JACKSON COUNTY REGIONAL HEALTH CENTER
601 HOSPITAL DRIVE
MAQUOKETA, IA 52060-0910
(563) 652-2474

DATE:_____ RETURN BY:_____

Dear Applicant for Financial Assistance:

Attached is the application form for Financial Assistance that you requested. Please fill out ALL areas on the form to the best of your ability. If you need assistance completing this application, please call our Patient Financial Services from 7:00 a.m. to 4:00 p.m., Monday through Friday and ask to speak to one of our representatives.

YOU MUST APPLY WITH D.H.S. TO TRY AND QUALIFY FOR ASSISTANCE FIRST. IF IN FACT YOU ARE DENIED, THAT LETTER MUST BE ATTACHED TO THE FOLLOWING INFORMATION.

You will **NEED** to return the following information to us:

1. Completed application for Financial Assistance. Be sure to attach a separate sheet listing other circumstances you feel should be considered during the review of your application.
2. PROOF OF INCOME
   a. Last year's Income Tax Return-Federal and State and a copy of applicable schedules attached such as schedule F, SE, etc. Be sure and copy last year's W2 also.
   b. Include the past two months of payroll check stubs for yourself and/or spouse, if working.
   c. Verification of wage from any Public Assistance Agencies.
3. An itemization of all expenses:
   a. Cost of shelter
   b. Cost of food
   c. Cost of utilities
   d. Cost of transportation
   e. Any other monthly expenses i.e. doctor bills, telephone, car payments, etc.

*Failure to send all requested information will result in a denial of your application and the full balance(s) of your account(s) will be due and payable within 30 days. If payment arrangements need to be made, please feel free to contact the Patient Financial Services at (563) 652-2474 to do so.

Thank you

JACKSON COUNTY REGIONAL HEALTH CENTER
MAQUOKETA, IA

APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Name_____
First Middle Last

Address_____
Number & Street City State Zip

Telephone: (_____) _____Cellular (_____)_____

Please circle appropriate item: Buying home Buying mobile home Renting house
Renting apartment Living with relatives Other

How long have you lived at this address? _____Years_____Months

Patient Name_____Date(s) of Service_____

Family Size: Number of Adults _____Number of Children_____Total_____

EMPLOYMENT: ENTER ALL EMPLOYMENT DURING THE PAST YEAR FOR EACH FAMILY MEMBER:

WORKERS NAME	NAME OF EMPLOYER	DATE OF EMPLOYMENT	GROSS INCOME LAST 12 MONTHS	GROSS INCOME LAST 3 MONTHS

YOU MUST ATTACH INCOME TAX RETURNS AND W-2'S TO THIS FORM!

OTHER SOURCES OF INCOME:

SOURCE OF INCOME	DATES INCOME RECEIVED	GROSS INCOME LAST 12 MONTHS	GROSS INCOME LAST 3 MONTHS
Self-Employment			
Workmans Compensation			
Social Security			
Social Security (Spouse)			
Social Security Disability(SSI)			
Child Support/Alimony			
Veterans Benefit			
Railroad Retirement Benefits			
Disability Insurance Payment			
Income on Stocks, Bonds, Annuities, Other Investments			
Personal Injury Insurance Settlement			
Cash from Relatives			
Public and/or General Assistance			
Tax Refunds			
Business/Personal Loans for Income			
Gross Business Income			
Gross Farm Income (Sale of Commodities/Livestock)			
Interest Income			
Unemployment Compensation			

CASH

CASH ASSETS	AMOUNT	NAME OF COMPANY/SOURCE
CASH ON HAND		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MARKET VALUE OF STOCKS, BONDS, ANNUITIES, OTHER INVESTMENTS		
TRUST FUND		
LIVE INSURANCE CASH VALUE		
TIME CERTIFICATES		

PERSONAL PROPERTY/REAL/BUSINESS

DESCRIPTIONS	DESCRIPTION	MARKET VALUE	AMOUNT OWED
Automobile/Truck			
Automobile/Truck			
Automobile/Truck			
Motorcycle/Moped			
Farm Equipment			
Snowmobile			
Boats/Motors/Trailers			
Mobile Home/Campers			
Recreational Vehicle			
Livestock			
Stored Grain			
Business Property			
Farm Land/Buildings			
Residential Property			
Other Rental/Income			

I UNDERSTAND THAT THE INFORMATION SUBMITTED CONCERNING ANNUAL INCOME/ASSETS AND FAMILY SIZE IS SUBJECT TO VERIFICATION.

