

CHARITY CARE



A HEALTH CARE PROVIDER'S GUIDE TO RHODE ISLAND REGULATIONS

Helping your patients apply for free or discounted hospital care

Uninsured? Need Medical Care?

You may qualify for free or discounted medical care based on family size and income.

To learn if you qualify, call or visit the Financial Services Office at any hospital in Rhode Island.

IT'S THE LAW!

RIGL § 23-17.14-15



Need Help? Call the Rhode Island Department of Health Information Line at 401-222-5960 if:

- » You feel you qualify but were denied help
- » You were denied care because you could not pay
- » You want a current copy of the income guidelines

HOURS OF OPERATION OF THE HEALTH INFORMATION LINE, 8:30AM-4:30PM.



www.health.ri.gov

RI DEPARTMENT OF HEALTH
PUBLIC INFORMATION HANDOUT
FOR PATIENTS (ABOVE)

CHARITY CARE AT A GLANCE

WHAT IS HOSPITAL CHARITY CARE?

Charity care (also known as “community free care”) is the provision of free or discounted hospital-based medical services for uninsured, low-income Rhode Island residents otherwise ineligible for state, federal, or employer sponsored health insurance.

IT'S THE LAW!

RIGL § 23-17.14-15

Rhode Island requires hospitals to provide essential medical services to qualified charity care patients. Hospitals must not discourage patients who cannot afford to pay from seeking essential medical services, nor direct them to seek those services from other providers.

Hospital charity care requirements cover those essential services necessary to diagnose, correct, or cure a medical condition that endangers life, causes pain and suffering, results in illness or infirmity, or causes a physical deformity or malfunction. Both inpatient and outpatient services are included. However, charity care is not comprehensive health insurance. Some items, such as outpatient prescription medications, durable medical equipment, and physician fees, *may* not be considered eligible. Hospital practices may vary and in some cases other community organizations and health care providers may step in to help fill unmet needs. For more information, visit www.health.ri.gov/hospitals/about/charity

WHO IS ELIGIBLE FOR CHARITY CARE?

YOUR UNINSURED PATIENTS MAY QUALIFY FOR FINANCIAL AID AS FOLLOWS:

FULL CHARITY CARE:

100% DISCOUNTED SERVICE

Patients whose annual family income is up to and including 200% of the Federal Poverty Level qualify. In addition to income, hospitals have the option to consider other assets. Most exclude a principal residence and a car used for personal transportation.

Example One:

A family of four has an annual income of \$35,000 per year. As their income is less than 200% of the Federal Poverty Level, a member will qualify for full charity care and get free services.

PARTIAL CHARITY CARE:

DISCOUNTED SERVICE COVERED AT LESS THAN 100%

Patients whose annual family income is between 200% and 300% of the Federal Poverty Level may get assistance based on a sliding scale. Hospitals may opt to consider financial assets in this category, as well.

Example Two:

A single adult with an annual income of \$28,000 per year has \$18,000 in assets. This meets the income qualifications for partial charity care (discounted care). If the hospital uses an asset test, a lesser discount may apply.



HOW DO I LET PATIENTS KNOW ABOUT CHARITY CARE?

Hospitals must prominently display notices in emergency departments, admission areas, outpatient care areas, hospital websites, and on patient bills that inform patients that they may be eligible for free or discounted care. Notices must be posted in the three most commonly spoken languages in your service area in addition to English. (See sample notice on page 4.) Hospitals are required to provide all eligible patients with necessary information to apply. This may include, but is not limited to:

- » Financial Aid Criteria (see page 4)
- » Application for Hospital Financial Aid (see page 4)

Patients must provide the information and documentation necessary for evaluation by hospital financial services workers or their applications for aid may not be successful. To connect your patients to financial services, you may direct them to a financial services intake worker, a hospital registration representative, or the hospital information desk.

Applicants who are denied should be given a number or an address for appeals within each hospital. Patients who feel that an application or appeal was wrongfully denied should call the Rhode Island Department of Health Information Line at 401-222-5960.

FINANCIAL AID CONTACT NUMBERS HOSPITALS IN RHODE ISLAND:	
BRADLEY HOSPITAL	444-6526
BUTLER HOSPITAL	455-6240
HASBRO CHILDREN'S HOSPITAL	444-7850
KENT HOSPITAL	737-8885 x500
LANDMARK MEDICAL CENTER	769-4100 x2447
MEMORIAL HOSPITAL	729-2000
THE MIRIAM HOSPITAL	793-2206
NEWPORT HOSPITAL	845-1490
OUR LADY OF FATIMA HOSPITAL	456-3276
RHODE ISLAND HOSPITAL	444-7850
REHABILITATION HOSPITAL OF RI	769-4100 x2447
ROGER WILLIAMS MEDICAL CENTER	456-2400
SAINT JOSEPH HOSPITAL	456-3276
SOUTH COUNTY HEALTH CARE SYSTEM	788-1386
THE WESTERLY HOSPITAL	348-3624
WOMEN & INFANTS HOSPITAL	274-1122 x1335

For more information or if you have any questions about the administration or regulation of charity care, please visit our website: www.health.ri.gov/hospitals/about/charitycare or contact the HEALTH Information Line at 401-222-5960.



