SAMARITAN HEALTH SERVICES
SYSTEM PATIENT FINANCIAL SERVICES
POLICIES AND PROCEDURES

- Patient Class "F"
- No deductibles or Copayments.

Revised: 10/01/99

Title: CHARITY PROCESSING

POLICY: Samaritan Health Services is dedicated to providing emergent medical care to all patients, regardless of age, sex, race, religion, national origin and/or ability to pay. In cases where the patient is unable to pay all or part of the amount they are for due to financial hardship, Samaritan Health Services will explore possible alternatives for financial assistance. In certain circumstances, federal, state, or local financial programs may be available to the patient.. Financial options must be explored and exhausted before considering charity care.

Each Charity Care application is considered on a case-by-case basis, with all aspects of a patient's situation taken into consideration during both the application and determination process. The facility Patient Services Director may, voluntarily or upon request, provide a recommendation for a Charity Care application. Final approval/disapproval for Charity Care allowance adjustment will be made by the Manager of SPFS Provider Relations, unless otherwise specified by the SPFS System Director.

REFERRAL OF ACCOUNT FOR CHARITY PROCESSING:

1) Upon the determination that a Patient/Guarantor is unable to meet their financial obligation for the patient liability of the account, refers the account to the Charity Representative in the Provider Relations department.

2) The Provider Relations Representative explains the Charity Care application process to the Patient/Guarantor. Explains to the Patient/Guarantor that collection procedures will continue until the financial packet has been returned and processed and they are encouraged to continue making payments.

3) Mail the Charity Care packet to the Patient/Guarantor, which includes a Cover letter of explanation of the items required, the Financial Statement, and postage paid return envelope.

4) Event "CAAM" with a notation that a Charity application has been mailed to the Patient/Guarantor.

5) Update "PATU" to a Patient Class "F" and the dunning message code via "CAAM" to "X", which will hold the patients billing statements.

6) Once the Patient/Guarantor it is reviewed for accuracy and completeness, which includes verification, have returned the Charity Care application information/documentation that all supporting documentation has been provided. Event "CAAM" that Charity application has been received. If the patient has not responded within 30 days from the date in which the application was mailed, the account will be removed from charity status.

(5) All Other Assets: Any other property (non-business) owned or mortgaged by the applicant must also be considered. Identify the total equity amount available.

Total the Property by adding the Residential Business Equities, Vehicles, and all other Assets.

Income: Based on the supporting documents provided by the applicant, determine the Employment Earnings by adding all of the pay stubs for the previous month and divide the number by the number of pay stubs to calculate the guarantors monthly income or by reviewing the previous years annual income tax, divide the gross income by 12.

Education Earnings: If the applicant is receiving any type of routine income due to educational programs, enter that amount here.

Self Employment: If the applicant is self employed, obtain a copy of the Business tax returns, Business bank statement & other supporting Business financial activity.

Other Income: This would be if the applicant is receiving any SSI, Pension, or child support income.

Total the Monthly Gross Income by adding the Employment earnings, education earnings, self-employment and other income. Then, calculate this number time's 12 months to create the Annual Gross income amount.

Medical Expenses: Document any medical expenses that are the Patient/Guarantors liability and are remaining outstanding.

a. Physician(s) Bills: Total all doctor bills for the Patient/Guarantor and add them together.

b. Prescription Drugs & Medications: Calculate the amount of expenses for the Patient/Guarantor for medications.

c. Eye Care: Record eye Care expenses for the Patient/Guarantor.

d. Dental Bills: Record any dental expenses for the Patient/Guarantor.

e. Hospital/Healthcare Facility Bills: Total any healthcare facility expenses (hospital, Care Center, etc.) outstanding by the Patient/Guarantor.

f. Other Medical Bills/Expenses: If the patient has other medical expenses not covered above (i.e., home health equipment) that were incurred.

g. Total Medical Expenses: Add all of the items listed under Medical Expenses.

