ANMED HEALTH

MEDICAL ASSISTANCE PROGRAM

800 North Fant Street, Anderson, South Carolina 29621

Approved:	
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The AnMed Health Medical Assistance Program (AMAP) is a hospital sponsored charity program that provides patients with assistance if they meet established guidelines. Patients approved for the AnMed Health Medical Assistance Program must comply with the AMAP application process and provide proof of their income, equitable and liquid resources through the required supporting documentation.

Who may apply?

- Any patient or guarantor that requests assistance
- Any patient or guarantor that a staff member determines may be eligible for assistance on any accounts in good standings

Who may NOT apply and exceptions to the general rule:

- **Out of state residents are not eligible for non-emergency services** (Exception Georgia)
- **Cosmetic services** are not covered under the AnMed Health Medical Assistance Program
- **Routine/elective procedures that are not medically necessary may not be covered** unless there is an extenuating circumstance, and will be considered on a case by case basis
- Patients will not be eligible for assistance on **bad debt/collection** agency accounts
- Patients will not be eligible for assistance on **settlement agreement** accounts
- As stated in the heading there are exceptions to every rule and at the discretion of the Assistant Manager, Manager or Business Services Director, Senior Director, Vice President of Finance, etc. accounts that exhibit extenuating circumstances may be considered for approval through the AnMed Health Medical Assistance Program

Screening Process:

- Staff members should screen patient/guarantor in advance to determine if the patient/guarantor is financially able to make payments. If so, financial arrangements should be made with the patient/guarantor. If the patient/guarantor is not financially able to make payments and does meet AMAP criteria, then staff members should forward patient/guarantor an AMAP application.

- If a staff member determines after screening a patient that he/she may have Medicare and/or Medicaid coverage, this information must be verified to determine present or future eligibility for Medicare and/or Medicaid coverage.

- During the screening if it is determined that the patient/guarantor is not just medically indigent, due to not having insurance, but may be disabled and/or burdened with a long term or chronic illness, then patient/guarantor should be referred to the DSS staff on site at AnMed Health.

- It is critical that patients are screened appropriately upfront in regard to any individual policies or liability information. If another party may be responsible for reimbursement on services rendered, they would be primary to assistance from the AnMed Health Medical Assistance Program.

- Any patient who is eligible for any state or federal program must apply and be either approved for assistance or denied before the AnMed Health Medical Assistance Program may help with any bills that may incur at AnMed Health.

- If other resources or programs are available to assist with payment of the patient's hospital bill, they must cooperate with these services. If they do not pursue all other payment options, their financial assistance application will not be considered. These sources may include money available through insurance sources, including but not limited to money available from third parties liable for injury to the patient. We reserve the right to reinstate these charges should we discover any failure on the patient's part to cooperate with or pursue any other services offered or should we discover any information given to us was false.

Qualifying Criteria:

- **Income**
  We will use the 200% Gross Annual Income on the table of Poverty Guidelines as determined by the Federal Government

- **Home Property**
  Total equitable value of home property must not exceed $60,000. Please note: if there is a life estate on a home, it will not be counted as an asset for purposes of AMAP eligibility.

- **Non-Home Real and Taxable Personal Property**
  Total equitable value of non-home real and taxable personal property must not exceed $10,000.

- **Liquid Assets**
  Total value of liquid assets must not exceed $1,000

Verification of Resources and Supporting Documentation:

Income

- We will need proof of income for four weeks prior to application date. Please note: income from a non-spouse significant other who lives in the household will not be considered in the income calculation.

- Computation of income will be calculated using an average of the four weeks income multiplied by fifty two weeks to establish total gross annual income and/or monthly income multiplied by twelve to establish the total gross annual income as applicable

- To verify self employment income or as applicable, we will use the prior year's federal tax return to establish patient/guarantor total gross annual income

- Documents that may be used to ***verify earned income*** include, but are not limited to the following:
    1. Pay stubs
    2. Employee W-2 forms
    3. Wage tax receipts
    4. Federal income tax return
    5. Self-employment bookkeeping records
    6. Sales and expenditures records
    7. Employer's wage records
    8. Statements from employer
    9. Employment Security Office

- Documents that may be used to ***verify other types of income*** include, but are not limited to the following:
    1. Social Security award letter
    2. Benefit payment check
    3. Unemployment compensation letter
    4. Pensions award notice
    5. Veterans Administration award notice
    6. Correspondence on benefits
    7. Income tax records
    8. Railroad award letter
    9. Support and alimony papers evidenced by court order, divorce or separation papers, contribution check
    10. Social Security Administration records and letters or bank statements of direct deposit
    11. Employment Security Commission
    12. Union records
    13. Workmen's Compensation records
    14. Veterans Administration records and letters
    15. Insurance company records
    16. Tax records
    17. Railroad Retirement Board records
    18. Department of Social Services Letter of Notification

- If patient/guarantor does not have any income, we will need documentation of patient/guarantor means of living to establish food and shelter

Home Property

- The equity value of home property must not exceed $60,000. Please note: Homes that are considered a life estate will not be included in the AMAP eligibility process.

