Call Trish 406-873-3731
NRMC Business Office

Northern Rockies Medical Center

right care. right Here.

**802 2nd Street SE**
**Cut Bank, MT 59427**

**NORTHERN ROCKIES MEDICAL CENTER**

**COMMUNITY CARE**

# FINANCIAL ASSISTANCE PROGRAM

Applications must be completed in full to be eligible, please read carefully.

Application is to include:

**1. Medicaid Denial or Signed Attestation Statement**
**2. Proof of income for the entire household**
- **2.1 Most recent tax return**
- **2.2 Bank Statements for previous 3 months**
- **2.3 Pay Stubs for previous 3 months**

**2.4 Financial Hardship Applications: All outstanding bills**

Chief Financial Officer, Chief Executive Officer or Patient Financial Services Manager will approve or deny all applications.

Dated _____

**Objective:**

Northern Rockies Medical Center, a not-for-profit community hospital, will not discriminate in providing medically necessary services to those in need regardless of their ability to pay. Determination of eligibility of a patient for Financial Assistance shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status, or marital status. Patients deemed unable to pay will be eligible to receive Financial Assistance. Northern Rockies Medical Center will work to identify candidates for Financial Assistance based upon information submitted by the patient or patient's representative and will provide Financial Assistance for those meeting the criteria of this policy. The patient is ultimately responsible to fulfill their financial obligation to Northern Rockies Medical Center and is not granted Financial Assistance until the application has been completed and approved.

The Financial Assistance Policy must be approved by the Medical Center's Board of Trustees. This policy outlines the criteria to be used to determine a patient's eligibility for the Financial Assistance Program.

**Definition:**

Financial Assistance shall be defined as the patient's demonstrated inability to pay, whereas, bad debt results from the unwillingness of the patient to pay.

**Methods for Applying for Financial Assistance Program:**

1. In person at Northern Rockies Rural Health Clinic, Northern Rockies Medical Center Business Office, and Northern Rockies Physical Therapy Center.
2. Via the Hospital's website at www.nrmcinc.org

**Measures for Publicizing Financial Assistance Program:**

Northern Rockies Medical Center will advise patients and their families of Financial Assistance Program through the following means:

1. Direct patient contact, in person, or by phone.
2. Financial Assistance Program will be posted in each registration area, Emergency Department, and other waiting areas.
3. Financial Assistance Program will be printed on applicable letters and statements.
4. Posted on the hospital's website at www.nrmcinc.org.
5. Financial Assistance Program will be posted annually in the local paper.

**Procedure for Determining Eligibility:**

A request for a Financial Assistance application 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 eligibility. Northern Rockies Medical Center requires that Power of Attorney documentation and/or a release of financial information be on file.

**Eligibility Criteria:**

Eligibility for Financial Assistance does not exist where an individual has, or can qualify, for other third-party coverage (Group or individual medical insurance plans; Workers Compensation plans; Medicaid, State, or County Medical programs; and other state, federal, or military programs). If an individual is not currently covered by a third-party, he/she may choose to apply for Medicaid or sign the attached attestation statement included in the Financial Assistance Program application. Northern Rockies Medical Center personnel will assist individuals that do not qualify for Medicaid to qualify them for health insurance on the Insurance

exchange, and other available programs. 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.

The patient, or representative, must fill out an application for Financial Assistance prior to being deemed eligible. The application shall be submitted with proof of income to be verified by previous year's tax return, three previous months' bank statements, and three previous months pay stubs. If the individual is unemployed and not collecting unemployment, an unemployment statement is to be provided. The applicant must sign a release form for all items not verified for Northern Rockies Medical Center to verify income. The bank account supplement must be completed if the applicant does not have a bank account.