SAMARITAN _____ FACILITY

PATIENT NAME _____

ACCOUNT NUMBER _____ EST. AMOUNT $ _____

CHARITY APPLICATION

A. ASSETS AND RESOURCES:

1. Cash and Securities: _____
2. Insurance Cash Values: _____
3. **Total Liquid Assets:** (Line 1 plus Line 2): _____
4. Equity in Residence: _____
5. Vehicles (Net Worth): _____
6. All Other Assets: _____
7. **Total Property** (Add Line 4 through Line 6): _____

STATUS	YES	NO
Applicant within Limits		
Liquid Assets $5,000 or Less		
Equity in Res $80,000 or Less		
Vehicles / All Other Assets $10,000 or Less		
Arizona Resident		

Number of Persons in Household:

OTHER CONSIDERATIONS:

B. INCOME:

1. Employment Earnings: _____
2. Education Earnings: _____
3. Self Employment: (Complete Section C) _____
4. Other Income: _____
5. **Total Monthly Gross Income** (Add Line 1 through Line 4): _____
6. **Total Annual Gross Income** (Line 5 x 12): _____

MEDICAL EXPENSES:

(Enter only those expenses that are patient responsibility)

7. Physician(s) Bills: _____
8. Prescription Drugs & Medications: _____
9. Eye Care: _____
10. Dental Bills: _____
11. Hospital / Healthcare Facility Bills: _____
12. Other Medical Bills / Expenses: _____
13. **Total Medical Expenses:** _____
14. **Total Net Income** (Line 6 minus Line 13): _____

MY SIGNATURE SIGNIFIES THAT THE INFORMATION ABOVE IS TRUE AND CORRECT.

SIGNED BY: _____ DATE _____
Patient / Responsible Party

REVIEWED BY: _____ DATE _____
Patient Representative

APPROVED BY: _____ DATE _____

APPROVED BY: _____ DATE _____

7) A. Supporting documentation requirements can vary depending on individual circumstances of the Patient/Guarantor.

- Paycheck stubs (three month's)
- Monthly bank statements (three month's)
- Mortgage company documentation verifying equity and/or the most recent year's tax evaluation letter for all properties
- Insurance verification of benefits (if applicable)
- If self-employed:
    - Business property documentation verifying equity and/or most recent year's tax evaluation letter for all business properties
    - Annual tax records
- Physician(s) bills/statements (last 12 months)
- Receipts for drugs/medications (last 12 months)
- Hospital/healthcare facility bills/statements (last 12 months)
- Other documentation that applies to patient's financial status, assets or supports outstanding unpaid medical expenses.

b. If required supporting documentation is incomplete, missing, or does not support the information on the Financial Statement, contact the Patient/Guarantor and request additional supporting documentation using the form letter Charity Contact.

If the Patient/Guarantor is unable to provide additional supporting information within two weeks, the Manager will be consulted for processing instructions and determined if the application will continue to be processed.

8) Once all information provided by the Patient/Guarantor on the Financial Statement form has been verified and confirmed, complete the Charity Financial Calculation Summary form.

A. Assets and Resources: Calculate each item as follows:

(1) Cash and Securities (checking, savings, CD's, etc.): Identify the ending balances of each type of account and combine the totals.

(2) Insurance cash values: If there are any insurance plans with an available cash value (life insurance, etc.).

Total the liquid assets by adding the Cash and Securities to the Insurance cash values.

(3) Equity in Residence: For the applicants' residential property (owned or mortgaged) identify the total equity amount available by calculating the actual value that the property could be sold for minus the mortgage balance owed.

(4) Vehicles Net Worth: Identify from the vehicles listed on the financial statement the blue book value of those vehicles minus the amount owed.

Banner Health Arizona
A division of Banner Health System

To patients applying for a discount/reduction in charges for services rendered, it is a *requirement* of the Federal Government that the financial statement be completed to the best of your knowledge.

In order for us to consider your application you must send us ALL the following documents:

- ☐ Completed **financial statement** (blue form)
- ☐ A copy of the **prior year tax return- (including schedule C if self employed)**
- ☐ A copy of **current pay stubs (4 weeks)**, if employed
- ☐ A copy of **social security, disability or unemployment check** or **award letter**, if applicable
- ☐ If unemployed, list **reason for unemployment:**
  ( ) Lay-off ( ) Quit ( ) Retired ( ) Last Place Worked _____
  ( ) Terminated: Date of Termination _____ ( ) Disabled: Date of Disability:_____
- ☐ Proof of **property value if you own your home or any other property.**
- ☐ A copy of your **last three bank statements (checking and savings)**Z
- ☐ A copy of any **outstanding medical bills**, including doctor bills, ambulance, etc.
- ☐ A copy of a state **AHCCCS Decision/Denial Notice.** You can obtain this by
- ☐ *Contacting the AHCCCS office in the area you live.* ***All potentially eligible patients must provide a valid "Notice of Action" from AHCCCS stating completion of the application and the reason for acceptance or denial.*** **Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this application for a charge discount and/or reduction.**

