

 HAWAII HEALTH SYSTEMS C O R P O R A T I O N <i>"Touching Lives Everyday"</i> Policies and Procedures	Department: Corporate	Policy No.: FIN 0520
	Issued by: Kelley Roberson COO & CFO	Revision No.: N/A
Subject: Charity Care	Approved by:	Effective Date: June 01, 2004
		Supersedes Policy: N/A
		Page: 1 of 5

I. PURPOSE: To establish procedural guidelines to identify, verify and qualify all applicants who wish to be considered for free health care under the HHSC Charity Program.

II POLICY:

- A.** HHSC shall give equal consideration to all patients who wish to be considered for free health care. Applicants shall not be discriminated upon based on race, age, color, sex, religion or national origin. General guidelines and exclusions are reflected on the application for HHSC Charity Program (Attachment I), also known as the "Application."
- B.** Maximum amount of HHSC sponsored charity shall be approved by the Board of Directors annually.

III. PROCEDURE: An Application under the charity program shall be issued and completed by the applicant, if possible, prior or during admission or upon receipt of medical treatment. Should the applicant be unable to complete the application, assistance may be sought through Admissions or Business Office.

A. Regular Admission:

1. At the time of admission, the patient may be made aware that HHSC provides for free health care under the charity program guidelines.
2. Should the patient indicate that he/she might be eligible for free health care based on the Eligibility Guidelines, the patient will be required to complete the Application for Charity Care prior to admission or receiving treatment unless the patient is in a condition not suitable for obtaining this information.
3. Upon completion of the Application, the patient shall turn in the completed Application to the Admissions or Business Office. They shall review the application for completeness.
4. The Business Office will receive the completed Application and immediately start to verify the information provided by the patient. If there are any questions that need further verification, Admissions or Business Office shall personally talk to the patient while he/she is still in the hospital. If the patient's condition is such that personal

contact is prohibitive, (ICU, isolation, comatose) attempts shall be made to personally contact the patient's spouse, son, daughter or representative for further information and verification.

5. During this period of information verification, the patient will be financially responsible for his/her hospitalization. Remittance of monthly statements will also continue to the patient or other responsible party.
6. If the patient has no insurance but has an application pending with the Department of Human Services (DHS) for medical assistance, the patient, upon notification that Application has been denied, may apply for charity assistance. Should the patient's Medicaid application be approved, billing may be processed upon receipt of the patient's eligibility card and/or coupon.
7. At any time during the collection of an outstanding bill, a patient may request consideration under the charity program. During this period, patients who appear to have difficulty in paying their bills will be informed of the charity program and encouraged to complete the application form.

B. Emergency Admissions:

1. In cases where an Emergency Admission is required, the Admissions department, upon routine follow-up, may advise the patient of the charity program.
2. Should the patient feel that he might qualify for free medical care, the patient will be required to complete an Application.
3. Upon completion of the Application, the application shall be routed to the Business Office for appropriate action.
4. The Business Office shall immediately start to verify the information provided by the patient. If there are any questions that need further verification, Admissions or Business Office shall personally talk to the patient while he/she is still in the hospital. If the patient's condition is such that personal contact is prohibitive (ICU, isolation, comatose) attempts shall be made to personally contact the patient's spouse, son, daughter or representative for further information and verification.
5. If the patient has no insurance but has an application pending with the Department of Human Services (DHS) for medical assistance, the patient, upon notification that application has been denied, may apply for charity program assistance. Should the patient's Medicaid application be approved, billing will be processed upon receipt of the patient's eligibility card and/or coupon.
6. At any time during the collection of an outstanding bill, a patient may request consideration under the charity program. During this period, patients who appear to have difficulty in paying their bills will be informed of the charity program and encouraged to complete the application form.

C. Outpatient Services:

1. At the time of service, the patient may be made aware that HHSC provides for free medical care under the charity program guidelines.
2. Should the patient indicate that they may be eligible for free medical care based on the Eligibility Guidelines, the patient will be required to complete an application prior to receiving treatment unless the patient is in a condition not suitable for obtaining this information.
3. Upon completion of the Application, the patient shall turn in the completed Application to the Admissions or Business Office. They shall review the application for completeness.
4. After the Application has been completed, the Business Office shall immediately start to verify the information provided by the patient. If there are any questions that need further verification, Admissions or Business Office shall personally contact the patient. If the patient is unable to or cannot answer said questions, inquiry may be made with the patient's spouse, son, daughter or representative.
5. If the patient has no insurance but has an application pending, with the Department of Human Services (DHS) for medical assistance, the patient, upon notification that Application has been denied, may apply for charity assistance. Should the patient's Medicaid application be approved, billing may be processed upon receipt of the patient's eligibility card and/or coupon.
6. At any time during the collection of an outstanding bill, a patient may request consideration under the charity program. During this period, patients who appear to have difficulty in paying their bills will be informed of the charity program and encouraged to complete the application form.

