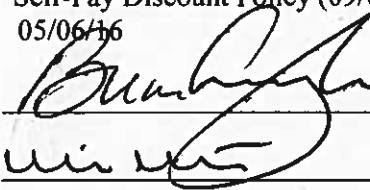
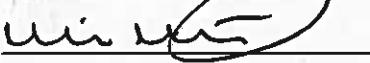


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FINANCIAL ASSISTANCE PROGRAM AND DISCOUNT POLICY

Orig Effective Date:	04/25/14 Self-Pay Discount Policy (09/01/07)	Reference #:
Revised Date:	05/06/16  Brian J. Murphy	Category: Administrative Patient Financial Services
Approved by:	 Tim Senn	CEO CFO

Relevance: Organization-Wide; Patient Financial Services.

Related Policies: Self-Pay Discount Policy (which is now incorporated into the Financial Assistance Program); Payment Arrangement Policy.

Related Documents: PARO Scoring System document, **Attachment A**; Financial Assistance Application (FAA) **Attachment B**; Determination Notice of Denial Letter, **Attachment C**; Determination Notice of Approval Letter, **Attachment D**; Federal Poverty Level Guidelines (FPL), **Attachment E**; Self Payor Form, **Attachment F**; Financial Assistance Program Determination Process Flow Chart, **Attachment G**; and Payment Plan Agreement.

1.0 PURPOSE

1.1 This policy is intended to:

- a) establish an effective Financial Assistance Program (Program) that identifies specific financial assistance criteria and creates standards and processes that guide Gila Regional Medical Center (GRMC) in its billing and collections for medically necessary care rendered to persons who are legal residents of the State of New Mexico Counties of Grant, Luna, Hidalgo, and Catron; who meet specific financial eligibility criteria; who require medically necessary health care services and who are uninsured, underinsured, ineligible for a government payor program, are self pay, or who are otherwise unable to pay for medically necessary health care services;
- b) identify those services which are not covered by the Program;
- c) promote GRMC's compliance with all applicable and relevant state, federal and local laws, rules, regulations, ordinances, and guidelines, including but not limited to: the New Mexico (NM) State Constitution; the NM Anti-Donation Clause; New Mexico Medicaid Rules; IRS requirements; EMTALA; the Affordable Care Act (ACA); and Office of Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS) requirements;
- d) promote GRMC's Mission, Vision and Values and provide access to health care to all individuals seeking medically necessary and emergency medical treatment regardless of their ability to pay;
- e) aid GRMC to manage its resources responsibly; and
- f) incorporate the GRMC Self-Pay Discount Policy into the Program, improve collections and provide discounts for self payors who do not qualify for discounts under the Program guidelines.

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2.0 DEFINITIONS

- 2.1 ***Anti-Donation Clause:*** A clause of the New Mexico Constitution, Article IX Section 14, that forbids, with a few specific and limited exceptions, all state, county, and local government subsidies to directly or indirectly lend or pledge its credit, or make any donation to or in aid of a person, association, or public or private corporation. The New Mexico Supreme Court has interpreted a “donation” as an allocation or appropriation of something of value, without consideration. Village of Deming v. Hosdreg Co., 62 N.M. 18, 28, (1956).
- 2.2 ***Bad Debt:*** Uncollectible accounts receivable that were expected to result in cash inflows for services provided by GRMC, for which the hospital anticipated, but did not receive payment. Bad debt results when a patient has the financial ability to pay for health care services that were rendered but refuses to pay the claim. Bad debt also often includes unidentified medically indigent or underinsured patients.
- 2.3 ***Charity Care:*** Health care services provided by GRMC for which GRMC has not received, or does not expect to receive payment because it has been determined based on the patient’s financial eligibility criteria and with the patient’s assistance that the patient is unable to pay for the services or meets the established self pay discount criteria. Charity care must be budgeted for and financed by the hospital. This Program incorporates GRMC’s Charity Care policies.
- 2.4 ***Contractual Adjustments:*** The difference between revenue at established rates and amounts realized from third party payers under contractual agreements.
- 2.5 ***Covered Services:*** The services covered under the Program are defined under “Eligible Hospital Services” in paragraph 2.7 of this policy and are limited to those GRMC inpatient, EMS or ER services that are determined to be “Medically Necessary.”
- 2.6 ***Disposable Income:*** Annual family income divided by twelve (12) months, less monthly expenses as requested on the Financial Assistance Program Application.
- 2.7 ***Down Coding:*** A potentially fraudulent billing practice also referred to as “undercoding” and occurs when the code billed does not adequately represent the full extents of the care and medical decision making and may result in lost revenue and allegations of billing fraud when a self pay patient bill is under-coded. This is because it provides a self pay patient a discount on the care without providing the same discounted care to Medicare/Medicaid Programs and other third party payors. It is also seen as an inappropriate inducement by CMS and is offering a “free service to a patient to encourage the provision of a service that would be covered by Medicare or Medicaid and is likely to inappropriately influence the patient to order or receive services from the hospital.” It also provides discounted care that is not in compliance with GRMC’s Financial Assistance Policy.
- 2.8 ***Eligible Hospital Services:*** GRMC services eligible for the Program are those goods and services provided by GRMC caregivers, GRMC EMS service providers or GRMC inpatient facilities and include the following:
 - a) EMS services;
 - b) emergency medical services provided in an emergency room setting;
 - c) inpatient services for a condition which, if not promptly treated, would lead to an adverse change in the health condition of a patient;
 - d) non-elective inpatient services provided in response to life-threatening circumstances in a non-emergency room setting;
 - e) medically necessary inpatient or ER services provided to Medicaid beneficiaries that are not covered by their respective Medicaid programs;