CHARITY CARE FORMS AT A GLANCE

NOTICE OF HOSPITAL FINANCIAL AID

To be no smaller than a standard 'letter' size (8.5" x 11") and prominently posted in Emergency Departments, admission areas, outpatient care areas and on the hospital's website. Notices must be posted in the three most commonly spoken languages in your service area in addition to English.

FINANCIAL AID CRITERIA

Full and discount care schedule. Notices must be posted in the three most commonly spoken languages in your service area in addition to English.

NOTICE of HOSPITAL FINANCIAL-AID

This hospital provides essential hospital care without charge (free) to uninsured Rhode Islanders with incomes up to 200% of the Federal Poverty Limits (and limited assets), and discounted care for incomes between 200% and 300% of the Federal Poverty Limits. For more information, please contact a financial services officer at (insert hospital financial services phone number).

APPLICATION FOR HOSPITAL FINANCIAL AID

To be used to determine eligibility for full and partial charity care. Notices must be posted in the three most commonly spoken languages in your service area in addition to English.

Effective April 1, 2007	FINANCIAL-AID CRITERIA	Effective April 1, 2007																				
<p>Hospital is proud of its commitment to provide quality care to all who need it. Hospital provides financial aid to patients without health insurance and who may not be able to pay for their care. Hospital also offers discounts to uninsured patients who may have difficulty paying their full hospital bill. This free and discounted care applies to essential hospital services ONLY.</p>																						
FULL CHARITY CARE																						
We provide hospital care without charge to uninsured Rhode Island residents with incomes less than:																						
<p><i>This Section is the actual disclosure, it is not an example! It may only be modified if the hospital expands its financial aid beyond this minimum requirement and/or if it drops the asset test (below).</i></p>	<table border="1"> <thead> <tr> <th>Size of Family Unit</th> <th>Annual Income Limits*</th> </tr> </thead> <tbody> <tr><td>1</td><td>\$19,600</td></tr> <tr><td>2</td><td>\$26,400</td></tr> <tr><td>3</td><td>\$33,200</td></tr> <tr><td>4</td><td>\$40,000</td></tr> <tr><td>5</td><td>\$46,800</td></tr> <tr><td>6</td><td>\$53,600</td></tr> <tr><td>7</td><td>\$60,400</td></tr> <tr><td>8</td><td>\$67,200</td></tr> <tr><td>each additional:</td><td>\$6,800</td></tr> </tbody> </table>	Size of Family Unit	Annual Income Limits*	1	\$19,600	2	\$26,400	3	\$33,200	4	\$40,000	5	\$46,800	6	\$53,600	7	\$60,400	8	\$67,200	each additional:	\$6,800	<p><i>This Section is the actual disclosure, it is not an example! It may only be modified if the hospital expands its financial aid beyond this minimum requirement and/or if it drops the asset test (below).</i></p>
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<p><small>* 200% of 2006 Federal Poverty Guidelines, subject to change when updated.</small></p> <p>Applicants with assets worth MORE than \$8,000 for an individual (or \$12,000 for a family) may not qualify for care without charge but may qualify for discounted care.</p>																						
PARTIAL CHARITY CARE																						
We also provide discounted hospital care to uninsured Rhode Island residents with incomes between:																						
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<p>To find out if you qualify for financial-aid, please contact _____ at _____.</p> <p>If you are denied financial-aid you may appeal the decision. You may also request the appeal process from the contact above.</p>																						

APPLICATION FOR HOSPITAL FINANCIAL-AID	
<small>Any approval of this request is temporary and expires 6 months from the date of approval</small>	
Hospital:	Date:
Patient:	Guarantor:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address:	Address:
Occupation & Employer:	
Employer Address:	
<small>Providing the information below on the patient's primary language, race & ethnicity is optional to the patient.</small>	
Language: English	Non-English
Ethnicity: Hispanic	Non-Hispanic:
Race: Asian	American Indian/Alaska Native:
Black/African American:	Native Hawaiian/Pacific Islander:
White:	Other or Multiple Races:
<small>Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor:</small>	
Name & Relationship to Patient:	SS# (if issued) & Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) & Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) & Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) & Date of Birth:
Employer, Phone & Address:	Home Address:
Name & Relationship to Patient:	SS# (if issued) & Date of Birth:
Employer, Phone & Address:	Home Address:
MONTHLY INCOME	
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Self-Employment Income:	Money Market Accounts:
Child Care Income:	Savings Bonds:
Rental Income:	Stocks:
Unemployment Compensation:	Bonds:
Temporary Disability Insurance:	Mutual Funds:
Child Support:	IRAs:
Alimony:	401(K)s:
Workers' Compensation:	403(b)s:
VA Benefits:	457s:
Social Security Payments:	Cash-In Value Life Insurance:
Dividend & Interest Income:	Personal Property:
Royalties:	2nd Home & Rental Property:
Pensions:	2nd Motor Vehicle:
Public Assistance:	TOTAL:
Other:	
MONTHLY INCOME:	
ANNUAL INCOME:	
<small>"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."</small>	
Signature:	Date:
Reviewer: Approval or Denial, Comments:	
DISCOUNT (%):	DISCOUNT (\$):

For the most recent poverty guidelines or the hospital Charity Care regulations, visit www.health.ri.gov/hospitals/about/charitycare