- The value of home property will need to be established through documentation from the patient/guarantor county tax assessor's office

- The patient/guarantor must provide proof/documentation of the payoff or total amount owed on home property from the lending or mortgage company

- Computation of home property equity must be determined by the following calculation: Value of home property - Amount owed on home property = Total equity value of home property

Non-Home Real and Taxable Personal Property

- The equity value of non-home real and taxable personal property must not exceed $10,000.

- Non-Home Real and Taxable Personal Property includes vehicles (motorcycles, cars, trucks, vans), boats, recreational vehicles, etc.

- Any home or land property that patient/guarantor owns separate from home property where patient/guarantor resides

- The value of this property may be established through Kelley Blue, NADA or county tax assessor's office documentation

- Computation of non-home property equity must be determined by the following calculation: Value of property – Amount owed on property= Total equity value of non-home property

Liquid Assets

- Total value of liquid assets/resources must not exceed $1,000

- Liquid asset resources include, but may not be limited to the following:
    1. Cash on hand
    2. Checking or savings accounts in banks or other savings institutions, including credit unions
    3. Savings certificates
    4. The market value of stocks or bonds
    5. Trust accounts except when inaccessible

6. Funds held in individual retirement accounts (IRA's). The entire cash value of the account, less the amount of any penalty for early withdrawal is counted.
7. Pension funds that are available
8. Federal and State Income Tax refunds
9. Pre-need burial contracts

- Computation of liquid assets for checking accounts is calculated based on the average of bank statement for three months prior to date of AMAP application. To calculate this we will use the average daily balance listed on the bank statement. If the average daily balance is not available we will use the ending balance minus any deposit made in 7 days.

AMAP Application Process:

- AMAP applications will be scanned into computer system and processed in the order of receipt, it is our goal to review applications within 30 days when feasible

- Patient accounts will be changed to financial class I, which places accounts on a temporary hold, until applications are reviewed and processed

- Staff member will utilize the AMAP worksheet to determine and document patient/guarantor income and asset limits

- If application is processed and approved, patient/guarantor will receive notification by letter of approval

- If an application is processed and missing required supporting documentation, patient/guarantor will receive notification by a pending letter with a request for the specific documentation needed to process patient/guarantor request for assistance

- If a patient/guarantor fail to return requested supporting documentation within 30 days from the date of pending letter, their request for assistance will automatically be denied

- If an application is processed and denied, patient will receive a letter of denial with the specified reason(s) of denial

- All documentation used to determine a patient/guarantor eligibility for assistance must be scanned into the computer system

AMAP Approval:

- If a patient/guarantor receiving medical services at AnMed Health meets AMAP qualifying criteria, they will receive a letter of approval for a period of 3 months beginning from the date of application and ending on the last day of the 3rd month.

- If a patient/guarantor receiving physician services at an AnMed Health participating Physician Practice meets AMAP qualifying criteria, they will receive a letter of approval for a period of 6 months beginning from the date of application and ending on the last day of the 6th month.

AMAP Denial:

- If a patient/guarantor does not meet AMAP qualifying criteria, their request for assistance will be denied. They will not be eligible to reapply for AMAP until 90 days from the date of denial

Adjustment Information:

- Accounts eligible for AMAP assistance will be adjusted to 998-9071

- If a patient has been approved AMAP and it is later determined that patient has Medicare, Medicaid, insurance, liability, etc. then AMAP adjustments will be reversed in order for appropriate party to be billed for reimbursement.

- If it is determined that an insurance or liability paid to the patient or is considering payment to the patient, then we will reverse the AMAP adjustment by the amount of the payment. The patient will then be responsible for this payment to AnMed Health.

Presumptive Charity:

Presumptive Eligibility: AnMed Health recognizes that not all patients are able to complete the financial assistance application or provide requisite documentation. For patients unable to provide required documentation (for example, deceased patients with no known estate, homeless or unemployed patients, non-covered medically necessary services provided to patients qualifying for public assistance programs, patient bankruptcies, and members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious organization), the hospital may grant financial assistance.

For patients who are non-responsive to hospital's application process, other sources of information will be used to make an individual assessment of financial need. This information will enable the hospital to make an informed decision on the financial need of non- responsive patients. This screening is conducted as a last resort after AnMed Health has reason to believe the patient will not qualify for any other funding sources.

For the purpose of helping all of the hospital's financially needy patients, including non-responsive patients, AnMed Health may utilize a third-party to review patient information

to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. These public records enable the hospital to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. The presumptive model applied systematically and properly, estimates the patient's financial need based on the best data available in the absence of information provided directly by the patient.

AnMed Health will utilize presumptive screening for the full current account balance. Patient accounts granted presumptive eligibility status will be adjusted accordingly. The presumptive screening intervention provides a community benefit by helping the hospital systematically identify the accounts of financially needy patients. These accounts will be reclassified under the financial assistance policy; they will not be sent to collection, will not be subject to further collection actions, and will not be included in the hospital's bad debt expense. Presumptive charity is not used to create an "on-going" state of charity and is not used to provide free care for future dates of service. Presumptive charity transactions will process under a separate transaction and adjusted to (insert adjustment code).