I ALSO UNDERSTAND THAT INFORMATION SUBMITTED ON THIS FINANCIAL ASSISTANCE APPLICATION WHICH IS FALSE OR MISLEADING WILL RESULT IN A DENIAL OF THE REQUEST.

DATE OF APPLICATION_____

SIGNATURE_____

==========

FOR HOSPITAL USE ONLY

Date Application Issued:_____Date Returned:_____

JACKSON COUNTY REGIONAL HEALTH CENTER
CONFIDENTIAL FINANCIAL DATA
(Information provided is kept strictly confidential)

DATE TO CLIENT_____RETURN TO JCRHC BY_____

Please complete this form and return to the JCRHC Business Office as soon as possible. If this form is not returned to our office by the date indicated above, we shall assume you wish to pay in full and you will be billed accordingly.

NAME_____SOC. SEC#_____

ADDRESS_____

CHOOSE ONE OF THE FOLLOWING: 1 OR 2

1:
I **DO NOT** WISH TO DISCLOSE MY INCOME AND AGREE TO PAY IN FULL.
DATE_____SIGNATURE_____

2:
IF YOU CHOOSE TO DISCLOSE YOUR INCOME INFORMATION:

YOU MUST COMPLETE THE FOLLOWING:

LIST OTHERS LIVING IN YOUR HOUSEHOLD:

NAME	RELATIONSHIP

ARE YOU CLAIMED ON ANYONE ELSES TAX FORM? ____YES ____NO

DO YOU OWN PROPERTY OTHER THAN WHERE YOU RESIDE? ___YES ___NO

*****PLEASE ATTACH A STATEMENT OF YOUR MONTHLY EXPENSES*****

A COPY OF YOUR FEDERAL AND STATE TAX FORMS, AND ALL ATTACHMENTS MUST BE SUBMITTED WITH THIS FINANCIAL DATA.

_____I AM NOT RETURNING THE ABOVE FORMS.

JACKSON COUNTY REGIONAL HEALTH CENTER

CONFIDENTIAL FINANCIAL DATA

(Information provided is kept strictly confidential)

Please provide the name, address, and phone numbers of **EACH** and **EVERY** bank or financial institution you utilize or have utilized within the past year.

NAME	COMPLETE ADDRESS	PHONE

I_____, authorize and give permission to the above named bank, financial institution, or entity, to provide any financial information to the Jackson County Regional Health Center, and in signing this release, I agree to release and hold such bank, financial institution, or entity harmless from any liability for the release of such information to the Jackson County Regional Health Center. A photocopy of this release may be given the same full force and effect as the original release.

_____ _____

SIGNATURE DATE

Jackson County Regional Health Center

Title: Financial Assistance		
Department(s): Hospital Wide		
Date Effective: 8/26/2003	Archive Date:	Originator: Board of Trustees
Review/Revised Dates: Restated 6/16, 9/17, 2/18, 6/18, 9/18, 4/19, 9/19, 3/20, 9/20, 1/21, 9/21		

Approved Signature on File	Date	Approved	Date
Approved	Date	Approved	Date

Policy:
The Board of Trustees of Jackson County Regional Health Center (JCRHC) is committed to providing quality, compassionate care to all of those in need regardless of ability to pay. In support of this commitment, JCRHC maintains this Financial Assistance Program ("FAP") policy to provide assistance for eligible individuals with covered health care needs.