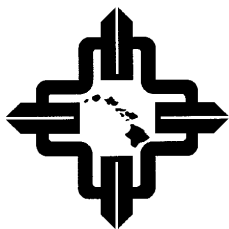
D. Administrative Review:

1. After all information on the Application has been verified by the Business Office, they shall submit the account to the Business Office Manager along with their supporting documents for review and approval. The Application shall also be forwarded to the Chief Financial Officer (CFO), for counter approval.
2. The charity care policy shall exclude the value of the patient's principal place of residence in the computation of income and assets. The value of any real property owned for the purpose of investments shall be included in the computation of income and assets
3. Eligibility will be determined based upon income and assets at the time the application is submitted and not at the time services were provided. If services were provided at a time when the patient would have been eligible for Medicaid coverage, but Medicaid coverage was not obtained, the current charity care application will cover those services.
4. If the patient's financial condition exceeds the Medicaid income and asset parameters, waive the requirement for the patient to apply for and be denied Medicaid eligibility and benefits. This is an unnecessary process for those

patients who have some financial means to support themselves and thereby disqualify them from receiving Medicaid benefits but may still qualify for charity care.

5. Applications for charity care from patients that are receiving inpatient mental health services and have exhausted all insurance benefits shall be automatically approved for charity care
6. Foreigners who are residents in the State of Hawaii may complete a charity care application. The foreign resident must provide proof of residency (i.e. passport, INS documents, etc.) and be a resident in the State of Hawaii for a minimum of 6 consecutive months. The foreign resident must meet the Charity Care income and asset qualification criteria.
7. For "out of state" Medicaid recipients, continue to bill the patient until Medicaid coverage can be verified. If an out of state Medicaid program does not cover the patient, the patient will be eligible for the Charity Care programs if all other criteria are met.
8. Allow physician services that are a part of the hospital's outpatient clinic operations to be eligible for charity care
9. Allow patients that qualify for a charity care discount and still have an outstanding balance in excess of \$2,500 after the discount is applied, to provide proof that they have made a good faith attempt to find additional resources (i.e. bank loan) to pay the remaining balance.
 - a. If an attempt is made to find additional resources with no success, allow the Regional CFO to approve an increase to the original discount percentage.
 - b. Many times, even after the charity care discount is applied, the patient is still not able to pay the remaining balance of the bill.
10. The qualification for free medical care shall be based on the HHSC Charity Program Eligibility Guidelines, revised annually. The Chief Financial Officer and the Business Office Manager shall make all considerations on an individual basis. The Regional Chief Financial Officer will be authorized to exercise exceptions to the charity care policy on a case by case basis
11. Submission of HHSC Charity Program Write-Offs for Administrative Review.
 - a. HHSC Charity Program Write-Offs shall be submitted to the Business Office Manager for review. The write-offs shall include an attachment which contains the following approved information
 - (1) Account Number
 - (2) Patient's Name
 - (3) Service Date
 - (4) Write-Off Amount
 - b. The HHSC Charity Program Write-Offs shall be submitted with the patient's ledger and completed Application to the Business Office Manager who shall review the Application for completeness, accuracy and signature.
 - c. All patients who applied for free medical care shall be notified in writing of the determination.

Attachment: 1. HHSC Charity Program Application



HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
"Touching Lives Everyday"

Attachment 1

**HAWAII HEALTH SYSTEMS CORPORATION
CHARITY PROGRAM APPLICATION**

I hereby request that HHSC make a written determination of my eligibility for free medical care. I understand that the information which I provide concerning my annual income, assets, and family size will be subject to verification by HHSC. I also understand that if the information provided is determined to be false, such a determination will result in the denial of any approved free medical care and that I will become liable for the charges for the services provided.

ACCOUNT #(S): _____

DATE(S) OF SERVICE: _____

PATIENT (First/M.I./Last): _____

ADDRESS: _____
(Number/Street/Apt.#/City/State/Zip)

FAMILY SIZE: _____

INCOME (include all income before deductions from sources below
for persons listed in family size):

	LAST 3 MONTHS	LAST 12 MONTHS
WAGES	\$ _____	\$ _____
SOCIAL SECURITY	\$ _____	\$ _____
UNEMPLOY. COMP	\$ _____	\$ _____
WORK COMP	\$ _____	\$ _____
ALIMONY	\$ _____	\$ _____
CHILD SUPPORT	\$ _____	\$ _____
PENSIONS	\$ _____	\$ _____
INCOME FROM RENT, DIVIDENDS, INTEREST	\$ _____	\$ _____
TOTAL INCOME	\$ _____	\$ _____

