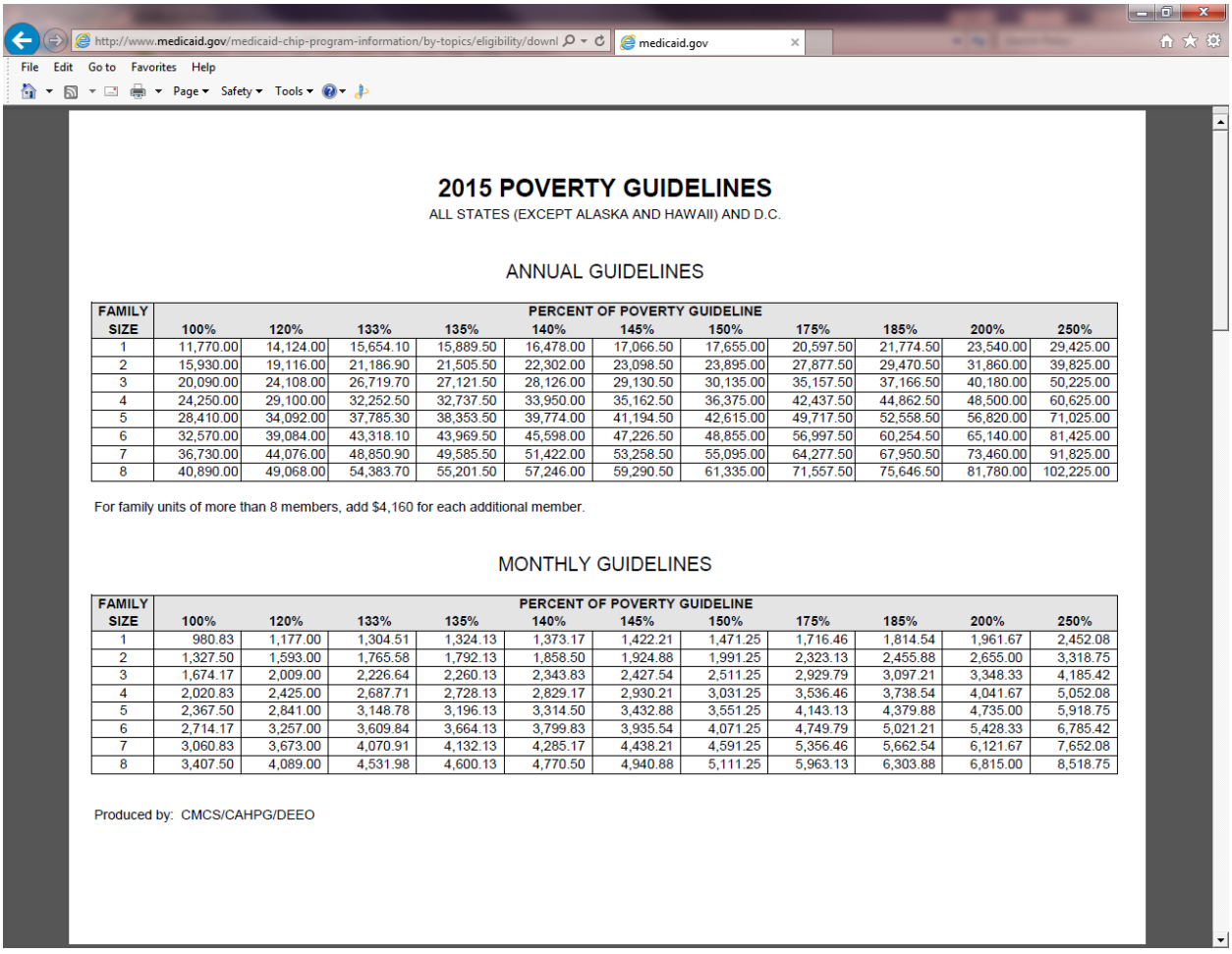
Monthly bills: Please attach documentation such as a copy of payment coupon or monthly statement.