Please be advised that this is not a guarantee that charges will be discounted, and payments should continue on a regular basis until a determination has been made. Your application will be considered and a decision rendered on the information provided and verified. **All information received remains confidential.**

For any questions, please call our business office at 640-3154 between 8:00AM - 2:30 PM. Thank you for your cooperation and we look forward to being of assistance to resolve your account.
Please note that all items must be returned within 30 days for consideration.

Sincerely,

Celia Garza
Provider Relations Representative

DATE COMPLETED_____

MEDICAL EXPENSES - PLEASE INCLUDE BILLS OR STATEMENTS OF BALANCE

PATIENT LIABILITY EXPENSES:
(Enter only those expenses for which the patient or responsible party is totally responsible for paying)

A. PHYSICIAN(S) BILLS:

B. PRESCRIPTION DRUGS/MEDICATIONS:
(Purchased regularly monthly/weekly etc.)

C. EYE CARE:

D. DENTAL BILLS:

E. HOSPITAL/HEALTHCARE FACILITY BILLS:

F. OTHER MEDICAL BILLS/EXPENSES:

G. TOTAL OTHER EXPENSES (Add Lines A through F):

COMMENTS:

I CERTIFY THAT ALL STATEMENTS MADE IN THIS FINANCIAL STATEMENT ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS FINANCIAL STATEMENT.

SIGNATURE	DATE

PLEASE RETURN IN ENCLOSED ENVELOPE OR RETURN TO:
PATIENT FINANCIAL SERVICES 3141 NORTH 3RD AVENUE, PHOENIX, AZ 85013-4345

FOR ASSISTANCE, PLEASE CALL PATIENT SERVICES
(602) 640-3100 OR 1-800-423-2928.

Bixby, David

From: Hartke, Shannon
Sent: Thursday, July 07, 2005 3:26 PM
To: Bixby, David
Subject: RE: Draft Grassley Responses

David,

WOW! What a nice job.... ☺ I do have a few corrections for Fairbanks.

- Premenate Fund Dividend is correct, please change Premenate Dividend Fund to Premenate Fund Dividend
- #16... The list Fairbanks provided was indeed complete for all years. The Collection agency solved their archiving issue and was able to obtain complete figures.
- On Community Charity Events (only if you want to include) I did not see American Hart Walk (FMH), and Christmas Family through Love Inc. (FMH Business Office)
- Forgive me for this one .... I would also run through spell check there is a couple of small typing errors.

Thanks-Shannon

From: Bixby, David
Sent: Wednesday, July 06, 2005 9:23 PM
To: Dahlen, Dennis; Sullivan, Betsy; Dahlgren, Kathleen; Buehrle, Jeff; Dzurinda, Paul; Hartke, Shannon; Davis, Lisa; Weinman, Dan; Boudreau, Thomas; Byron, Bill
Cc: Fine, Peter
Subject: Draft Grassley Responses

Attached is a rough first draft of the responses to the Grassley letter. I will reformat this somewhat, and will include an introductory statement with some general information about Banner and its legacy organizations. There are obviously quite a few gaps, where I am still waiting for information or am awaiting clarification (or, in the case of identifying the actual amount of charity care, need to take the time to add up the charity allowances from the audit workpapers that have been provided to me). Thanks to all of you for getting so much information to me so far—this has been a bit of an education for me.

I have sent a draft to the outside lawyers to review and sanitize for litigation purposes. I would ask each of you to review the attachment for accuracy and completeness. I will be doing the same tomorrow. As of today, our deadline to have this in Senator Grassley's hands is still Monday, although the AHA will be meeting with his staff to ask for more time on Friday. In any event, I would like to get this off of my desk as soon as possible, even if an extension is given. So...time is of the essence in getting your comments (and additional information) back to me. Thanks.

David M. Bixby
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