Fisher-Titus Medical Center
Hospital Care Assurance Plan
Policies & Procedures
2020

Fisher-Titus Medical Center will provide medically necessary services to all patients regardless of their ability to pay. Uninsured patients may qualify for financial assistance under one of the many programs available at FTMC.

The first program available is the Hospital Care Assurance Program – HCAP.
This is a State of Ohio mandated program. It requires Ohio Hospitals to provide all inpatient and outpatient medically necessary services covered under the Medicaid program, free to any Ohio resident who has no third party coverage and has a family income at or below the federal poverty income guidelines.

Person(s) in family/ household	2020 0%-100% FPL **HCAP**
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

Eligibility is determined using a patient's income for:

1) The twelve months preceding the date of service (or)
2) Income for three months preceding the date of service annualized by multiplying by four.

A. Patients requesting free care will be referred to FTMC Financial Services Counselors/Clerks who will determine eligibility.

B. If the patient has not already qualified for Medicaid and may be eligible, the patient will be referred to their county of residence for possible Medicaid eligibility, (a different program for indigents under age 21, over age 65, disabled, pregnant or blind.)

C. If the patient does not meet Medicaid qualifications, Financial Services will determine eligibility for HCAP. The guarantor of the account(s) completes an application and provides proof of income based on:

- Check stubs three months prior to the date(s) of service, (or)…
- A W-2 if the patient cannot provide check stubs (or)…
- Bank statement…

- If the patient has no income, a written statement from the patient or guarantor must be provided as to how they are being supported. This statement must be signed and dated.

If the Financial Counselor/Clerk feels that Medicaid eligibility is possible, FTMC Counselors will provide the necessary paperwork to apply for Medicaid on behalf of the patient. The account will be held until a determination is made.

D. If the patient's family income falls at or below the federal poverty guidelines and the patient does not qualify for any other state aid, the patient's charges will be written off as part of the HCAP. ***Any patient payments made on an account written off to HCAP will be refunded to the patient.***

E. Having identified the patient's account(s) to be eligible for assistance, Financial Services will then write-off accounts that have cleared insurance and/or are self-pay. Any total guarantor balance of $5,000.00 or above will be reviewed and signed by the Financial Counselor, the Director of Patient Access and the Controller. Any total guarantor balance write-off exceeding $15,000 will be reviewed and signed by the Chief Financial Officer.

F. Financial Services will scan all appropriate documents into Cerner for that Guarantor's record including proof of income records, copies of applications and copies of patient's Medicaid/Insurance cards.

G. These files will be retained for no less than a period of seven years for audit purposes.

H. Fisher Titus Medical Center reserves the right to revoke and/or reverse charity approval to patients based on assets, income or non-taxable income (i.e. S.S., Pensions, Dividends, IRA / 401k withdraws, etc.,) that were not previously reported. The Fisher Titus Medical Center Charity Program is for those individuals and families that have no ability to pay.

I. Our billing procedure (after insurance payments and/or self-pay) provides four statements to the patient. The first statement includes a 10% discounted amount as prompt payment in full. The second and third statements simply state the full balance due. The fourth and final statement has a large red Final Notice stamped directly across the page. If the patient ignores or does not respond to this notification, regardless of payments being made, the account then goes into a collection status. The account remains in that status for 30 days before being turned over to an outside collection agency. It is the patient's responsibility to contact the Financial Services office to set-up reasonable payment plans if they cannot pay in full within those four statements. It is also the responsibility of the patient to complete a charity application if they believe their annual income for their family size may qualify them for possible assistance.

* **This requirement first appears in O.H.A. Bulletin 99-001, so noted on this date, 2-17-99.**