Eligibility is entirely determined based on gross income. The applicant's family income must be at or below 200% of the Federal HHS poverty guidelines. The HHS poverty guidelines are published each year in the Federal Register and shall be published where the availability of the Financial Assistance Policy is published. A person can qualify by having income for a twelve month period, or the most recent three months at or below the guidelines. If an individual qualifies for Financial Assistance by meeting the three month criteria, that person's income for the applicable three months will be annualized for the purposes of this calculation. If an individual is normally employed seasonally, their yearly income shall be used for making this determination. Applicants with no Insurance coverage that have been determined at or below 200% of the federal poverty guidelines will receive a 100% write-off.

The amount of Financial Hardship Assistance per patient shall be determined as follows:

| PERCENT AT OR BELOW FPG | PERCENT OF WRITE OFF |
|---|---|
| 100% | 100% |
| 125% | 80% |
| 150% | 60% |
| 175% | 40% |
| 200% | 20% (at least AGB variance) |

*Amount Generally Billed (AGB) is currently 19%

Persons qualifying for the Financial Assistance Program will be charged not more than the Amounts Generally Billed other payers. That amount is determined by the Medical Center and periodically updated. The Medical Center's Board of Trustees must approve each periodic update to the AGB's. Revised AGB's must be implemented within 45 days of Board approval.

Northern Rockies Medical Center adopts the U. S. Census Bureau's definition of family household for this policy. The applicant must be financially responsible for family members included on the application. (i.e. listed on tax return)

All medically necessary services will qualify for the Financial Assistance Program. Individuals can apply at the time of service.

Charges not generated by this facility that are not eligible include:

1. Clinic pathology charges.
2. Reference laboratory charges.
3. Consulting radiology charges (i.e. e. MRI, CT, Ultrasound, etc. ).
4. Specialty care delivered by consultants (Speech, Occupational).

If an individual gives the facility a payment before applying for Financial Assistance, that amount may be refunded to the patient if it is determined they are eligible for 100% write-off of charges

Patients denied Financial Assistance will be notified by mail informing them of the reason for denial. Patients who are approved Financial Assistance shall be notified by mail stating the qualifying discount. The financial obligations which remain after the application of qualifying discount may be payable in monthly installments over a reasonable period of time which should be consistent with the established monthly payment plan guidelines. Failure to make payment will result in the remainder of the patient account being sent to a third-party collection agency and the Financial Assistance application void.

Northern Rockies Medical Center's business office will keep a log of Financial Assistance Policy provided each fiscal year, along with all applications, of those approved and denied. Accounts notes will be maintained as well.

**Patient Collections Practices:**

1. Patient will continue to receive statements for 120 days
2. Notice to patient after 90 days informing that in 30 days account will be sent to collections
3. Extraordinary collection actions (ECA's) start on day 121
4. Time frame for Application Period (240 days)
5. ECA's will be suspended with request for financial assistance up to 240 days of the application period until eligibility is determined

**Billing Patients that do not qualify for the Financial Assistance Program:**

Patients are billed full charges if they do not apply for the Financial Assistance Program. A "Self-pay discount" of 15% will be offered to uninsured patients who pay visit in full within 30 days of first statement, 10% when paid in full within 2 statements, and 5% when paid in full within 3 statements.

Patient's not qualifying for the Financial Assistance Program may apply for financial hardship. The unpaid balance after third party payments for patients qualifying for Financial Hardship will be discounted. The Chief Executive Officer, the Chief Financial Officer or Patient Financial Services Manager will determine that full payment may cause social and financial hardship so as to significantly harm the patient or the family unit.

Northern Rockies Medical Center will determine what monthly payment amount could be made for a period of 12 months and the remaining balance will be adjusted to Financial Assistance.

Attachment:

Financial Assistance Work Sheet

**NORTHERN ROCKIES MEDICAL CENTER**
And
**RURAL HEALTH CLINIC**
802 2nd St SE
Cut Bank, Montana 59427
Ph. (406) 873-2251

**Financial Assistance Policy Work Sheet**

All other sources of possible payment must be exhausted before this office will consider any Financial Assistance Policy. You are expected to apply for any Public Assistance, Supplemental Security Income, and/or Medicare which may be eligible to you.