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- f) medically necessary inpatient or ER services not covered in paragraph 2.7(a) through (e) which are evaluated at GRMC's discretion on a case by case basis.
- 2.9 ***Emergency Medical Condition:*** As defined by the Emergency Medical Treatment Act and Active Labor Act (EMTALA) means any condition manifesting itself by acute symptoms such that the absence of immediate medical attention could result in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ, or, with respect to a pregnant woman who is having contractions, inadequate time to transfer prior to delivery or a transfer that may pose a threat to the health of the woman or unborn child. 42 U.S.C. § 1395dd (e)(1) (2006).
- 2.10 ***EMTALA:*** Emergency Medical Treatment Act and Active Labor Act, 42 USC § 1395dd (2006). Federal statute that in summary, requires hospitals with emergency departments to provide for an appropriate medical screening exam to any individual who comes to the emergency room requesting treatment or an exam, to determine if an emergency medical condition exists and to stabilize the emergency medical condition or to appropriately transfer the patient to another medical facility, after minimizing the risk of the transfer to the patient.
- 2.11 ***Family:*** The patient, his/her spouse and his/her legal dependents according to the Internal Revenue Service rules. Therefore, 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.
- 2.12 ***Family Income:*** Income that is determined on a before tax basis and includes: all earnings, gross wages, salaries, unemployment compensation, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, spousal support, alimony, child support, educational assistance, annuity payments, income from life insurance, rents, royalties, estates and trusts and other miscellaneous sources. It does not include capital gains and losses, non-cash benefits (i.e. food stamps and housing subsidies) and non-family household income.
- 2.13 ***Federal Poverty Level (FPL):*** The poverty guidelines updated periodically in the Federal Register (FR) by the US Department of Health and Human Services (DHHS) under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code (USC).
- 2.14 ***Financial Assistance Program (FAP):*** A Program that allows hospitals to provide uninsured, underinsured or medically indigent patients an established discount on certain health care services as defined by hospital policy when patients meet residency, medical necessity and financial criteria. Sometimes referred to as "Charity Care" and provides a method to distinguish "bad debt" from discounted care.
- 2.15 ***Financially Qualified Patient:*** A patient who has met the following requirements: NM State and GRMC geographic service area residency requirements; is not insured or is underinsured; has met established GRMC financial eligibility criteria; and has received GRMC health care services that are covered in the Program and that meet medical necessity criteria.
- 2.16 ***Geographic Service Area (GSA):*** GRMC's GSA includes New Mexico Counties: Grant; Hidalgo; Luna; and Catron Counties.
- 2.17 ***GRMC Health Care Services:*** Inpatient, EMS, or ER health care services that are provided at GRMC's hospital facility by GRMC employees and are eligible for billing and collection by GRMC.

