
	SECTION: Administrative Manual	Page 1 of 12
	NUMBER: QSP-ADM-MI-0011	Revision Level: 3
FORMULATED: 10/01/2016	TITLE: Medical Financial Assistance Program	
REVISED: 12/10/2019, 07/01/2020, 6/27/2025	APPROVAL: TITLE: Chief Financial Officer or Designee	
REVIEWED:	SIGNATURE: 	
This document contains information of a proprietary nature. Information contained herein shall be kept in confidence and divulged only to persons who by nature of their duties require access to such documentation.		

Policy Statement:

Self Regional Healthcare provides for all patients regardless of race, sex, creed, national origin, and ability to pay. Self Regional Healthcare will make medically necessary or urgent services available at no charge to those who are unable to pay and meet certain financial guidelines.

Any patient requesting financial assistance should be referred to the Patient Financial Advocate for assistance. Appropriate documentation/information must be gathered to support the approval of the Medical Financial Assistance Application. All completed applications must be signed by the patient and/or an authorized representative (unless the patient qualifies for partial Medicaid coverage on an inpatient stay.)

Scope:

The policy applies to Self Regional Healthcare.

Responsibility:

The Patient Financial Advocate will review all the documents provided by the patient and/or authorized representative for accuracy before sending to the Manager of Patient Access, Assistant Vice President/Controller, and/or Chief Financial Officer for approval.

Process:

The general qualifications for the Self Regional Healthcare Medical Financial Assistance Program are based on the family income, family composition, resources and assets. The Medical Financial Assistance Program is based on 200% of the current Federal Poverty Guidelines (FPG) as published annually by the Department of Health and Human Services (DHHS).

Self Regional Healthcare (SRH) expects and requires uninsured patients to participate in the application process for federal/state assistance programs, Subsidized Health Insurance at the Federal Marketplace Exchange, Employer sponsored health insurance or privately purchased health insurance. Patients determined to be eligible for state/ federal funding, sources, Subsidized Health Insurance at the Federal Marketplace Exchange, Employer sponsored health insurance or privately purchased health insurance but who fail to cooperate through the employer application process are not eligible for SRH financial assistance unless the insurance cost/premiums are deemed unaffordable based on the patient's household income. If the patient is not eligible for state/ federal funding sources, Subsidized Health Insurance at the Federal Marketplace Exchange, Employer sponsored health insurance or privately purchased health insurance he/she is screened for the SRH Medical Financial Assistance Program.

A Medical Financial Assistance application is required every 30 days for inpatient admission and no more than every 180 days from the initial date of service for outpatient visits. An approval application applies eligibility to accounts for all family members that are part of the same household and are declared on the applicant's Federal Income Tax, contingent upon the family members not being eligible for Medicaid.

1 – COVERAGE

1.1 Covered Services

The following services are covered under the Medical Financial Assistance Program:

- All emergency care and required follow up services from SRH
- Inpatient and outpatient care determined to be medically necessary
- Other services such as Self Medical Group physician offices and home health services when requested by these entities.

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

The following services are not covered under the Medical Financial Assistance Program:

- Elective services (This includes but is not limited to cosmetic, bariatric, and dental services)
- Services that require the issuance of a Medicare Advance Beneficiary Notification (ABN)
- Services that are statutorily excluded by Medicare and do not require an ABN (i.e. pharmaceuticals, dental, etc.).
- Physicians providing services that are not employees of the Hospital (i.e., "Private practice physicians) are not covered under this policy.
- To access a complete list of providers, employed/covered and/or not employed/not covered, please refer online to the 'Financial Assistance Policy' page under the 'Health Information' tab at the top of the Self Regional Healthcare home page.

1.2 Residency Requirements

To be eligible for the Medical Financial Assistance Program you must be a legal resident of the state of South Carolina.

1.3 Third Party Coverage

Applicant and/or dependents must enroll in third-party coverage through their employer when available unless otherwise justified.

1.4 Income

Patients' income must be at or below 200% of the FPG (Federally Poverty Guideline) and/or must qualify for Catastrophic Event Financial Assistance (See below).

