Purpose

Our Community Hospital (OCH) maintains a policy to provide uncompensated medical services either free of charge or on a discounted basis to those patients who demonstrate an inability to pay.

Summary

Services that qualify for financial assistance or financial hardship are limited to:

- Emergent Services that in the absence of immediate medical attention, could reasonably be expected to result in a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part and are limited to services provided in the Emergency Department.

- OCH Physician Approved Services are services that are non-emergent but necessary and appropriate to prevent serious deterioration in the health of the patient from injury or disease. Often follow up services for care originating in the Emergency Department is included. OCH Physician approval is required prior to the service being provided.

Patients must meet certain financial criteria to be determined eligible for financial assistance. The financial criteria for eligibility is:

- Household income equal to or less that 150% of the federal poverty guidelines determined by house hold size and based on the adjusted gross income of the family for the current or prior year.

- If assets (401k, mutual funds, property, etc.) are identified during the application process, the financial assistance adjustment may be reduced by the amount of the estimated equity value of the assets. The patient's primary residence is exempt from consideration in any asset determination.

- Patients that are approved for Medicaid may be eligible for financial assistance.

To be eligible for a Financial Assistance Adjustment, the patient is expected to have applied for and complied with all processes related to seeking assistance from other insurers and/or programs (including all potentially applicable governmental programs) as requested by OCH. Patients that are noncompliant or uncooperative in attempting to obtain other assistance may be denied Financial Assistance Adjustments.

- Patients that are determined to be ineligible for financial assistance may still be eligible for discount in their outstanding balances that would be equivalent to 5% of the patient's household adjusted gross income for the year.

- Eligibility is applicable to all Acute Care; Emergency Room and Outpatient visits for a period of one year. The Private Diagnostic Clinic does not have a Financial Assistance Policy but will honor the financial assistance determinations made by OCH in response to a patient's financial assistance application.

- A financial assistance adjustment will be applied when the patient has been determined eligible via the application process and the service rendered is a qualifying service. When a patient is approved for financial assistance adjustments will be processed for any open, active or bad debt balance that is patient responsibility.

- Once eligibility has been determined, patients will not be charged more for emergency or other medically necessary care that amounts generally billed to patients that have insurance covering such care.

How To Apply

- Financial hardship applications can be obtained at Our Community Hospital, by calling customer service at 252-826-4144 or by coming by the business office.

- To apply for financial assistance, a complete Financial Hardship application is required. A complete Financial Hardship application is inclusive of, but not limited to, disclosure of household income, assets, resources; and supporting documents (e.g current year tax forms, pay stubs). Undocumented residents (non-U.S. citizens living as residents in the U,S.) and patients who are without a home address may apply for financial assistance.

- Complete Financial Assistance applications should be submitted to Our Community Hospital at P.O. Box 405 Scotland Neck, NC 27874 for review and determination of eligibility. The percentage of the financial assistance adjustment is determined by Our Community Self Pay Collections using a sliding scale based on income and family size. Once a determination has been made, the self pay department will send a determination letter to the patient. Determinations are normally completed within 30 business days after receipt.

- The full financial assistance policy, financial assistance policy summary and application are available in Spanish and are available electronically or in paper form.

- Copies of the full Our Community Financial Assistance policy and financial hardship application are available free of charge upon request by writing to the Self Pay Collections Department at PO Box 405 Scotland Neck, NC 27874.

Instructions for Completing the Our Community Hospital Financial Hardship Form

Section 1. Patient/Guarantor Information

Patient's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient or guarantor.

Patient's Address: Clearly print on the blank line the address where you live including the city, state and zip.

Patient's Date of Birth: clearly print on the blank line you date of birth

Patient's Social Security Number: Clearly print on the blank line you social security number

Patient's Marital Status: Clearly print single or married

Section 2. Spouse Information (may be skipped if you are single)

Spouse's Name: clearly print on the blank line the first name, middle initial, and last name of the patient or guarantor's spouse.

Spouse's Address: either clearly print on the blank line the address where your spouse resides or indicate "Same" if you and your spouse reside at the same address

Spouse's Date of Birth: Clearly print on the blank line you spouse's date of birth

Spouse's Social Security Number: Clearly print on the blank line you spouse's social security number

Section 3. Household Information

Number of Dependents: Clearly print the number of dependents in your household you can claim on your taxes (children or adults who you financially provide more that 50% of their living expenses)

Total Monthly Household Income: Clearly print the amount of income from all sources your household (yourself, your spouse, and dependents) receives monthly (including but not limited to wages, profits from business, rental income from rental properties, social security income (SSI/SSDI), Income from investments, estates, trusts, alimony, child support, aid to dependent children, etc…

Total Household Assets: clearly print the value of all assets excluding the primary residence (including but not limited to: Savings, Checking, Mutual Funds, Stocks, Bonds, Rental property value, etc…)

Required Documentation

The documents listed in this section are needed to help us determine if you qualify for charity care under out financial assistance policy. If you do not have, or cannot produce the items listed, please include an explanation as to why.

Comments

Use this section to share any additional information you would like us to consider in the evaluation of your charity care application.

Acknowledgement

Patient/Guarantor's Signature: Sign and date the application

Spouse's Signature: Have you spouse (if married) sign and date the application

Required Documentation

Attach copies for yourself and spouse as listed below:

- □ Most recent tax return, including W-2 forms and supporting schedules.
- □ Last 2 pay stubs
- □ Written verification of any other income received (e.g. child support, social security, alimony).

Or

- □ A letter from an employer verifying income (include employer's phone number and address).
- □ A letter or comment below from you stating your source for paying living expenses, if you have no income.

Additional Comments

Acknowledgement

I hereby acknowledge that the above information is true and accurate to the best of my knowledge.

I further grant the Health System authorization to verify any or all information given and also authorize a consumer credit report, if necessary.

Patient/Guarantor's Signature:______________________________________Date:____________________

Spouse's Signature:____Date:____________________

Mailing Instructions/Contact Information

Mail Documentation to:

Our Community Hospital
PO Box 405
Scotland Neck, NC 27874

Contact Information:

252-826-4144

Note: Please allow 4-6 weeks for processing

Financial Assistance Application

Patient/Guarantor Information

Patient's Name: ____
First *M.I.* *Last*

Patient's Address:____
Street *City* *State and Zip Code*

Patient's Date of birth:__________________

Patient's Social Security Number:____

Patient's Marital Status:_______________________
Single or Married

Note: If you are married, then you spouse's financial information and signature is required in order to process you application.

Spouse Information

Spouse's Name:____
First *M.I.* *Last*

Spouse's Address:____
Street *City* *State and Zip Code*

Spouse's Date of Birth__________________________________

Spouse's Social Security Number:__________________________

Household Information

Number of Dependents: ____
Total Monthly Household Income (including social security income)___________________________

Household's value of assets beyond primary residence:_____________________________________
(Savings, Checking, Mutual Funds, Stocks, Rental, Alimony, etc.)