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- 2.18 ***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.
- 2.19 ***Ineligible Hospital Services:*** Health care related services that are not covered under the Program include, but may not be limited to:
- a) non-GRMC employed physician or provider billed services, treatments or procedures;
 - b) non-GRMC transport or transfer services;
 - c) elective goods or services not necessary to treat an illness or injury;
 - d) non-medical services such as social services, educational services, or vocational services;
 - e) goods or services provided principally for cosmetic purpose;
 - f) fertility services;
 - g) reversal of vasectomy;
 - h) tubalplastics;
 - i) outpatient services (such as outpatient surgery, therapy, Home Health, Hospice, Cardiology Clinic, Pain Clinic or Cancer Center services); and
 - j) EMS, ground transport, or air transport services not provided by GRMC employed providers; and
 - k) other services identified from time to time as determined by the GRMC Medical Executive Committee, Utilization Review Committee and GRMC.
- 2.20 ***Medically Necessary Service:*** Any inpatient health care service provided by GRMC that is covered by and considered to be medically necessary under Title XVIII of the Federal Social Security Act, or CMS, and is based on the clinical judgment of the medical provider and GRMC's Utilization Review Committee.
- 2.21 ***Non-Covered Services:*** Include those defined as "Ineligible Hospital Services" and any service that is not medically necessary as defined under paragraph 2.18 of this policy.
- 2.22 ***Patient with High Medical Costs:*** An under-insured person whose household income does not exceed 350% of the current year's FPL, who does not receive a discounted rate from the hospital as a result of his/her third party coverage and who meets one of the three (3) criteria listed below:
- a) annual out-of-pocket costs incurred by the patient at the hospital for hospital services exceed 10% of the patient's household income in the prior twelve (12) months; or
 - b) annual out-of-pocket costs incurred by the patient at the hospital for hospital services exceed 10% of the patient's household income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's household on behalf of the patient in the prior twelve (12) months; or
 - c) meets a lower level determined by GRMC in accordance with GRMC's Financial Assistance Policy.
- 2.23 ***Payment Assistance Rank Order (PARO) scoring system:*** A scoring methodology used by hospitals to effectively and efficiently identify patients who may be eligible for financial assistance. Such a scoring system may be used, separately, or in conjunction with other scoring systems, such as credit scoring, to determine a patient's financial eligibility to participate in the Program. *See, Attachment A.*
- 2.24 ***Payment Plan Arrangement:*** A written and signed Payment Plan Agreement between GRMC and an underinsured, uninsured, or self pay patient who has account

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balances remaining, and which is entered into in accordance with GRMC's Payment Arrangement Policy.

- 2.25 ***Presumptive Eligibility (PE):*** A state policy option expanded under the Affordable Care Act (ACA) that allows hospitals that provide Medicaid Services to make Presumptive Eligibility decisions giving temporary Medicaid (and/or CHIP) coverage to children, pregnant woman, parents and adults which is based on gross family income. PE provides only temporary Medicaid coverage which will expire in accordance with NM regulations if the patient is not found eligible through the full regular application process by the end of the month following the initial application.
- 2.26 ***Self Pay Payor:*** A patient who is uninsured. A self payor may also include a patient who is underinsured and has a large deductible or co-pay and who agrees to be individually responsible for the payment of the billing charges and waive all insurance billing and reimbursement.
- 2.27 ***Self Pay Discount:*** A discount given in accordance with this policy when the patient does not meet the criteria required under the Program residency, medical necessity, and/or financial eligibility criteria. A Self Pay Discount may not be given where an insurance payor has been billed for any portion of the discounted services.
- 2.28 ***Uncompensated Care Charges:*** The overall measure of hospital care for which no payment was received from the patient or insurer. It is equal to the total bad debt charges and the charity care charges.
- 2.29 ***Underinsured:*** The patient has some level of insurance coverage or third party assistance to pay for the health care services rendered, but still has a balance due and out of pocket expenses that exceed his/her financial capacity to pay.
- 2.30 ***Uninsured:*** The patient has no insurance coverage at any level or third party assistance to pay for the health care services which were rendered or the patient with a high deductible chooses not to use his/her insurance coverage to enter into a self pay discount and payment plan arrangement to reduce his/her total out of pocket cost.

3.0 POLICY

- 3.1 ***Non-discrimination:*** GRMC shall offer financial assistance in accordance with this policy to any eligible and financially qualified patient who has received medically necessary or other eligible/covered services, as defined by this policy. Program participation status will be which is based on an individualized determination of residency status, medical necessity, and financial eligibility irrespective of race, color, national origin, ancestry, sex, serious medical condition, physical or mental handicap, religion, age, spousal affiliation, sexual orientation, and gender identification.
- 3.2 ***Communication to Patients of Potential Payor Sources:***
 - a) During scheduling, registration, or prior to discharge all reasonable efforts will be made to explain to the patient GRMC's Financial Assistance Program (Program), GRMC's Self-Pay Discount, Presumptive Eligibility, Medicaid and other private and governmental payor programs.
 - 1) Patients whose visits qualify for Presumptive Eligibility will be temporarily enrolled in Medicaid and assisted with the complete application process as allowed under the Affordable Care Act (ACA) and New Mexico State Medicaid rules.