1.5 Effective Date

Patient must meet qualifications on Date of Service or Date of Admission. All open account balances on or before eligibility determination will qualify for Medical Financial Assistance up to one year. Review on case by case bases will be conducted to determine retroactive application of financial assistance to services prior to date of application beyond one year.

1.6 Applicant-Supplied Information; Timeliness; Disputes

Applicants will be asked to provide:

- Valid South Carolina and/or Governmental photo ID
- Proof of income for all members in the household
- Proof of current address (rent receipt, driver's license, or voter's registration)
- Verification of all members in household including their names, relationships, and dates of birth
- Monthly checking account statements or monthly savings account statements
- Income verification from employer or most recent check stubs
- Federal Income Tax Return
- Verification of self-employment and/or proof of eligibility denial from programs such as Social Security, Department of Social Services, Workers Compensation, Child Support Service, etc.
- Proof of any whole life insurance policies

All information requested of the applicant to support the eligibility determination must be provided within 30 days of the request date. Determination is made within 30 days of completion of the financial assistance application and the patient is notified by letter. If the patient disputes the decision, he/she may appeal to the Manager of Patient Access.

2 - DETERMINING ELIGIBILITY

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

2.1 Family Composition

The first step in determining the amount of income and resources available to the applicant is to establish the family composition. A family is defined as the applicant and dependents or legally responsible relatives that live in the same household and are declared on the applicant's Federal Income Tax. Consideration must be given to the applicant's dependent status in determining the family composition.

If the applicant is legally and financially dependent upon someone else in the house-hold, the family is composed of the following household members:

- The applicant
- The persons upon whom he is dependent (i.e., the responsible person)
 - All persons related to the applicant by blood, marriage, or adoption that are also legally or financially dependent upon the responsible person

If the applicant is a minor child that lives in the home with a step-parent, the step-parent is considered a member of the family only if the step-parent claims the child as an income tax dependent.

If the applicant is an adult that is financially dependent upon someone else in the household, the applicant is considered a family member only if the person upon whom he is dependent is a relative and both parties agree that one is financially dependent upon the other (i.e., one could be claimed by the other as a dependent for income tax purposes, whether or not a return is filed).

If the applicant is **NOT** dependent upon someone else, the family is composed of the following household members:

- The applicant
- The person related to the applicant by birth, marriage, or adoption and who are legally or financially dependent upon the applicant.

If the applicant has step-children living in the home, the step-children are included as members of the family only if the step-parent claims them as income tax dependents.

Unmarried Individuals Living Together

Unmarried individuals who live together that do not have common children are not considered members of the same family. Ordinarily the income and resources of one would not be attributed to the other since they are not legally or financially responsible for each other. However, if both parties agree that their income is mutually available, half of the total gross annual income is attributed to the applicant.

Minors or Students Absent from Home

Consideration must be given to the minor's or the student's financial dependence upon the parents. Examples of such minors are students or children that choose not to live with their parents.

For purposes of this program, an applicant that is a minor child or a student that is still financially dependent upon his parents is considered a member of his parent's household. If his parents do not live in the same home, he is considered a family member of the parent that holds legal custody.

A minor child is always considered a dependent of his parent(s) unless a court order exists which divests the parent(s) and the child of their rights, privileges and immunities, duties, and obligations with respect to each other. If such a document exists, the child is not considered a member of the parent's family and the parent's income and resources are not available to the child. A copy of the court order must be filed in the case record as documentation. For students over age 18, the applicant must provide a copy of the latest tax return on which he/she is claimed as a dependent. If it is determined that the student is not financially dependent upon the parent(s), the student is not considered a member of their family and the parent's income and resources are not included as income.

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

2.2 Income Standards

Computation of Income

The gross annual income of the individual and his family is measured against the annual FPG for the appropriate size family. Gross family income should be representative of the family's average earnings. For this reason, the method of calculating gross annual income will vary depending on the employment status of the family members.

