SAMPSON REGIONAL MEDICAL CENTER

607 Beaman Street
Clinton, NC 28329

Financial Assistance Guidelines
Policy and Procedure

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1. Objective
    a. To define Charity Care, as distinguished from bad debts, and to establish policies and procedures to ensure consistent identification and recording of Charity Care.
    b. Applications for Financial Assistance can be picked up at any SampsonRMC location or by calling 910 590-8751 or on our website at www.sampsonrmc.org/financialassistance .
2. Definition
    a. Charity Care represents health care services that are provided but cannot be expected to result in cash flow. Charity Care results from a determination of a patient's ability to pay, not their willingness to pay.
    b. Charity Care will only be considered for:
        i. residents of Sampson County, North Carolina,
        ii. Out-of-county residents who arrive at SRMC's Emergency Department by ambulance,
        iii. Out-of-county residents who are referred to SRMC for inpatient or outpatient services by an active member of the SRMC medical staff.
    c. Charity Care will not be available to patients and patients' families when group health insurance is offered by the employer and declined.
3. These guidelines shall apply to all services provided by Sampson Regional Medical Center including, but not limited to, Sampson Regional Medical Center (the Hospital), Sampson Regional Medical Center's Outpatient Diagnostics Center, Sampson Regional Medical Center Outpatient Rehabilitation Services, and all Hospital-owned practices (Sampson Regional Professional Services, Sampson Regional Medical Services, Sampson Regional Hospitalists, Sampson Regional Emergency Professional Services).
4. Policy
    a. A 30% discount will be applied to all self-pay accounts to bring the balances to amounts generally billed for emergency or other medically necessary services.
    b. The determination of Charity Care should be made at admission or at time of service or shortly thereafter.
        i. Events after admission could change a person's ability to pay, making retrospective determination possible.
    c. Designation of Charity Care will only be considered after all other resources have been exhausted.
        i. This includes making application for applicable insurances including, but not limited to, Medicare, Medical Assistance, and any liability insurance.
    d. Only the portion of a patient's account that meets the definition of Charity Care is to be recognized as such.
    e. Transactions for Charity Care will be posted in the month the determination is made.
    f. The following balances do not qualify for Charity Care allowances:
        i. Wellness Center Services
        ii. Balances not routinely covered as medically necessary (such as cosmetic surgery)
        iii. Medicare and Medical Assistance deductibles, coinsurance, and co-pays.
5. Criteria to be considered in determining eligibility for Charity Care may include, but are not limited to:
    a. The patient's gross family income should be within the Federal Poverty Guidelines (FPG) or a function thereof.
        i. A family is determined by number of dependents claimed on the prior year's Federal Income Tax return.
        ii. Documentation is required to support legal guardianship when nieces, nephews, and grandchildren are claimed as dependents.
    b. The patient's family net worth and liquidity.

c. The patient's employment status and capacity for future earnings.
d. Other living expenses and financial obligations.
e. The previous exhaustion of all other available resources.
f. Catastrophic illness where the medical bills exceed the family's annual gross income.
g. Statutory regulations by the state.
h. The Charity Advisor Status from AccuReg.

6. Procedure
   - ***a. Inpatient, Observation, Surgical, Infusion, and Physician Practice Patients***
     i. Complete a Financial Assistance Request (exhibit 1) prior to, during or immediately after receiving services. Forms will be available at all locations. Applications for hospital services will be processed by the Business Office, located at 612 Beaman Street (910-590-8751). Applications for physician practices will be processed at each practice.
     ii. Patient's family net assets will be considered and evaluated for payment in catastrophic and non-catastrophic cases.
   - ***b. Emergency Department Patients (presumptive charity care)***
     i. If AccuReg determines that a patient qualifies for Charity Care based on the Federal Poverty Level (FPL), it is not necessary to complete the Financial Assistance Request (exhibit 1); the printout from AccuReg will serve as the application for Charity Care.
     ii. Emergency Department Patients deemed eligible from AccuReg will qualify for non-catastrophic Charity Care (section 5b).
     iii. Patients receiving financial assistance based on AccuReg scores will still receive a bill and/or statement with their original balance.
     iv. A Financial Assistance Request (exhibit 1) must be completed for patients requesting catastrophic charity care.
   - ***c. Outpatient Diagnostic, Cardiology, and Rehab Services Patients (presumptive charity care)***
     i. If AccuReg determines that a patient qualifies for Charity Care based on the Federal Poverty Level (FPL), it is not necessary to complete the Financial Assistance Request (exhibit 1); the printout from AccuReg will serve as the application for Charity Care.
     ii. Patients deemed eligible from AccuReg will qualify for non-catastrophic Charity Care (section 5b).
     iii. A Financial Assistance Request (exhibit 1) must be completed for patients requesting catastrophic charity care.
7. Charity Guidelines
   a. Non-catastrophic Charity Care will be based on the Federal Poverty Guidelines (exhibit 2).
      i. If patient's family income is at or below 125% of FPG, they will receive 100% Charity Care allowance.
      ii. If patient's family income is between 126% and 250% of FPG, they will receive reduced Charity Care per exhibit 2.
   b. Catastrophic Charity Care will be considered when the medical bills exceed the family's annual gross income.
      i. Patient's family net assets will be considered and evaluated for payment in catastrophic cases.
      ii. If no reasonable payment can be made within a 5-year period considering net assets, the 250% of FPG guidelines will be considered (per exhibit 2).
         1. If patient's family income is at or below 250% of FPG, they will receive 100% Charity Care allowance.
         2. If patient's family income is between 251% and 400% of FPG, they will receive reduced Charity Care per exhibit 2.
8. Balances after the self-pay discount and/or financial assistance adjustments are subject to Sampson Regional Medical Center's collection policies, including third-party collection agencies and/or legal proceedings.
9. Exceptions to this policy may be made by Administration on a case-by-case basis.