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- 2) Patients that may be eligible to participate in the Program or Self Payor Discount will be asked to apply for the applicable payment assistance and will be provided a Program Application and given instructions on how to apply.
 - 3) Patients who are Self Pay will be given the opportunity to enter into a Payment Plan Agreement in accordance with GRMC's current Payment Arrangement Policy.
- b) This Policy, Program Application and related documents shall be made available to the public upon request and shall be published on the GRMC intranet and internet sites with instructions to complete the Program Application and contact resource information to address patient/applicant questions concerning the Program.
 - c) This Policy and related Program documents shall be provide in English and Spanish.
 - d) There shall be signs located in the Emergency Department and Registration Department notifying patients in English and Spanish of the Financial Assistance Program.
 - e) Patients may be informed of the Program by publication of notices in patient bills.
 - f) Referrals to the Program may be made by any GRMC caregiver, or member of the Medical Staff, or independent contractor.
 - g) Requests for Program referral may be made directly by the patient, family member, POA, guardian, or other person on behalf of the patient, subject to HIPAA and applicable privacy laws.
 - h) GRMC will insert terms into its agreements with every collection agency to which GRMC refers its accounts to require the agency to provide a telephone number Uninsured/Underinsured Patients can call to request payment assistance and participation in the Program.
- 3.3 **Determination of Eligibility:** GRMC shall use an application process and an established Payment Assistance Rank Order (PARO) scoring system, credit scoring, or other publicly available recognized payment assistance scoring methodology to determine the patient's ability to pay. *See, Attachment A.*
- a) **Method of application for assistance under the Program:**
 - 1) There shall be an individual assessment of financial need as follows:
 - i. patients shall complete an application process in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. Patients shall complete the Financial Assistance Program Application (Application) and shall provide GRMC with the documents listed on the Application. *See, Attachment B.* If a patient does not accurately complete the application process or supply the necessary documentation to determine eligibility within thirty (30) days from the date of service of the account visit, or the information supplied cannot be verified, the patient will be deemed ineligible for assistance under the Program;
 - a. if a patient is non-responsive or otherwise physically or mentally incapacitated and cannot complete the application and other sources of information are readily available to perform an individual assessment of residency status, medical necessity and financial need, such as existing eligibility for Medicaid or PARO or credit scores, these sources of information may be used to support and/or validate the decision for qualifying a patient under the Program.

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- ii. the determination of financial eligibility shall include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as PARO system scoring or credit scoring);
 - iii. the determination of financial eligibility shall include reasonable efforts GRMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
 - iv. the determination of financial eligibility shall take into account the patient's available assets, and all other financial resources available to the patient;
 - v. the determination of financial eligibility shall include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history; and
 - vi. when gathering information to determine a patient's financial eligibility, GRMC will ensure that its communications and financial counseling are non-discriminatory, clear, concise, correct and considerate of the needs of the patient and family member, in accordance with the principles of the PATIENT FRIENDLY BILLING Project. *See, <http://www.hfma.org/pfb>.*
- b) **Determination of Patient Resident Status Eligibility:**
- 1) Prior to determining any other criteria, there shall be a review of the patient's residency status to determine if the patient meets residency eligibility requirements. Patients must meet residency eligibility criteria to participate in the Program.
 - i. The patient must be living in GRMC's Geographic Service Area as defined by paragraph 2.15 of this policy and demonstrate an intention to remain in the state.
 - ii. Residency or intention to remain in the state may be established by occupying a home, enrolling children in school, obtaining a NM driver's license or ID, renting a post office box, or obtaining employment.
 - iii. Residency may be demonstrated by bank statements, home ownership documents, rental leases, utility bills, pay stubs, income tax returns, or other similar documents.
 - iv. Temporary Visas do not establish an intention to stay in the state.
 - v. Patients who do not meet the Resident Status criteria outlined above in paragraph 3.3(b)(1)(i) because they are not: United States citizens; resident aliens; or lawfully present in the United States, may be eligible for financial assistance under the following circumstances:
 - 3.3.b.1.v.1 the patient is treated for an emergency medical condition. *See, paragraph 2.8 of this policy;*
 - 3.3.b.1.v.2 the patient is treated for signs/symptoms of a communicable disease whether or not the symptoms were caused by a communicable disease; or
 - 3.3.b.1.v.3 the patient was given immunizations.
- c) **Determination of Medical Services Eligibility:**
- 1) After the patient's residency eligibility status has been established, there shall be a review of the health care services provided and a determination made to decide if the health care services meet the Program requirements:
 - i. the services covered under this Program that will be eligible for financial assistance are those defined by this policy in paragraphs 2.5, 2.8, 2.17 and 2.20;