Methods of Computation

The following describes methods of computing gross annual income based on the manner in which the income is received:

- **Fixed Monthly Income:** This person receives a set monthly benefit or a set income for work performed (e.g., someone receiving Social Security benefits, or a teacher).
In this situation, determine gross annual income based on income received in the month prior to the effective date of application, multiplied by 12.
- **Hourly/Salaried Income with Bonuses, Commissions, and Overtime:** This person receives a wage based on the number of hours worked or a salary which is subject to additional earnings due to overtime, commissions, or bonuses. In this situation, determine the gross annual amount by adding income received in the 8 weeks prior to the effective date of the application. Divide the total by the number of times paid to get the average income per pay date. Multiply by 52 if paid weekly; multiply by 26 if paid bi-weekly (every 2 weeks); multiply by 24 if paid semi-monthly (twice a month); multiply by 12 if paid monthly.
 - **Irregular Income:** This person's income varies from week to week or month to month. An example, people who work odd jobs or are seasonal employees. In this situation, determine gross annual income based on income received in the 8 weeks prior to the effective date of application. Divide the total by the number of weeks to get an average weekly income, and multiply by 52
- **Self Employed Income:** This person's income is derived from their own business (e.g., farmers, beauticians, "shade tree" mechanics, loggers, etc.). If the person does not report income on a weekly, bi-weekly, or monthly basis, determine gross annual income based on the most recently filed income tax return. Deductions for the cost of doing business are allowed for self-employed income.

Temporary Disability

When a physician certifies (written or verbal) that an individual is unable to work for a specific period of time (e.g., 4 weeks), prospective budgeting procedures must be used to arrive at a more accurate determination of income. Subtract the number of weeks the individual will not be allowed to work from 52. Multiply the average weekly amount by this figure. Also budget the income of a spouse who is needed in the home/hospital to care for the incapacitated individual prospectively.

Earned Income


Earned income includes all income earned by an individual through the receipt of wages, salary, commissions, or profit from activities in which he/she is engaged as a self-employed individual or as an employee. This earned income may be derived from his/her employment, such as a business enterprise or farming, or derived from wages or salary received as an employee.

Unearned Income

Unearned income is any income that does not meet the definition of earned income.

The following are considered unearned income (this is not all-inclusive):

- Unemployment Compensation and Workmen's Compensation
- Assistance Payments Based on Need – AFDC, SSI, and other cash payments
- Pensions and Benefits – Annuities, pension retirements, veteran's or disability benefits, Social Security benefits, and other such pensions and benefits

	SECTION: Administrative Manual	Page 6 of 12
	NUMBER: QSP-ADM-MI-0011	Revision Level: 3
FORMULATED: 10/01/2016	TITLE: Medical Financial Assistance Program	
REVISED: 12/10/2019, 07/01/2020, 6/27/2025	APPROVAL:	
	TITLE:	Chief Financial Officer or Designee
REVIEWED:	SIGNATURE:	

- Strike Benefits
- Support and Alimony from non-household members
- Cash Contributions made to any member of the family by a non-family member (gift or loan) • Trust Funds
- Lump Sum Payments – Since this income will not be received again, it is not annualized, but added to other gross annual income. NOTE: Federal and state income tax refunds are excluded from income.
- Educational Loans, Grants, and Scholarships – Any portion of loans, grants, and scholarships which may be used to meet the person's current living expenses (food, clothing, or shelter) is counted as income. Any portion which is clearly designated for tuition is excluded from income.
- Capital Gains Income – Any gain received from the sale of an asset is counted as income.

Income from Self-Employed

Self-employed income is allowed deductions from the cost of doing business. The applicant must provide a record of expenses incurred in the production of the income.

Allowable costs for producing self-employed income are:

- Identifiable cost of labor, such as salaries, employer share of social security, insurance, etc.
- Rent and cost of maintenance for the business building
- Business telephone costs
- Costs of operating a motor vehicle when required in connection with the operation of the business
- Insurance premiums and taxes on the business
- Costs of feed or work stock
- Costs of meals for children when day care is provided in the applicant's home
- Interest paid to purchase income-producing property

After the self-employed income is given, the cost of doing business is deducted and the resulting income is then added to any other income earned.