Purpose:
To meet the needs of the community, JCRHC has established a fair and equitable FAP to provide Financial Assistance that reflects the status of JCRHC non-profit healthcare provider, which promotes its mission. The FAP is focused on those patients who are unable to sustain the extraordinary burden of medical expenses due to limited income and resources. The FAP applies to any emergency and other Medically Necessary Care for eligible individuals and is intended to comply with the Code Section 501(r) Requirements.

Definitions:
Please see Appendix 1 for a complete list of definitions used in this FAP.

General Considerations:
This policy will apply to all patients regardless of national origin, age, race, color, sex, creed, culture, education, ability to pay, sexual orientation, veteran status, religion, handicap/disability, diagnosis, or political affiliation. Reasonable efforts will be taken to ensure that any language or hearing barriers are addressed, consistent with the Code Section 501(r) Requirements.

Practice/Procedure:

A. SCOPE:

1. General: The FAP applies to all emergency and other Medically Necessary Care provided by JCRHC to eligible patients, including all such care provided in JCRHC.

2. Exclusions: Patient care that is not considered emergency or Medically Necessary Care, elective, cosmetic, or other care deemed to be generally non-reimbursable by government payers shall not be considered eligible for Financial Assistance.

3. Publicity: Facility will widely publicize the availability of the FAP to all patients. The measurers for widely publicizing the FAP are provided in Appendix 2.

4. Other Programs and Discounts. JCRHC will make available to all patients information on its FAP as well as other JCRHC programs that may provide assistance, such as prompt-pay discounts, and financing options.

B. ELIGIBILITY CRITERIA AND FINANCIAL ASSISTANCE:

1. Insured Status. Financial Assistance may be available for patients who are uninsured or underinsured, if they meet applicable eligibility criteria. An uninsured patient is a patient who has no level of insurance or third-party payment assistance. An underinsured patient is a patient who has some level of insurance or third-party payment assistance but whose out-of-pocket expenses exceed his/her financial abilities.

2. Minimum Balance. Effective on date of service July 1, 2016, the minimum balance on any account to qualify for Financial Assistance must be equal to or greater than $200.00.

3. FAP Application and Criteria. The primary criterion for determining eligibility for Financial Assistance is household income, including certain available net assets, based on the information requested and provided in the FAP Application, as explained in Section D. An individual will not be denied Financial Assistance based on information that has not been specified or required in the FAP or in the FAP Application.

4. Financial Assistance Sliding Scale. Effective date of service January 1, 2016, Financial Assistance shall be available pursuant to the sliding scale found in Appendix 3, which is based on the Federal Poverty Income Guidelines ("FPIG"). Consistent with the sliding scale, 200% Financial Assistance (i.e., full Charity Care) shall be provided to documented homeless patients, deceased individuals without estates, and underinsured and the uninsured patients earning 200% or less of FPIG.

   Furthermore, a patient determined to be eligible for Financial Assistance shall not be financially responsible for more than the Amount Generally Billed (AGB), as defined in Section C., for emergency or other Medically Necessary Care. Discounts available under the FAP are based on gross charges applicable to the service. Patients may be eligible for discounts such as prompt-pay discounts in addition to, or in lieu of, this FAP.

5. FPIG. The Patient Financial Services (PFS) Dept. Manager shall be responsible for updating the FPIG every calendar year.

6. Extenuating Circumstances. On occasion, extenuating circumstances may exist which would cause JCRHC to grant Financial Assistance to a patient who may otherwise not meet quantitative criteria. In such cases, the PFS Manager or appropriate Management staff will document why the assistance was granted and supporting documentation will be maintained.

7. Offsets. In the event a patient is awarded a settlement from pursuing legal proceedings or has received financial resources specifically identified to cover the care that was delivered, it is the obligation of the patient to inform JCRCH and make appropriate payment to JCRHC at that time. JCRHC may reverse the decision of Financial Assistance and document accordingly, to the extent allowed by the Code Section 501(r) Requirements.

8. Cooperation. Any patient who fails or refuses to provide requested information to a third party payor that results in a denial will not be eligible for the FAP. A patient who furnishes materially incorrect or fraudulent information in connection with this FAP may be deemed ineligible for Financial Assistance at the sole discretion of JCRHC.