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- ii. the services defined under paragraphs 2.19 and 2.21 of this policy shall not be eligible for financial assistance under the Program;
 - iii. all health care services must meet the medical necessity criteria to be eligible for financial assistance. The medical necessity for medical treatment of any patient will be based on the clinical judgment of the provider and/or the Utilization Review Committee without regard to the financial status of the patient; and
 - iv. all health care services must meet the definition of GRMC Health Care Services as defined in paragraph 2.17 of this policy to be eligible for financial assistance. GRMC may not compensate patients for services provided by non-employed medical providers or independently contracted medical groups.
- d) **Financial Eligibility Criteria:**
- 1) After residency status eligibility and medical necessity have been established there shall be a review of all the financial information provided by the patient during the application process to determine the patient's financial assistance eligibility.
 - i. The application process and review of financial eligibility shall be conducted at least every one hundred and twenty (120) days. The review and reapplication may be conducted more frequently if changes in the patient's residency status or income status warrant such review;
 - ii. The application process and review of financial eligibility shall be conducted at the time of scheduling, at the time service, at the time of discharge and/or before the patient is billed;
 - iii. If the patient is not eligible for financial assistance under the Program and the patient is self-pay, the patient shall be eligible for the Self Pay Discount as outlined in paragraph 3.3(g) of this policy.
- e) **Final Financial Assistance Program Eligibility Determination**
- 1) All patients must meet the following eligibility requirements to receive a discount under the Program:
 - i. Resident status
 - ii. Medical Necessity
 - iii. Financial status
 - 2) Patients who do not meet the criteria under any one of the above requirements set out in paragraphs 3.3(e)(1)(i) through (iii) will not be eligible to participate in the Program and will be sent a Determination Notice of Denial Letter (Denial Letter) explaining the reasons for the denial with instructions on how to appeal the denial. *See, Attachment C.*
 - i. *Patient Appeal of Denial:*
 - 3.3.e.2.i.1 Patients who receive a Denial Letter may appeal the denial within thirty (30) days from the date of the Denial Letter by submitting a written request for a review of the denial to Patient Financial Services giving the basis for such request.
 - 3.3.e.2.i.2 Requests for appeal of denial submitted beyond the thirty (30) day cut off will not be reviewed unless the patient has new financial eligibility evidence that impacts their financial eligibility status.

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- 3.3.e.2.i.3 If additional information is requested from the patient to facilitate the denial review and it is not provided, the appeal review will be conducted without the information.
- 3.3.e.2.i.4 The denial decision may be reviewed by any or all of the following: Patient Financial Services Director, GRMC CEO, CFO or the GRMC Utilization Review Committee where a final decision will be made within thirty (30) days of the patient's written request for appeal/review.
- 3.3.e.2.i.5 Patients will be notified in writing and in a timely manner of the final review decision.
- ii. Patients who do not meet the eligibility requirements to participate in the program may still qualify for the Self-Pay Discounts described in paragraph 3.3 (g).
- 3) Patients who meet all the criteria set out in the requirements in paragraph 3.3(e)(1)(i) through (iii) will be eligible to participate in the program and receive a discount as set out in section 3.3 (f)(1)(i) through (iv) of this policy and will be sent a Notice of Determination Approval Letter (Approval Letter) describing the amount of the discount and the remaining patient responsibility. *See, Attachment D.*
- 4) Patients will remain eligible to participate in the Program for a period covering one hundred and twenty (120) days from the initial date of service for which approval to participate in the Program was granted.
- i. The eligibility period of 120 days may be shortened if any of the following occur:
- 3.3.e.4.i.1 the patient's income or household income increases to a level that would decrease the patient's discount percentage, which may then be adjusted accordingly;
- 3.3.e.4.i.2 the patient's income or household income increases to a level where they no longer qualify for the Program; or
- 3.3.e.4.i.3 the patient is no longer uninsured.
- ii. Upon the expiration of the 120 day eligibility period, the patient must submit a new application and complete the full application process to re-apply to participate in the Program.
- 5) **Timing of Program Eligibility Determinations**
While GRMC will make every practical effort to make Program eligibility determinations before or at the time of service, especially where eligibility for Program participation has been previously established or is readily apparent, eligibility determinations may be made at any time during the revenue cycle.
- f) **Financial Assistance Calculation Process:**
- 1) Patients who meet the eligibility requirements under the Program will be given financial assistance on a sliding scale in accordance with financial need as determined

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by the financial need review process and based on the FPL which is in effect at the time of the determination.

- i. Patients whose family/household income is at or below 200% of the FPL are eligible to receive a discount of 100% of hospital charges.
- ii. Patients whose family/household income is between 201% - 250% of the FPL are eligible to receive a discount of 75% of hospital charges;
- iii. Patients whose family/household income is between 251% - 300% of the FPL are eligible to receive services at the highest average rate the hospital would receive for providing services from Medicare, Medicaid, or any other government sponsored program in which GRMC participates.
- iv. Patients whose financial liability after the initial discounts provided in paragraphs 3.3(f)(1)(i), 3.3(f)(1)(ii) and 3.3(f)(1)(iii) is in excess of 15% of their annual income, shall be eligible for an additional discount for all amounts that exceed the 15% threshold.
- v. Patients who meet the definition of a Patient with High Medical Costs, as defined in paragraph 2.21 will be eligible to receive a discount in an amount not to exceed the remaining patient responsibility after the third party or government payor payment.