The prior year income tax 1040 can be used as proof of income.

2.3 Verification


All income must be verified and the method, amount, and date of verification must be documented. Information provided by the patient in the financial assistance application is subject to verification via credit reporting software (e.g., Experian or Equifax).

The following are documents that can be used to verify earned income:

- Pay stubs
- Employee's W-2 forms
- Wage tax receipts
- Federal income tax return
- Self-employed bookkeeping records
- Sales and expenditures records
- Employer's wage records
- Statement from employer
- Employment Security Office

The following are documents that can be used to verify other types of income:

- Social Security award letter (changes in benefits will not always be reflected)
- Benefit payment check
- Unemployment compensation award letter

	SECTION: Administrative Manual	Page 7 of 12
	NUMBER: QSP-ADM-MI-0011	Revision Level: 3
FORMULATED: 10/01/2016	TITLE: Medical Financial Assistance Program	
REVISED: 12/10/2019, 07/01/2020, 6/27/2025	APPROVAL:	TITLE: Chief Financial Officer or Designee
REVIEWED:	SIGNATURE:	

- Pension award notices
- Veterans Administration award notice
- Correspondence on benefits
- Income tax records
- Railroad award letter
- Support and alimony evidenced by court order, divorce/separation papers, or contribution checks
- Social Security Administration records and letters
- Employment Security Commission
- Union records
- Workers Compensation records
- Veterans Administration records and letters
- Insurance company records
- Tax records
- Railroad Retirement Board records
- Department of Social Security Services Letter of Notification

NOTE: Persons claiming no income must provide a completed and signed Basic Needs Statement. Applicant should be carefully interviewed to determine how he/she obtains food, clothing, and shelter. This information must be documented within the application and the applicant must sign an attesting document. If the accuracy of this statement is in question, the applicant may be required to register with the Employment Security Commission and provide verifiable documentation.

2.4 Resource Standards

Liquid Assets/Resources

The applicant's total liquid assets (e.g., checking and savings) may not exceed \$6,000 for an individual or \$8,000 for a family of 2 or more.

Examples of liquid resources are:

- Cash on hand
- Checking or savings accounts in banks or other savings institutions, including credit unions
- Savings certificates
- The market value of stocks and bonds
- Funds held in individual retirement (IRA'S) - The entire cash value of the account, less the amount of any penalty for early withdrawal, that is over 100K is counted
- Pension funds that are available
- Jointly Owned Liquid Resources

When accounts (e.g., savings or checking, stocks or bonds, etc.) are jointly owned and the applicant and/or his family have access to the entire amount in the account, the entire amount is counted toward the resource limit.

- To determine whether the person has access to the entire amount, the worker will need to determine if both signatures are needed for access to the resource or if only one signature is needed. One signature means the entire amount is accessible. When both signatures are needed, only a proportional ratio share of the account is applied to the resource limit.
- Trusts
 - If an applicant and/or a member of his family are the beneficiary of a trust and he has unrestricted access to the principal of the trust, the value of the principal is counted as a resource. The value of the trust principal is measured against the liquid asset resource limitation.

NOTE: Clothing, household goods/effects, personal effects, furnishings, and basic transportation used for day to day living are **NOT** included.

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

2.5 Full/100% Approval

Only those persons whose gross family income is equal to or less than 200% of the current FPG may qualify for full financial assistance through the SRH Medical Financial Assistance Program.

The following statuses will be granted automatic approval for 100% financial assistance

- Homeless patient or guarantor. Confirmation of the status may be a judgment call by clinical or Patient Financial Advocate staff.
- Guarantor currently resides in a shelter of some type (Must be legal resident of South Carolina). Confirmation can be attempted through a telephone call to the shelter or other means.

The Internal Revenue Service limits certain hospitals with financial assistance programs to charging eligible patients no more than the average amount normally charged to patients with public or private insurance benefit plan coverage of the services provided. This amount is referred to as the "Average Generally Billed" rate, or AGB rate. Due to the fact that patients eligible for financial assistance will be charged 0% he or she will never be charged more than Self Regional Healthcare's AGB rate.