Mortgage/Rent:	Credit cards:
Car payment:	Other:

I hereby certify that I am of legal age and that the foregoing statements are true and complete to the best of my knowledge and are made for the purpose of determining my eligibility for Financial Assistance at Ouachita County Medical Center. I understand that this application is and shall remain the property of Ouachita County Medical Center. I authorize Ouachita County Medical Center to make all inquiries that it deems necessary to verify the statements made herein. I understand that if I give any false information in this application, I may be denied Financial Assistance.

_____ _____
Applicant's signature Date

EXHIBIT A



http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downl

medicaid.gov

File Edit Go to Favorites Help

Page Safety Tools

2015 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE										
	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	11,770.00	14,124.00	15,654.10	15,889.50	16,478.00	17,066.50	17,655.00	20,597.50	21,774.50	23,540.00	29,425.00
2	15,930.00	19,116.00	21,186.90	21,505.50	22,302.00	23,098.50	23,895.00	27,877.50	29,470.50	31,860.00	39,825.00
3	20,090.00	24,108.00	26,719.70	27,121.50	28,126.00	29,130.50	30,135.00	35,157.50	37,166.50	40,180.00	50,225.00
4	24,250.00	29,100.00	32,252.50	32,737.50	33,950.00	35,162.50	36,375.00	42,437.50	44,862.50	48,500.00	60,625.00
5	28,410.00	34,092.00	37,785.30	38,353.50	39,774.00	41,194.50	42,615.00	49,717.50	52,558.50	56,820.00	71,025.00
6	32,570.00	39,084.00	43,318.10	43,969.50	45,598.00	47,226.50	48,855.00	56,997.50	60,254.50	65,140.00	81,425.00
7	36,730.00	44,076.00	48,850.90	49,585.50	51,422.00	53,258.50	55,095.00	64,277.50	67,950.50	73,460.00	91,825.00
8	40,890.00	49,068.00	54,383.70	55,201.50	57,246.00	59,290.50	61,335.00	71,557.50	75,646.50	81,780.00	102,225.00

For family units of more than 8 members, add $4,160 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE										
	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	980.83	1,177.00	1,304.51	1,324.13	1,373.17	1,422.21	1,471.25	1,716.46	1,814.54	1,961.67	2,452.08
2	1,327.50	1,593.00	1,765.58	1,792.13	1,858.50	1,924.88	1,991.25	2,323.13	2,455.88	2,655.00	3,318.75
3	1,674.17	2,009.00	2,226.64	2,260.13	2,343.83	2,427.54	2,511.25	2,929.79	3,097.21	3,348.33	4,185.42
4	2,020.83	2,425.00	2,687.71	2,728.13	2,829.17	2,930.21	3,031.25	3,536.46	3,738.54	4,041.67	5,052.08
5	2,367.50	2,841.00	3,148.78	3,196.13	3,314.50	3,432.88	3,551.25	4,143.13	4,379.88	4,735.00	5,918.75
6	2,714.17	3,257.00	3,609.84	3,664.13	3,799.83	3,935.54	4,071.25	4,749.79	5,021.21	5,428.33	6,785.42
7	3,060.83	3,673.00	4,070.91	4,132.13	4,285.17	4,438.21	4,591.25	5,356.46	5,662.54	6,121.67	7,652.08
8	3,407.50	4,089.00	4,531.98	4,600.13	4,770.50	4,940.88	5,111.25	5,963.13	6,303.88	6,815.00	8,518.75

Produced by: CMCS/CAHPG/DEEO

EXHIBIT B

Ouachita County Medical Center
Sliding Scale - Based off of 2015 Federal Poverty Guidelines

Amounts Generally Billed Calculated at 31.7% for 2015. Patient will not be responsible for more than 31.7% of gross charges.