g) Self Pay Discount

- 1) *Self-pay patients will be given one of the following discounts:*
 - i. a fifty percent (50%) discount if fifty percent (50%) of the estimated charges are paid within ten (10) days from the time of service; or
 - ii. forty percent (40%) discount if they pay sixty percent (60%) of actual charges within thirty (30) days from the date of billing; or
 - iii. a thirty percent (30%) discount if they pay seventy percent (70%) of actual charges within ninety (90) days from the date of billing; or
 - iv. a twenty percent (20%) discount off actual charges if the terms of a mutually agreed upon payment arrangement are fulfilled and paid in full within the time frames agreed upon in the payment arrangement, which is in accordance with GRMC's Payment Arrangement Policy.
- 2) *Self-pay patient discount at the time of service:*
 - i. All self-pay patients presenting for services will be advised by the registrar that they are entitled to a fifty percent (50%) discount if they pay fifty percent (50%) of their estimated charges within ten (10) days from the time of service or prior to receiving services.
 - ii. A good faith estimate will be prepared based on the provider's orders and using the Estimate of Charges Worksheet.
 - iii. Once an estimate is determined the registrar will collect fifty percent (50%) of the estimated amount of charges.
 - iv. The registrar will then notify the financial counselor and send a copy of the signed estimate of charges to the Patient Financial Services Office. The financial counselor will then reconcile the payment and adjustment to the actual charges

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on the account. The patient will be required to pay any additional payment within thirty (30) days from the date of billing. The financial counselor will contact the patient by either phone or mail, to inform them of any additional balance owed.

- 3.3.g.2.iv.i The self pay discount will be documented in the patient billing account and the form will be signed by the patient. See, **Attachment F**.
- v. The financial counselor will also be responsible for initiating any refund due to the patient, if the actual charges are less than the amount of estimated charges.
- 3) *Self-pay patient discount for payment within thirty (30) days from the date of billing:*
- i. Self-pay patients will be given a forty percent (40%) discount if they pay sixty percent (60%) of actual charges within thirty (30) days from the date of billing. The patient will be contacted either by phone and/or mail and the discount will be offered.
 - ii. The Self Pay Discount will not apply to payment arrangements unless the balance owed is paid in full within the thirty (30) day time frame.
- 4) *Self-pay patient discount for payment after thirty (30) days and before ninety (90) days from the date of billing:*
- i. Self-pay patients will be eligible for a thirty percent (30%) discount if they pay seventy percent (70%) of the actual charges within ninety (90) days from the date of billing. Financial counselors and cashiers will be allowed to make this offer when appropriate.
- 5) *Self-pay patient discount when payment arrangement terms are met:*
- i. Self-pay patients will be offered a twenty percent (20%) discount off of actual charges if the terms of their payment arrangements are met. Payment arrangements must be determined in accordance with hospital policy. The discount will be posted at the end of the month that the last payment is received.
 - ii. The agreed upon amount and terms of the payment arrangement as documented in **Attachment F**, must be met in a timely manner for this discount to apply.
- 6) *Prohibition on Insurance billing when Self Pay Discount Applied:*
- i. Once an account has been determined to be eligible for a Self Pay Discount and a discount applied to the account, neither GRMC, or the patient, may bill any insurer, third party payor or governmental program for any portion of the account.

3.4 Change in Patient Income or Eligibility Status.

a) **Patient Income Increase or Decrease**

- 1) If a patient and/or patient's family/household experiences a decrease in income that would affect their eligibility status a new review and eligibility determination will be made at the patient's request and appropriate modifications of the discount calculation applied to the patient's remaining liability.
- 2) Where a patient who has previously qualified for a discount under the Program experiences an increase in his/her and/or his/her family's/household's income that would affect the patient's eligibility status to participate in the Program, GRMC may

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at its sole discretion conduct a new financial eligibility review and determine if the patient is still eligible to participate in the Program. If the patient is no longer financially qualified to participate in the program, GRMC may bill the patient for the adjusted amount due without the discount applied.

3) Patients will be notified of this requirement at the time of application to the Program.

3.5 Notification of Patient or Patient Guarantor of Program Eligibility Status and Discount Calculation. Reasonable attempts shall be made to notify the patient in writing and in a timely manner of their eligibility determination and associated discount calculation. See, *Attachments C and D*.

3.6 Collection Practices

a) Suspension of Collection Activities

1) Collection activities will be suspended on the related patient accounts while the eligibility determination is being made unless collection activities are needed to collect financial eligibility information. If collection activities are determined to be necessary to collect financial eligibility information the patient will be informed of the necessity before the collection activities are initiated.