C. AMOUNTS GENERALLY BILLED (AGB):

For purposes of the FAP, JCRHC calculates AGB using the prospective method consistent with the Code Section 501(r) Requirements. Members of the public may readily obtain the applicable AGB percentage and a description of the calculation in writing and free of charge by contacting the PFS Dept. (see page 5 for contact information), or visiting JCRHC.

D. APPLICATION PROCESS:

1. FAP Application. Patients seeking Financial Assistance must complete a FAP Application to document income and expenses (liabilities) unless they meet the presumptive eligibility criteria (see Section D.5). JCRHC may ask for a credit card statement to support the information provided in the FAP Application. FAP Applications may be found online at www.jcrhc.org, contacting the PFS Dept. or visiting JCRHC.

2. Income Verification. Income (household income) will be estimated yearly by the patient supplying any of the following:
   - A copy of the most recent tax return
   - A copy of the most recent W-2 form and 1099 forms
   - Copies of the 2 most recent pay stubs
   - Written income verification from an employer if paid in cash

3. Completeness. JCRHC recognizes that not all patients are able to provide complete financial and/or social security information. Therefore, approval for Financial Assistance may be determined based on available information.

4. Identification. To verify a patient's name, date of birth, and/or address, the patient must provide any of the following:

    - A valid passport
    - A valid birth certificate
    - A certificate of citizenship, U.S. or foreign (including but not limited to DHS Forms N-560 or N-561)
    - An identification card issued by the U.S. or a foreign government (including but not limited to DHS Form I-197)
    - An official military record of service
    - A certification of a foreign birth (including but not limited to form FS-545)
    - A report of birth abroad (including but not limited to Form FS-240)
    - A Certificate of Report of Birth issued by the U.S. Department of State (Form DS-1350) or similar form issued by a foreign government
    - A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database
    - A government census record
    - A certificate of naturalization, U.S. or foreign (including but not limited to DHS Forms N-550 or N570)

    If the patient is not able to provide a document from the above list, the patient must provide an alternate written means through which JCRHC can verify the patient's name, date of birth and/or address.

5. External Sources. JCRHC may utilize previously completed Financial Assistance applications to make presumptive eligibility determinations. In addition, demonstration of one or more of the following will result in a presumptive eligibility determination:

    a. Homelessness
    b. Deceased with no estate
    c. Mental incapacitation with no one to act on patient's behalf
    d. Medicaid eligibility, but following date of service, or not for non-covered services
    e. Recent personal bankruptcy
    f. Incarceration in a penal institution

    In these instances where assistance is found to be appropriate, notice will be forwarded to patient via reduced balance on their statement, which shall include information regarding how to apply for potentially more generous Financial Assistance within a reasonable period of time (see E.1.a).

6. Remaining Balance. All balances owing after Financial Assistance has been provided may choose financing options pursuant to the standard payment procedures of JCRHC or make monthly payments for up to six (6) months if application to a financing institution is denied.

7. Referral Sources. Patient referrals may come from the patient or anyone acting on his/her behalf, including medical staff. In addition, the PFS Dept. shall routinely review the payment history of accounts to determine possible candidates with emphasis on those with demonstrated payment history that are willing but unable to pay more.

8. Timeline for Establishing Financial Assistance Eligibility.

    a. A FAP Application will be accepted and processed by JCRHC at any time during the Application Period pursuant to the procedures outlined in Section E.

    b. The information contained in a FAP Application is valid for six (6) months, and, after that time period expires, the application will need to be renewed.