A. Total income for last 3 months \$ _____ X 4 = \$ _____

B. Total income for last 12 months \$ _____

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4028

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CHARITY PROGRAM APPLICATION

ASSETS (include all assets owned by all persons listed in family size):

REAL PROPERTY (House, Condominium, etc.) \$_____

(Excludes the value of the patient's principal place of residence. The value of any real property owned for the purpose of investments shall be included in the computation of income and assets)

BANK ACCOUNTS (Savings, Checking, etc.) \$_____

STOCKS, BONDS, ETC. \$_____

TOTAL ASSETS \$_____

TOTAL INCOME & ASSETS \$_____

Patient's/Requestor's Signature

Date

CHARITY PROGRAM APPLICATION

FAILURE TO COMPLY AND REMIT THE REQUIRED DOCUMENTS WILL RESULT IN THE REJECTION OF YOUR APPLICATION.

HHSC has developed a HHSC Charity Program to provide without charge or at a reduced charge to eligible persons who can not afford to pay for care.

The HHSC Charity Program will be available in all service areas except those health services provided under contract or in a leased portion of HHSC facilities.

To determine eligibility, please refer to the attached schedule.

To become eligible for free medical care, you are required to:

1. Complete the enclosed application form.
2. Apply for Medicaid (DHS) assistance. If denied, attach a copy of you're "Medicaid Denial Notice: to the application. (Failure to maintain schedule appointment with "Worker" does not constitute as a bona fide DHS denial.)
3. Attach a copy of income verification for the past twelve (12) months (paycheck stubs, Federal and/or State tax returns, checking or savings account bank statements, unemployment, social security, etc.) Return all of the above to this office as soon as possible.

The HHSC Charity Program applies only to HHSC's Hospital and Outpatient Clinic services and excludes the following:

1. Emergency Room, Laboratory, Anesthesiology, EKG, EEG, Cardiopulmonary, Nuclear Medicine, Radiology and Radiotherapy professional fees. You will receive a separate bill from the physician.
2. Your Medicare deductible.

CHARITY PROGRAM APPLICATION**FOR HHSC USE ONLY**

PATIENT: _____

ACCOUNT #(s): _____

Patient ineligible for DHS Assistance due to:

- ____ 1) Non U.S. Citizenship
- ____ 2) Assets exceeding Federal guidelines
- ____ 3) Being able-bodied and able to work
- ____ 4) Other (specify): _____

Type of service (check all that apply):

- ____ Acute Inpatient
- ____ Long Term Care
- ____ Outpatient

Determination of Eligibility:

____ Eligible for: ____ **NO PAY CARE**____ **PART PAY CARE**

PATIENT PAY ____%

CHARITY COV ____%

____ Ineligible (reason):

SIGNED: _____
Application Processor_____
DateSIGNED: _____
Manager of Business Services_____
DateSIGNED: _____
Chief Financial Officer_____
Date

CHARITY PROGRAM APPLICATION

HHSC CHARITY PROGRAM ALLOWABLE CHARGES WORKSHEET

PATIENT: _____

ACCOUNT#(s) _____

1. **TOTAL CHARGES** \$ _____

2. **LESS EXCLUDED CHARGES**

a. Third party payments \$ _____

b. Contractual Adjustments \$ _____

c. Patient payments \$ _____

d. Other (specify) \$ _____

3. **TOTAL ALLOWABLE CHARGES** \$ _____

4. **CHARITY WRITE-OFF:**

a. **NO-PAY PATIENT**

Total allowable charges (line #3) X 100% = total charity write-off

\$ _____ X 100% = \$ _____

b. **PART-PAY PATIENT**

Total allowable charges (line #3) X ____ % = total charity write-off

\$ _____ X ____ % = \$ _____

5. **SIGNED:** _____ **DATE:** _____

Account Representative

CHARITY PROGRAM APPLICATION**HHSC CHARITY PROGRAM DETERMINATION NOTIFICATION**

Dear _____;

Account #(s) _____

Your application for the HHSC Charity Program services at HHSC for the period _____ has been reviewed and the following determination has been made:

1. ____ You are eligible for: _____ free care or _____ part-pay care

Your share of charge is _____ %

The HHSC Charity Program applies only to the HHSC's Hospital and Outpatient Clinic services and excludes the following:

- A. Emergency Room, Laboratory, Anesthesiology, EKG, EEG, Cardiopulmonary, Nuclear Medicine, Radiology and Radiotherapy professional fees. You will receive a separate bill from the physician.
- B. You're Medicare deductible.

2. ____ You are ineligible because: (circle one)

- A. The eligibility standards under the HHSC Charity Program schedules are not met.
- B. The requested services are not eligible under our allocation plan.
- C. Lack of verification of income and/or assets.
- D. Third party coverage was available.
- E. Other (specify):

Manager of Business Services_____
Date