CHARLOTTE GASTROENTEROLOGY & HEPATOLOGY

Policy

CGH financial assistance is for patients, who do not qualify for other medical assistance, and are unable to pay for services, co-pays, co-insurance for treatments rendered by our providers and/or facility due to severe financial hardship.

Charity Care

The purpose of this policy is to outline the requirements and circumstances for providing charity care to patients whose financial situation makes it impossible for payment of medically necessary services. This does not include elective services. Those who meet the eligibility criteria established in the below outlined policy will quality to receive care from Charlotte Gastroenterology & Hepatology. Confidentiality of patients who qualify will be maintained and each patients handling of personal health information will meet HIPAA requirements.

1. Patients who wish to apply for indigent/charity care can apply and applications will be reviewed and approve patients for indigent care.
2. Charity care availability may be limited based upon budgetary constraints.
3. The patient must complete the Financial Hardship application in its entirety and supply the requested documents in order to be considered for indigent/financial hardship.
    - Total Household income will be reviewed
    - Documents from patient and spouse or from the responsible party for a dependent should include:
        - Last two paycheck stubs
        - Prior year's Income tax return
        - Forms from Medicaid or other State or Federal funded assistance programs (Disability forms, etc.)
    - Completion of the application does not mean financial assistance will be granted.
4. Once all documentation is reviewed, the annualized, household income will be compared to the current Federal Poverty Guidelines. Discounts will be given according to the following table:

Income Ranges and Percent of Charges Adjusted as Charity for 2023				
Number in Family**	**100%**	**75%**	**50%**	**25%**
1	$0 - $13,590	$13,591 - $16,988	$16,989 - $20,385	$20,386 - $23,783
2	$0 - $18,310	$18,311 - $22,888	$22,889 - $27,465	$27,466 – 32,043
3	$0 - $23,030	$23,031 - $28,788	$28,789 - $34,545	$34,546 - $40,303
4	$0 - $27,750	$27,751 - $34,688	$34,689 - $41,625	$41,626 - $48,563
5	$0 - $32,470	$32,471 - $40,588	$40,589 - $48,705	$48,706 - $58,823
**For each additional family member, add $4,540				

5. Once a determination has been made, each applicant will be notified that they have been designated as eligible to receive charity care.

6. Discounts/hardship will only be granted for 3 months. Re-application will be necessary for continued need.

7. Patients without an income source may be classified as charity if they do not have a job, mailing address, residence or insurance. If a patient does not have an income source, a letter of support should be supplied to CGH explaining their need for charity care consideration.

8. Patient accounts will be reviewed for charity care eligibility before being sent to an outside collection agency.

9. Patients who are in bankruptcy status and deceased patients without an estate or third party coverage may be considered for charity care.

Financial Assistance

10. Patients unable to pay their bill, outside of the scope of charity care, co-pay, co-insurance will be offered an interest free payment plan. The patient must sign an official budget arrangement in order for monthly payments to be recognized as a "payment plan."
    - Monthly payments will be offered in an amount that would allow for the bill to be paid within 6 months. Additional increments of 3 months will be offered if necessary.
    - Monthly payments of <$50.00 will not be accepted.
11. Patients unable to meet an approved payment arrangement, may be considered for indigent care provided they meet the following criteria
    - Patient is pending, denied, or ineligible for Medicaid
    - Patient is uninsured
    - Patient is determined to be unable to pay for services received

Indigent Care Application

Patient Information

First Name: Last Name: MI:

Date of Birth: SSN: Patient ID:

Payee Information (Person Responsible for Payment)

First Name: Last Name: MI: Relationship:

Date of Birth: SSN: Patient ID:

Street Address:

City: State: Zip:

Home Phone: Work Phone: # Of Dependents:

Household Monthly Income

	Person 1	Person 2	Person 3
Monthly Wages/Salary			
Unemployment			
Social Security/Pensions			
Alimony/Child Support			
Other			
Total Income:			

Household Monthly Expenses

	Person 1	Person 2	Person 3
Mortgage/Rent			
Utilities: Electric/Gas/Water			
Food/Grocery			
Credit Cards			
Car Payments			
Gasoline			
Insurance			
Phone			
Other			
Total Expenses:			

The following items must accompany the application in order to be considered – Where applicable, include pay stubs from both the patient, spouse and/or guardian of dependent patients.

1. Copies of last 2 most recent pay stubs.
2. Copy of the previous year's tax return.
3. Copy of the most recent bank statement with transaction details.
4. Medicaid or other State/Federal forms, such as disability, as proof of denial or pending status.
5. Any other documentation to prove you are unable to pay your medical bills and still be able to pay for basic, necessary, expenses (Housing, Food, Utilities).

Please read and sign the following verification:

I attest the information written above is accurate and complete, to the best of my knowledge. I understand that this application will be denied for any falsification of information or documents. I understand this is an application only, and not a guarantee of assistance. I also understand that this application is confidential. I understand that if approved, the approvals term is for 3 months and re-application will be necessary for additional consideration.

X _____ _____

Responsible Person's Signature **Date**

For Business Office Use Only:

Approved Assistance? YES/NO _____ Percent %

Effective Dates of Assistance: _____ to _____

X _____ _____

Revenue Cycle Manager Signature Date

X _____ _____

Chief Executive Officer Signature Date