E. BILLING AND COLLECTIONS PROCESS:

As described below, JCRHC will make reasonable efforts to determine whether a patient is eligible under this FAP for Financial Assistance before it engages in an extraordinary collection action (ECA). Once a determination is made, JCRHC may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. Except as provided below, a patient may submit a FAP Application at any time during the Application Period, which is generally 240 days from the date of the first post-discharge bill as defined in Appendix 1. JCRHC will not be obligated to accept a FAP Application after 240 days from the date of the first post-discharge bill (including patients who have fully paid applicable charges) unless otherwise specifically required by the Code Section 501(r) Requirements. Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

    a. Presumptive Eligibility Determinations. If a patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application submitted with respect to prior care), JCRHC will notify the patient of the basis for the determination and give the patient a reasonable period of time to apply for more generous assistance before initiating an ECA.

    b. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted, JCRHC will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement for the care is sent to the patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one or more ECA(s) to obtain payment for care from a patient who has not submitted a FAP Application, JCRHC shall take the following actions:

        i. Provide the patient with a written notice that indicates Financial Assistance is available for eligible individuals, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;

        ii. Provide the patient with a plain language summary (see Appendix 4); and

        iii. Make a reasonable effort to orally notify the individual about the FAP and the FAP Application process.

    c. Incomplete FAP Applications. In the case of a patient who submits an incomplete FAP Application during the Application Period, JCRHC shall notify the patient in writing about how to complete the FAP Application and give the patient seven (7) calendar days to do so. Any pending ECAs shall be suspended during the reasonable opportunity, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.

    d. Complete FAP Applications. In the case of a patient who submits a complete FAP Application during the Application Period, JCRHC, shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

    e. Restrictions on Deferring or Denying Care. In a situation where JCRHC intends to defer or deny, or require a payment before providing, Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP, the patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible patients and stating the deadline, if any, after which JCRHC will no longer accept and process an application submitted (or, if applicable, completed) by the patient for the previously-provided care at issue. This deadline shall be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement was provided for the previously provided care.

2. Determination Notification.

    a. Determinations. Once a completed FAP Application is received on a patient's account, JCRHC will evaluate the FAP Application to determine eligibility and notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days. The

notification will include a determination of the amount for which the patient and/or responsible party will be financially accountable. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

b. Refunds. JCRHC will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

c. Reversal of ECA(s). To the extent a patient is determined to be eligible for Financial Assistance under the FAP, JCRHC will take all reasonably available measures to reverse any ECA taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien on the individual's property, and remove from the individual's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

3. Appeals. The patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the PFS Department within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the PFS Manager for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to the patient, legal guardian, and/or responsible party.

4. Collections. Upon conclusion of the above procedures, JCRHC may proceed with ECAs against uninsured and underinsured patients with delinquent accounts, as determined in JCRHC procedures for establishing, processing, and monitoring patient bills and payment plans. To the extent applicable, JCRHC will utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts and shall comply with the Code Section 501(r) Requirements applicable to third parties.

F. ADMINISTRATION:

1. General. The FAP is administered by JCRHC PFS Department at the direction of the Board of Trustees.

2. Interpretation. JCRHC has the sole discretion to interpret, enforce, and administer this FAP consistent with all federal, state, and local laws, and regulations that may apply.

3. Amendment. This FAP may be amended from time to time by the Board of Trustees of JCRHC.

G. PROVIDER LIST:

A list of providers ("Provider List") that provide emergency or Medically Necessary Care at JCRHC is maintained and updated from time to time by Medical Affairs and can be accessed by contacting JCRHC.

H. JCRHC PATIENT FINANCIAL SERVICES:

For purposes of obtaining additional information about the Financial Assistance Program or for assistance in completing a Financial Assistance application, please contact the PFS Dept. at the following address and phone number:

Jackson County Regional Health Center
Patient Financial Services Dept.
700 West Grove Street
Maquoketa, Iowa 52060
(563) 652-2474

References:
GHS Financial Assistance Policy
Fair Debt Collection and Practices Act
Federal Register, Annual Poverty Guidelines
Section 501(r) of Internal Revenue Code of 1986

Appendix 1
DEFINITIONS

Amounts Generally Billed or "AGB". The amounts generally billed for emergency or other Medically Necessary Care to individuals who have insurance covering such care, as further explained in Section C.