3 - CATASTROPHIC MEDICAL EXPENSES

Catastrophic Medical Expenses Financial Assistance will occur when the patient is not able to meet their financial obligations due to the extraordinary size of their medical bills. Upon completion of a financial evaluation (which may include the evaluation of assets) and with appropriate managerial approval, special consideration may be granted to forgive or reduce such patients bills. Patient's liability will be limited to 20% of the patient's and/or guarantor's annual income. Charges for healthcare services provided to patients who qualify are written off to transaction code "4017 – Financial Assist-Catastrophic".

4 – PARTIAL APPROVALS / PAYMENT PLANS

Appropriate payment plans must be established for all partial approvals and the applicant must sign a payment plan agreement based upon SRH's Payment Plan policy. If the applicant defaults on the payment plan, the account(s) will be subject to reversal of financial assistance.

5 - DISCRETIONARY APPROVAL GUIDELINES

Discretionary approval will be granted based on the cumulative account balances as follows:

Balance	Approval Authority (Required Signatures)
< \$2,500	Patient Financial Advocate
\$2,500 - \$24,999	Manager Patient Access
\$25,000 – \$99,999	Assistant Vice President/Controller
\$100,000 and above	Chief Financial Officer

- Upon approval any balance less than \$500 will automatically adjust.
- Any balance greater than \$500 will require review for cumulative balance approval.

6 - REFUNDS

If the patient is eligible for Medical Financial Assistance, there will be a refund for any payments applied to accounts prior to or after the application. Any credit balances that result after financial assistance is applied will be adjusted to a zero balance using the appropriate transaction code.

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

7. PRESUMPTIVE MEDICAL FINANCIAL ASSISTANCE

For patients who are non-responsive to Self Regional Healthcare's application process, other sources of information may be used to make an individual assessment of financial needs. This information will enable Self Regional Healthcare to make an informed decision on the financial need of non-responsive patient utilizing the best estimates available in the absence of information provided directly by the patient.

For the purpose of helping patients in need of financial assistance, Self Regional Healthcare may utilize a third-party to review patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporated public record data to calculate a social-economic and financial capacity score that includes estimates for income, assets and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for Self Regional Healthcare. The predictive model enables Self Regional Healthcare to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process.

Information from the predictive model may be used by Self Regional Healthcare to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. After efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients. When predictive modeling is the basis for presumptive eligibility, a 100% discount will be granted for eligible services for retrospective dates of service only.

In the event a patient does not qualify under the presumptive rule set, the patient may still be considered under the traditional medical financial assistance application process.

When presumptive eligibility is established for financial assistance, a 100% discount will be granted for eligible services. Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. These accounts will not be sent to collections and will not be included in bad debt expense,

8. Uninsured Discount (Hospital accounts only)

In keeping with the mission and core values of Self Regional Healthcare, patients who are uninsured will be treated fairly and with respect at all times, regardless of their ability to pay.

All self-pay patients presenting for medically necessary services, excluding those receiving elective cosmetic procedures and other already discounted procedures (e.g., self-pay, bariatrics, etc.), will receive a managed care like discount, referred to as an "uninsured discount".

For this policy, the term "uninsured patients" refers to patients who are not covered by an insurance policy or other benefit plan. Government-sponsored programs such as Medicare and Medicaid are considered benefit plans. Therefore, recipients of Medicare, Medicaid, and other government-sponsored programs are generally not eligible for these discounts.

However, if patient has an insurance policy that does not cover his or her medically necessary treatment, then that patient is deemed to be "uninsured" for that service or procedure, and eligible under the Uninsured Discount policy. This does NOT include procedures that were not properly authorized or pre-certified.

If an uninsured patient is injured in an accident and medical treatment for the injuries is partially covered by liability insurance (e.g., an auto insurance policy owned by the patient or another party), then the patient will be considered insured and not eligible for these discounts. If the liability policy does not cover the medically necessary treatment, then the patient is deemed to be "uninsured". The uninsured service would be eligible for the Uninsured Discount policy.