Sampson Regional Medical Center
Charity Care Guidelines
as of April 1, 2023

	Federal Poverty Guidelines (2023)		125% of Federal Poverty Guidelines		250% of Federal Poverty Guidelines	
FAMILY SIZE	Annual Gross Income	Monthly Gross Income	Yearly 125% Gross Income	Monthly 125% Gross Income	Yearly 250% Gross Income	Monthly 250% Gross Income
1	$14,580	$1,215	$18,225	$1,519	$36,450	$3,038
2	$19,720	$1,643	$24,650	$2,054	$49,300	$4,108
3	$24,860	$2,072	$31,075	$2,590	$62,150	$5,179
4	$30,000	$2,500	$37,500	$3,125	$75,000	$6,250
5	$35,140	$2,928	$43,925	$3,660	$87,850	$7,321
6	$40,280	$3,357	$50,350	$4,196	$100,700	$8,392
7	$45,420	$3,785	$56,775	$4,731	$113,550	$9,463
8	$50,560	$4,213	$63,200	$5,267	$126,400	$10,533
$5,140 for each additional family member			$6,425 for each additional family member		$12,850 for each additional family member	

Non-Catastrophic Charity

Based on Federal Poverty Guidelines, if income is

between	and	charity amount is
1%	125%	100%
126%	150%	85%
151%	175%	60%
176%	200%	45%
201%	225%	30%
226%	250%	15%
over 250%		0%

Catastrophic Charity Care

Based on 250% Federal Poverty Guidelines, if income is

between	and	charity amount is
1%	250%	100%
251%	275%	85%
276%	300%	60%
301%	325%	45%
326%	350%	30%
350%	400%	15%
over 400%		0%

SAMPSON
REGIONAL MEDICAL CENTER

612 Beaman Street, Clinton, NC
910.590.8751
www.SampsonRMC.org/FinancialAssistance

Return completed application and any required additional information to: Sampson Regional Medical Center's Business Office, located at 612 Beaman Street, Clinton, NC or mail to PO Box 260, Clinton, NC 28329

Financial Assistance Application

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.

Screening Information

Do you need an interpreter? ☐ Yes ☐ No If Yes, list preferred language:_____
Has the patient applied for Medicaid? ☐ Yes ☐ No (May be required to apply before being considered for financial assistance.)
Does the patient receive state public services such as TANF or SNAP Benefits? ☐ Yes ☐ No
Is the patient's medical care need related to a car accident or work injury? ☐ Yes ☐ No
Does the patient's employer/spouse's employer/guardian's employer offer health insurance? ☐ Yes ☐ No
(If no, must have letter from employer.)

Do you file a federal tax return? ☐ Yes ☐ No If no, list why:_____

Please Note

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

Patient and Applicant Information

Patient First Name:_____ Middle Name:_____ Last Name:_____
Birthdate:_____

Person Responsible for Paying Bill:_____ Relationship to Patient:_____
Birthdate:_____

Mailing Address:_____ City:_____ County:_____
State:_____ Zip:_____
Main Contact Phone Number(s):_____ _____
Email Address:_____
Employment status of person responsible for paying bill: ☐ Employed (date of hire:_____)
☐ Unemployed ☐ Self-Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other:_____

Family Information

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income:	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
Wages, Unemployment, Self-employment, Worker's Compensation, Disability, SSI, Child/Spousal Support, Work Study Programs (students), Pension, Retirement Account Distributions, Alimony Income, Rental Income, Investment Income,
Other (please explain)_____

Income Information

REMEMBER: You must include proof of income with your application and return to Sampson Regional's Business Office located at 612 Beaman St Clinton, NC or mailed to PO Box 260 Clinton, NC 28329.

You must provide information on your family's income. Income verification is required to determine financial assistance.

Examples of proof of income include:

- A "W-2" withholding statement or 1099 or 1040
- If self employed, gross business income - Schedule C
- Last year's income tax return, including schedules if applicable.
- Copy of pay stubs or proof of income covering 30 days.
- Written verification of any other income received (child support, Social Security, alimony, unemployment, aid to dependent children, food stamps, disability income, and assistance from relative/friend, etc.)
- Written verification that you are not eligible for Medicaid. This is not required if you have health insurance. If Medicaid is pending, return your application with all other required information and documents to meet the 30 day timeframe.
- If unemployed, explain in the comment section below how you currently pay your bills.

Comment:_____

_____

If you have no proof of income or no income, please attach an additional page with an explanation.

Expense Information

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

Rent/Mortgage $_____ Medical Expenses $_____

Insurance Premiums $_____ Utilities $_____

Other Debt/Expenses $_____ (child support, loans, medications, other)

Asset Information

This information may be used if your income is above 101% of the Federal Poverty Guidelines.

Current Checking Account Balance $_____ Bank Name:_____

Current Saving Account Balance $_____ Bank Name:_____

Cash on Hand $_____

Home Assessed Value $_____

Second Home Assessed Value $_____

Auto Estimated Value $_____

Auto Estimated Value $_____

Auto Estimated Value $_____

Does your family have these other assets? Please check all that apply.

☐ Stocks ☐ Bonds ☐ 401K ☐ Health Savings Account(s) ☐ Trust(s) ☐ Property (excluding primary residence)

☐ Own a Business

Additional Information

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

Patient Agreement

I understand that Sampson Regional Medical Center and its practices may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date