Application Period. The period during which a Financial Assistance application may be submitted to JCRHC. Application Period begins on the date care is provided and ends on the later of the 240th day after the date the first post-discharge statement for the care is provided or either: (i) the date specified in a written notice from JCRHC regarding its intention to initiate ECAs; or (ii) in the case of a patient who has been deemed presumptively eligible for Financial Assistance less than 200%, the end of the reasonable time to apply for Financial Assistance as described in Section E.

Charity Care. Payment relief for which JCRHC will not seek payment for services rendered based upon a determination that an individual does not have the ability to pay his or her full obligation.

Code Section 501(r) Requirements: The requirements of Section 501(r) of the Internal Revenue Code of 1986, as amended from time to time, and the related Treasury Regulations pertaining to financial assistance, limitations on charges, and billing and collections activities.

Deductibles and Co-Pays. Patient's financial liability for care as determined by individual insurance coverage benefits.

Extraordinary Collections Actions or "ECAs". For purposes of this FAP, ECAs are those activities identified under the Code Section 501(r) Requirements, which may include:

1. Selling an individual's debt to another party, unless the purchaser is subjected to certain restrictions as provided in the Code Section 501(r) Requirements.

2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

3. Deferring or denying, or requiring a patient before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the FAP.

4. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding.

Family Size. The number of individuals for whom a personal exemption is claimed on the patient's most recent Federal Income Tax return (in the case of a patient who is a dependent, the return of that patient's parent or guardian). If no Federal Income Tax return is filed, then family size will consist of the patient, his or her documented spouse, and his or her documented dependents as defined by the Internal Revenue Code of 1986, as amended from time to time.

Federal Poverty Income guidelines (FPIG): The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2), which are used in comparing levels of applicable Financial Assistance available under the FAP.

Financial Assistance: Payment relief for which JCRHC will apply to a patient's financial obligation, including Charity Care, as indicated in Appendix 3, provided that an individual eligible for Financial Assistance will not be found financially responsible for more than AGB for emergency or other Medically Necessary Care.

Household Income: As may be identified and requested on the FAP Application, cumulative total of gross income(s) for all members of a patient's household as shown on tax forms (income tax return), which may include, but is not limited to, the following:

1. Wages.
2. Self-employment income.
3. Unemployment compensation.
4. Social Security.
5. Social Security Disability.
6. Veterans' pension.
7. Veterans' disability.
8. Private disability.
9. Workers' compensation.
10. Retirement income.
11. Child support, alimony or other spousal support.

12. Other income.
13. Available net assets, including, but not limited to, cash, bank and/or investment accounts, and real estate.

HMO: Health Maintenance Organization; Type of third party payor (insurance company).

PPO: Preferred Provider Organization; Type of third party payor (insurance company).

Medically Necessary Care: As determined pursuant to a physician's order and/or clinical supervision during rendition of service, standard medical care required because of disease, disability, infirmity or impairment. Furthermore, Medically Necessary Care shall:

- Be consistent with the diagnosis and treatment of the patient's condition;
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- Be the least costly type of service which would reasonably meet the medical need of the patient.

Medicare Advantage Plan: Medicare replacement plan; can be HMO, PPO, or PFFS.

Self-Pay: Any account where anticipated reimbursement form a third party payor is not available.

APPENDIX 2

MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSISTANCE PROGRAM

JCRHC will have a means of widely publicizing the availability of the FAP to all patients. The measures taken to widely publicize the FAP include, but are not limited, to the following:

1. A conspicuous written notice will be included on the healthcare bill, statement, invoice or summary of charges that notifies and informs recipients about the availability of Financial Assistance under the FAP and includes the telephone number of the Patient Financial Services Dept. and the direct website address where copies of the FAP, a description of the FAP Application process and a copy of the FAP Application, and a plain language summary of the FAP may be obtained.

2. Signs in the admission, emergency room, registration, and other appropriate areas provide the billing options form that explains that the provider offers a FAP and how to obtain more information. Such signs shall be posted in English and in any other language that is the primary language of at least five percent (5%) of the patients served by the applicable hospital annually.