3.7 Payment Plans

a) Patients who have remaining balances after a Program or Self Pay discount is applied or who do not qualify for participation in the Program or Self Pay discount and are uninsured may pay off the remaining balances under an established Payment Plan Agreement that is signed by the patient or patient's guardian/POA or guarantor and is in accordance with GRMC's Payment Arrangement Policy.

b) Patients may ask for a Payment Plan at any time a balance on their account remains.

3.8 Record Keeping

a) The appropriate record keeping for Financial Assistance Program discounts and related charges are:

- 1) Record services at the full-established charges amounts in revenue and receivables as services are rendered consistent with all other services.
- 2) Adjust revenue and receivables to the amount that a payor (or payors) has an obligation to pay. If it is possible to determine that an amount qualifies as a Financial Assistance Program discount it is written off as described in paragraph 3.7(a)(4). If collection efforts are needed to identify patients who qualify for the Program, it will be necessary to estimate the amount as described in paragraph 3.7 (a)(3).
- 3) Estimate the amount of remaining receivables that will eventually be written off as a Financial Assistance Program discount. This amount is recorded as a provision under the Program and an allowance under the Program. The supporting documentation for the estimation shall be retained.
- 4) Write off receivables as they are subsequently determined to meet the Program requirements against the allowance for the Program. The documentation concerning the eligibility of the patient and the account shall be retained.

3.9 Monitoring and Reporting Requirements

- a) There shall be a quarterly evaluation conducted to determine the adequacy of the allowance for the Program discounts, with adjustments to increase or decrease the allowance offset by adjustments in the provision of discounts under the Program.
- b) There shall be an annual audit of the Program and related discounts performed by an external objective audit source.

**Gila Regional Medical Center
Policy and Procedure**

- c) In accordance with the AICPA audit guide the Financial Assistance Program discounts are not to be reported in revenue or receivables.
 - d) The use of a separate account for Financial Assistance Program discounts shall be established which is separate from Bad Debts.
 - e) The total amount of discounted care under this Program, including Self Pay Discounts shall be distinguished from Bad Debt and reported accurately and annually on GRMC's Cost Report, P/L statements, Finance Department Dashboards and where required by all applicable state and federal laws and in compliance with all state and federal laws.
 - f) The amount of discounted care provided under this Program shall be reported to the GRMC Board of Trustees on a regular basis.
- 3.10 **Budgetary Considerations.** The projected fiscal year cost of the Program shall be calculated and included in the GRMC budget on an annual basis. Reviews and necessary adjustments shall be made to the Financial Assistance Program which take into account GRMC budgetary constraints.
- a) GRMC shall set up a separate expense account and budget line item to track all costs related to this Program.
- 3.11 **Administrative Write-offs.** No other discounts shall be given except as described in this Policy, with the exception of certain Administrative write offs which are approved by the Hospital CEO, CFO, and CCO. Such Administrative write offs must comply with all CMS/OIG regulations and the NM Anti-Donation Clause and may be made for liability reduction purposes.
- 3.12 **Down Coding or Under Coding:** No patient's medical record will be completed in such a way as to create an impression of lesser care than the patient actually received and no patient's billing claim will be intentionally or knowingly "down coded" or "under coded" for the purpose of providing a patient with a discount or for any other fraudulent or unlawful purpose.
- 3.13 **Personal Injury Litigation Discounts.** Patients who obtain health care services at GRMC for treatment of injuries resulting from a motor vehicle collision or other personal injury and who file legal personal injury claims against the tortfeasor shall not be eligible for any additional discounts not specifically or explicitly defined in this policy. Requests for reductions in medical bills at the demand of the patient's attorney shall be forwarded to the Risk Management Department for follow up and a lien shall be filed by GRMC Patient Financial Services against the relevant patient account.
- 3.14 **Regulatory Compliance.** In implementing this Policy, GRMC shall comply with all relevant federal, state, and county rules, regulations, statutes, OIG and CMS requirements, including but not limited to Stark, the Anti-Kick Back Statute, the Civil Monetary Penalty Act, False Claims Act, EMTALA, ACA, the NM Anti-Donation Clause, the Immigration and Nationality Act, and HIPAA.

4. PROCEDURE

4.1 Procedural Steps:

- a) The general procedural steps required of GRMC registration and the Patient Financial Services Department to implement the requirements under this policy are included in Attachment G. See, **Attachment G**.

**Gila Regional Medical Center
Policy and Procedure**

4.2 *Training:*

- a) Appropriate training will be provided to all caregivers necessary to implement this policy, including, but not limited to the following areas: Accounting; Administration; Discharge Planning; ER; Finance; HIM; Medical Staff Services; Nursing; Patient Financial Services; Registration; Scheduling; and Utilization Review.

