

ASHTABULA COUNTY MEDICAL CENTER

SUBJECT: Hospital Care Assurance Program	PROCEDURE #
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DEPARTMENT: Patient Financial Services	RELATED POLICY #
APPROVED BY: Terry Hocevar, PFS Director	EFFECTIVE: 1/1/2009 REVISED:

Purpose

Ashtabula County Medical Center will provide, to the individual, basic medically necessary hospital-level services to individuals who are residents of the State of Ohio, are not recipients of the medical assistance program and whose income is at 200% or below the federal poverty guidelines. Recipients of the Disability Assistance (DA) program are also deemed to qualify for these services. Basic medically necessary hospital-level services include all inpatient and outpatient services covered under the Medicaid Program. Physician or transportation services are not considered hospital level services and are not included in HCAP.

Determination of Eligibility

- ◆ Resident of State of Ohio
- ◆ Individuals cannot be enrolled in the Medicaid Program (Including Medicaid HMO)
- ◆ Family (household) income at or 200% the federal poverty guidelines
- ◆ Family includes the parent(s), their spouse(s), and all children, natural or adopted, under the age of 18, who live in the home.
- ◆ Family income is determined in two ways:
 - By counting the income for every family member for the year prior to the date of service (not the date of application).
 - By multiplying by four the income of the family for the three months prior to the date of service.
- ◆ Income shall be defined as total salaries, wages and cash receipts before taxes, receipts that reflect reasonable deductions for business expenses shall be counted for both farm and non—farm self-employment.
- ◆ Gross income includes: gross (pre-tax) wages, gross income from self employment, public assistance, rental income, social security, unemployment compensation, strike benefits, alimony, child support, military family allotments, pensions and veteran's benefits. Sources of income apply to all applicant family members. However, child support only counts if the child for whom the child support payments are made is the patient.
- ◆ The patient's family size: family shall include patient, the patient's spouse, and all of the patient's children. IF the patient is under the age of eighteen, the family shall include the patient, the patient's natural or adoptive parents(s), and the parent(s) children, natural or adoptive under

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the age of eighteen who live in the home. If the patient is the child of a minor parent who still resides in the home of the patient's grandparent, the family shall include only the parent(s) and any of the parent(s)' children, natural or adoptive who reside in the home. On the application, the family member's name, relationship and age are required to determine family. The frame of reference when determining family size for HCAP eligibility is always the patient. A step child or step parent of the patient is only counted in the family size if the child is under the age of 18, lives in the home, and has been adopted by the step parent; otherwise, the step child or step patient should not be counted. If the patient is employed or going to school, obtain the name of the employer/school.

◆ Verification of Income

- ◆ ACMC does not require proof of income.
- ◆ Declaration of zero income must have written statement from patient or guardian explaining how they are surviving. Who is providing their food and shelter?
- ◆ ACMC has the right to request proof of income for any account deemed to be fraudulent.

ACMC patient statements include a notice of the HCAP program. Patient may call or write requesting an application.

Completed applications will be reviewed by the customer services representative and approved by the supervisor. If the account is over \$8,000 the Director of Patient Financial Services will approve the application. The patient is notified whether or not he/she qualifies for HCAP.

This policy is to be applied to all patients completing an application for HCAP benefits on or after the effective date of this policy. ACMC has a three year limit on applications, beginning on the date of the first follow-up notice sent to a patient, not the date of service. (OAC 5101:3-2-07.17 (B)(5))

PROCEDURE:

HCAP Application

Documentation of the patient or family income for HCAP eligibility will be based upon a best evidence methodology. Hospital employees will proceed through the following in an effort to secure the best evidence available for the patient or guarantor at the time of their encounter.

1. A completed HCAP application inclusive of the patient or guarantor's signature.
2. A completed HCAP application, which includes the signature of the patient representative securing the information from the responsible party.

If the application cannot be secured at the time of the encounter, the responsible party will be provided with a return envelope. They will be asked to provide this information upon their return to their home. In the event that the information is received, it is to be reviewed and considered against the above-defined eligibility determination criteria. If it is not returned within 14 days of discharge, contact the patient via telephone to complete the application.

For outpatient hospital services, the eligibility determination is effective for ninety days from the initial service date. During this period a new eligibility determination need not be completed. Eligibility for inpatient hospital services must be determined separately for each admission, unless the patient is readmitted within forty-five days of discharge for the same underlying condition. Eligibility for recipients of the disability assistance program must be verified on a monthly basis.

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In the event the patient does not complete an application during the encounter, and as a result of the HCAP communication, patient statements, or result of collection efforts, hospital staff will complete the HCAP application, over the telephone or in-person, on behalf of the responsible party.

TELEPHONE PROCEDURES:

After completing the application with the responsible party over the telephone, the hospital representative will sign the application at the appropriate hospital representative location. The hospital staff member will make a copy of the application, and mail the copy to the responsible party for their signature, along with a return envelope. IF the returned information is unclear or incomplete, the hospital representative will call or write the responsible party in an effort to properly complete the application. If the application is not returned, the original application retained is to be used to document the patient's eligibility for HCAP benefits.

NOTICE REQUIREMENTS

Attached is the notice, both in English and Spanish, which will be posted at the following locations:

Emergency Department

All Admissions/Registration areas

Patient Financial Services Department.

This posted notice must be readable at a distance of 20 feet and from the visitor's vantage point. All personnel shall make reasonable efforts to communicate the contents to persons they have reason to believe cannot read the notice.

All patients with a self-pay balance will receive HCAP notification on all patient statements.

Policy Administration

The procedures defined in this policy are to be applied to all patients regardless of registration location, time, financial class, race, gender, religion or age.

Ashtabula County Medical Center



2420 Lake Avenue
Ashtabula, OH 44004

Phone: 440-997-6670
Fax: 440-997-6308
www.acmchealth.org

Dear ACMC Patient,

Under the Ohio Hospital Care Assurance Program (HCAP), The Ashtabula County Medical Center offers basic, medically necessary hospital-level services free of charge to individuals whose income is at or below the Federal Poverty Income Guidelines.

In addition to the HCAP program, ACMC provides financial assistance to patients with a family income levels up to two (2) times the Federal Poverty Guidelines.

2015 Federal Poverty Income Guidelines*

Family Size	*(HCAP) 2015 Federal Poverty Income Level	ACMC'S Financial Assistance Program (Family income up to 200% of Federal Poverty Level)
1	\$11,770.00	\$23,540.00
2	15,930.00	31,860.00
3	20,090.00	40,180.00
4	24,250.00	48,500.00
5	28,410.00	56,820.00
6	32,570.00	65,140.00
7	36,730.00	73,460.00
8	40,890.00	81,780.00
For each additional family member add \$4160.00		

If you believe that you might qualify based on the income guidelines listed, please call the Billing Department at (440) 997-6670 and ask for a Care Assurance application.

An application form will be sent to you. Upon receipt of the completed application and income verification such as copies of pay stubs, Form 1040, Social Security statement, we will make a determination of your eligibility.

Sincerely,

Ashtabula County Medical Center
Patient Financial Services Department