PATIENT: _____ PHONE: _____
ADDRESS: _____ MSG OR CELL: _____
_____ SIZE HOUSEHOLD: _____

HOUSEHOLD INFORMATION: (Individual applicant has financial responsibility)

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

INSURANCE/MED COVERAGE: YES_____ NO_____ TYPE_____

*(Only Applicants above 200% the HHS Poverty guidelines will need to complete the Household Monthly Expenses)*

| HOUSEHOLD MONTHLY INCOME | | HOUSEHOLD MONTHLY EXPENSES | |
|---|---|---|---|
| Wages | _____ | Rent/House payment | _____ |
| Social Security Benefits | _____ | Utilities | _____ |
| Unemployment Benefits | _____ | Personal Items | _____ |
| Workers Compensation Benefits | _____ | Auto Payment | _____ |
| Pension | _____ | Insurances | _____ |
| Child Support | _____ | Medical Expenses | _____ |
| Alimony | _____ | Credit Cards (list) | _____ |
| Any other (please list) | _____ | Loan Payments (list) | _____ |
| _____ | _____ | Other | _____ |
| _____ | _____ | TOTAL MONTHLY HOUSHOLD EXPENSES: | |
| TOTAL MONTHLY INCOME: | $_____ | | $ _____ |

*This is to certify that I am unable to meet my financial obligation to the Northern Rockies Medical Center for medical services rendered. Completion of this form is my request for assistance to help satisfy my obligations. The completion of this form does not guarantee assistance will be provided. I further certify that the information given on this form is true and correct to the best of my knowledge. I agree to provide copies of documents supporting the above information as requested by this office.*

Patient/Guarantor: _____Date: _____

Witness Signature: _____ Date: _____

**Office Use Only:**
Approved (%):_____
Not Approved:_____
Signature of CFO, CEO or PFS:_____

**Additional Information: (Unemployment Statement, Bank Account Documentation)**

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**NORTHERN ROCKIES MEDICAL CENTER**
ATTESTATION STATEMENT
(Check all that apply)

__ I am not age 65 or older, blind, disabled, pregnant; nor do I have a dependent child under the age of 19 in my home.

__ My yearly income does not exceed 200% of the Federal Income Poverty Guideline.

__ I live out of state and do not qualify for Montana Medicaid.

Patient: _____ Dated: _____

| Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty | | | | | | |
|---|---|---|---|---|---|---|
| **Poverty Level*** | **100%** | **125%** | **150%** | **175%** | **200%** | **>200%** |
| **Family Size** | **100% discount** | **80% discount** | **60% discount** | **40% discount** | **20% discount** | **0% discount** |
| **1** | $12,490 | 15,613 | 18,735 | 21,858 | 24,980 | 31,225 |
| **2** | $16,910 | 21,138 | 25,365 | 29,593 | 33,820 | 42,275 |
| **3** | $21,330 | 26,663 | 31,995 | 37,328 | 42,660 | 53,325 |
| **4** | $25,750 | 32,188 | 38,625 | 45,063 | 51,500 | 64,375 |
| **5** | $30,170 | 37,713 | 45,255 | 52,798 | 60,340 | 75,425 |
| **6** | $34,590 | 43,238 | 51,885 | 60,533 | 69,180 | 86,475 |
| **7** | $39,010 | 48,763 | 58,515 | 68,268 | 78,020 | 97,525 |
| **8** | $43,430 | 54,288 | 65,145 | 76,003 | 86,860 | 108,575 |
| **For each additional person, add** | $4,320 | $5,525 | $6,630 | $7,735 | $8,840 | $11,050 |

*Based on 2019 HHS Poverty Guidelines (http://aspe.hhs.gov/poverty-guidelines)

**Office Use Only**

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