FORMULATED: 10/01/2016

TITLE: Medical Financial Assistance Program

REVISED: 12/10/2019, 07/01/2020, 6/27/2025

APPROVAL:

TITLE: Chief Financial Officer or Designee

REVIEWED:

SIGNATURE:

OVERVIEW

1. All accounts that are registered as Self-Pay will automatically have their resulting charges reduced by 40% in the EPIC system.
2. An additional "prompt-pay" discount of 10% can be applied to the resulting Self-Pay balance on the account if the patient pays the entire balance within 10 days of the initial negotiation.
3. All discounts will be reversed if the patient is found to have active insurance coverage for the account in question.
4. NOTE: This discount applies to all "Self-Pay" patients and is NOT based on any type of family income and/or assets.
5. NOTE: This discount does NOT apply to patients who are receiving elective cosmetic procedures and other already discounted procedures (e.g., self-pay one-day delivery patients, bariatrics, etc.). These patients will be registered Self-Pay.

9. Contact Information

If need assistance with the application process please call the Patient Financial Advocate that corresponds with the first letter of the patients last name.

Last Name Letter	Contact number
A – B	(864) 725-4135
C- G	(864) 725-5047
H-L	(864) 725-6079
M-R	(864) 725-3438
S-Z	(864) 725-4122

Main Line: (864)725-6070

Applications can be found at www.selfregional.org

A patient may obtain a copy of the collection policy by request to Patient Financial Services (864) 725-7800.

References:

Federal Poverty Guidelines (FPG)

Definitions:


Applicant: A person who has, directly or through his authorized representative, made an application for assistance through the Medical Financial Assistance Program.

AGB – (Amount Generally Billed) – The average amount normally payable from insurance and Medicare payers.

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free to individuals who meet the established criteria.

Cost-to-Charge Ratio – A ratio of the cost divided by the charges

Earned Income – All income in cash earned by an individual through the receipt of wages, salary, commissions, or profit from activities in which he/she is engaged as a self-employed individual or as an employee.

	SECTION: Administrative Manual	Page 11 of 12
	NUMBER: QSP-ADM-MI-0011	Revision Level: 0
FORMULATED: 10/01/2016	TITLE: Medical Financial Assistance Program	
REVISED:	APPROVAL:	TITLE: Chief Financial Officer or Designee
REVIEWED:	SIGNATURE:	

Emergency medical condition – Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Family – Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Services rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits, (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count)

Family Income – Family income is determined using the Census Bureau definition, which used the following income when computing federal poverty guidelines:

Fiscal Year – any yearly period without regard to the calendar year, at the end of which the hospital determines its financial condition.

Fixed income – A set of benefits or set income for work performed.

Gross charges – The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Hourly/Salaried Income with Bonuses, Commission, and Overtime – Income received regularly based on the number of hours worked or a salary which is subject to additional earnings due to overtime, bonuses, or commission.

Irregular Income – Income which varies from week to week or month to month.


Liquid Asset – Assets in the form of cash or easily converted into cash.

Self-employed Income – Self-employed income is income derived from an individual's own business.

Self-Pay – Patients who pay for health care services out of pocket primarily because they do not have health care coverage through an insurance company. Patients are required to disclose any benefit coverage that is designed to cover hospital services. It is the policy of Self Regional Healthcare to pursue and file any known insurance coverage that a patient may have.

Medically Necessary – As defined by Medicare (services or items reasonable and necessary for the diagnosis and treatment of illness or injury.)

Total Charge – Total cost of your medical services

	SECTION: Administrative Manual	Page 12 of 12
	NUMBER: QSP-ADM-MI-0011	Revision Level: 0
FORMULATED: 10/01/2016	TITLE: Medical Financial Assistance Program	
REVISED:	APPROVAL: TITLE: Chief Financial Officer or Designee	
REVIEWED:	SIGNATURE:	

Uninsured – The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.