ANNUAL GUIDELINES

	PERCENT OF POVERTY GUIDELINE										
Family Size	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	$ 11,770.00	$ 14,124.00	$ 15,654.10	$ 15,889.50	$ 16,478.00	$ 17,066.50	$ 17,655.00	$ 20,597.50	$ 21,774.50	$ 23,540.00	$ 29,425.00
2	$ 15,930.00	$ 19,116.00	$ 21,186.90	$ 21,505.50	$ 22,302.00	$ 23,098.50	$ 23,895.00	$ 27,877.50	$ 29,470.50	$ 31,860.00	$ 39,825.00
3	$ 20,090.00	$ 24,108.00	$ 26,719.70	$ 27,121.50	$ 28,126.00	$ 29,130.50	$ 30,135.00	$ 35,157.50	$ 37,166.50	$ 40,180.00	$ 50,225.00
4	$ 24,250.00	$ 29,100.00	$ 32,252.50	$ 32,737.50	$ 33,950.00	$ 35,162.50	$ 36,375.00	$ 42,437.50	$ 44,862.50	$ 48,500.00	$ 60,625.00
5	$ 28,410.00	$ 34,092.00	$ 37,785.30	$ 38,353.50	$ 39,774.00	$ 41,194.50	$ 42,615.00	$ 49,717.50	$ 52,558.50	$ 56,820.00	$ 71,025.00
6	$ 32,570.00	$ 39,084.00	$ 43,318.10	$ 43,969.50	$ 45,598.00	$ 47,226.50	$ 48,855.00	$ 56,997.50	$ 60,254.50	$ 65,140.00	$ 81,425.00
7	$ 36,730.00	$ 44,076.00	$ 48,850.90	$ 49,585.50	$ 51,422.00	$ 53,258.50	$ 55,095.00	$ 64,277.50	$ 67,950.50	$ 73,460.00	$ 91,825.00
8	$ 40,890.00	$ 49,068.00	$ 54,383.70	$ 55,201.50	$ 57,246.00	$ 59,290.50	$ 61,335.00	$ 71,557.50	$ 75,646.50	$ 81,780.00	$ 102,225.00

For family units of more than 8 members, add $4060 for each additional member

MONTHLY GUIDELINES

FAMILY	PERCENT OF POVERTY GUIDELINE										
SIZE	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	$ 980.83	$ 1,177.00	$ 1,304.50	$ 1,324.12	$ 1,373.16	$ 1,422.20	$ 1,471.25	$ 1,716.45	$ 1,814.54	$ 1,961.66	$ 2,452.08
2	$ 1,327.50	$ 1,593.00	$ 1,765.58	$ 1,792.13	$ 1,858.50	$ 1,924.88	$ 1,991.25	$ 2,323.13	$ 2,455.88	$ 2,655.00	$ 3,318.75
3	$ 1,674.17	$ 2,009.00	$ 2,226.65	$ 2,260.13	$ 2,343.84	$ 2,427.55	$ 2,511.26	$ 2,929.80	$ 3,097.21	$ 3,348.34	$ 4,185.43
4	$ 2,020.83	$ 2,425.00	$ 2,687.70	$ 2,728.12	$ 2,829.16	$ 2,930.20	$ 3,031.25	$ 3,536.45	$ 3,738.54	$ 4,041.66	$ 5,052.08
5	$ 2,367.50	$ 2,841.00	$ 3,148.78	$ 3,196.13	$ 3,314.50	$ 3,432.88	$ 3,551.25	$ 4,143.13	$ 4,379.88	$ 4,735.00	$ 5,918.75
6	$ 2,714.17	$ 3,257.00	$ 3,609.85	$ 3,664.13	$ 3,799.84	$ 3,935.55	$ 4,071.26	$ 4,749.80	$ 5,021.21	$ 5,428.34	$ 6,785.43
7	$ 3,060.83	$ 3,673.00	$ 4,070.90	$ 4,132.12	$ 4,285.16	$ 4,438.20	$ 4,591.25	$ 5,356.45	$ 5,662.54	$ 6,121.66	$ 7,652.08
8	$ 3,407.50	$ 4,089.00	$ 4,531.98	$ 4,600.13	$ 4,770.50	$ 4,940.88	$ 5,111.25	$ 5,963.13	$ 6,303.88	$ 6,815.00	$ 8,518.75

% CALCULATIONS

% of Financial Assistance	**100%**	**100%**	**100%**	**95%**	**90%**	**85%**	**80%**	**75%**	**70%**	**70%**	**70%**
% of chgs Patient Responsible	**0%**	**0%**	**0%**	**5%**	**10%**	**15%**	**20%**	**25%**	**30%**	**30%**	**30%**