3. Make paper copies of the FAP, the FAP Application, and plain language summary available upon request and without charge, both by mail and in public locations in all emergency room and admission areas.

4. Designated staff that can explain the FAP.

5. Staff that can direct patients to appropriate patient representatives for explanation.

6. A notice located in a prominent place on JCRHC's website that Financial Assistance is available at the hospital, along with copy of the FAP, the FAP Application, and a plain language summary of the FAP.

7. Notify and inform patients about the FAP by offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process.

8. Make available translations of the FAP, the FAP Application, and plain language summary in the language spoken by groups that constitute the lesser of 1,000 individuals or five percent (5%) of the community served by the applicable hospital or the population likely to be affected or encountered by the applicable hospital.

9. Take measures to notify and inform members of the community about the FAP, which includes sharing information with the Community Health Needs Assessment Committee.

JCRHC 2021 APPENDIX 3
FINANCIAL ASSISTANCE
PROGRAM
PERCENT OF PATIENT RESPONSIBILITY BASED ON INCOME AND # IN HOUSEHOLD
INCOME GUIDELINES BASED ON 200% FEDERAL POVERTY INCOME GUIDELINES
(FPIG)

HOUSEHOLD #:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
100%	25,760	34,840	43,920	53,000	62,080	71,160	80,240	89,200
90%	25,761	34,841	43,921	53,001	62,081	71,161	80,241	89,201
	28,336	38,324	48,312	58,300	68,288	78,276	88,264	98,120
80%	28,337	38,325	48,313	58,301	68,289	78,277	88,265	98,121
	30,912	41,808	52,704	63,600	74,496	85,392	96,288	107,040
70%	30,913	41,809	52,705	63,601	74,497	85,393	96,289	107,041
	33,488	45,292	57,096	68,900	80,704	92,508	104,312	115,960
60%	33,489	45,293	57,097	68,901	80,705	92,509	104,313	115,961
	36,064	48,776	61,488	74,200	86,912	99,624	112,336	124,880
50%	36,065	48,777	61,489	74,201	86,913	99,625	112,337	124,881
	38,640	52,260	65,880	79,500	93,120	106,740	120,360	133,800
40%	38,641	52,261	65,881	79,501	93,121	106,741	120,361	133,801
	41,216	55,744	70,272	84,800	99,328	113,856	128,384	142,720
30%	41,217	55,745	70,273	84,801	99,329	113,857	128,385	142,721
	43,792	59,228	74,664	90,100	105,536	120,972	136,408	151,640
20%	43,793	59,229	74,665	90,101	105,537	120,973	136,409	151,641
	46,368	62,712	79,056	95,400	111,744	128,088	144,432	160,560
10%	46,369	62,713	79,057	95,401	111,745	128,089	144,433	160,561
	48,944	66,196	83,448	100,700	117,952	135,204	152,456	169,480

REVIEWED AND APPROVED BY:

CHIEF FINANCIAL OFFICER

DATE

APPENDIX 4

Below you will find the **Plain Language Summary:**

If you believe that you are eligible for financial assistance, or if you would like to learn more about possible financial assistance, please contact the Jackson County Regional Health Center (JCRHC) Patient Financial Services (PFS) Dept. at (563) 652-2474. PFS staff will be able to provide you with additional information regarding our Financial Assistance Policy and how to apply for assistance.

To qualify for financial assistance, JCRHC will require information from you about your financial situation. This includes, but is not limited to, your household income, assets you own and the number of people living in your household. This information will be used by JCRHC to determine how your financial situation compares to the Federal Poverty Level and to what extent this may qualify you for discounts to your bill.

You can also go directly to the JCRCH website at www.jcrhc.org to read more about our Financial Assistance Policy, how to contact a JCRHC PFS Representative, and how to obtain a free Financial Assistance Application by mail. Once you receive your application, you will need to complete the application and attach any requested documents needed instructed in the application.

Thank you.

Jackson County Regional Health Center