Attachment A

PARO **Payment Assistance Rank Order**

Introduction

PARO was developed as a tool to help hospitals more effectively, efficiently and less intrusively identify patients who may be eligible for charity care/payment assistance.

Background

The application and approval process for healthcare payment assistance efforts and charity care is widely fragmented, time consuming and not effective in assisting many of the patients it is intended to assist.

Healthcare providers need a tool to simplify interactions with the patients in order to streamline the process for those patients who are engaged and to evaluate those accounts when the patient is not responsive to the charity care/payment assistance application process.

Existing scoring systems, such as collection scores and credit scores, analyze a debtor's *likelihood* of repayment and were developed based on an approach to maximize cash collections. For example, credit scores focus on the credit capacity of the responsible party. However, in healthcare, scoring systems should be based on the debtor's *ability* to pay, which is the purpose of the PARO system.

PARO Development

PARO was conceived as a methodology to apply consistent screening and application standards to all patients. Special attention was paid to those socio-economic factors that might adversely affect those patients deserving the most attention.

Historically, healthcare providers have used manual application processes to assess a patient's financial need, largely for accounting and regulatory purposes. These processes require patients to complete complicated forms and to submit personal financial documents such as bank statements and tax returns with the application. The information submitted by the patient during this application process is then usually verified by credit/FICO scores.

PARO research has proven that patient financial need has a high correlation to where a patient lives, educational background, marital status, age, gender, and language/culture. Traditional credit scoring does not provide an adequate measure of these underlying conditions. The PARO score has been demonstrated to aptly identify those individuals with the highest level of financial need. More than 47 million people in the U.S. are uninsured while 78 million are considered poor or are likely to fall into poverty within any 12 month period. Many consumers living in poverty are challenged by literacy and the high cost of banking. This further contributes to lack of participation in traditional charity programs which require completed applications including bank account information and tax returns. A large portion of these people have been overlooked for charitable assistance.

The developers of PARO approached CHW with the proposition to utilize historical data to develop a predictive model for healthcare financial assistance that encompassed approved financial assistance applications, rejected financial assistance applications, and non-responsive patients.



Attachment B

GRMC Financial Assistance Program Application			
Patient Account Number		Date of Healthcare Service on Billing Account	
Patient Last Name	Patient First Name	Patient Social Security #	Patient Date of Birth
Guarantor Last Name (If Different)	First Name	Guarantor Social Security #	Date of Birth ()
Guarantor Home Address		Home Telephone Number	
City	State	Zip Code	
\$			
Guarantor's Employer Name	Guarantor's Annual Income		Guarantor Job Function/Department
Do you have Health Insurance? <input type="checkbox"/> Y <input type="checkbox"/> N	Insurance_____	Policy #_____	Group #_____ ()
Guarantor's Employer address		Guarantor's Employer Telephone	
City	State	Zip Code	
Spouse's Employer Name	Spouse's Annual Income		Spouses' Job Function/Department
Does your Spouse have Health Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Insurance_____	Policy#_____	Group#_____ ()
Spouse's Employer Address		Spouse's Employer Telephone	
City	State	Zip Code	
People in Household			
Name	Date of Birth	Employer	Employer Telephone number
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			



Attachment B

GRMC Financial Assistance Program Application (Continued)

Please complete the table below as completely as possible.

Income Analysis		Qualified Monetary Asset Analysis	
<i>In order to determine your eligibility for the GRMC Payment Assistance Program, please provide us with information about your <u>annual before-tax household income</u>.</i>			
Job Income	\$ _____	Checking Account(s)	\$ _____
Spouse Job Income	\$ _____	Savings Account(s)	\$ _____
Business Income	\$ _____	Stocks, Bonds & CDs	\$ _____
Rental Income	\$ _____	Other Monetary Assets	\$ _____
Interest/Dividend Income	\$ _____	Total Qualified Savings	\$ _____
Social Security Income	\$ _____		
Alimony or Support Payments	\$ _____		
Other Income	\$ _____		
Total Income	\$ _____		

IMPORTANT PLEASE READ: THIS FORM MUST BE ACCURATELY COMPLETED AND ALL DOCUMENTATION REQUESTED SUBMITTED WITHIN THIRTY (30) DAYS OF THE DATE OF YOUR HEALTH CARE SERVICE IN ORDER FOR YOUR APPLICATION TO PARTICIPATE IN THE FINANCIAL ASSISTANCE PROGRAM TO BE CONSIDERED. APPLICATIONS THAT ARE NOT COMPLETED WITHIN THIRTY (30) DAYS WILL BE DENIED.

In order to determine whether you meet the criteria for financial assistance, it is required that you submit this fully completed application and provide the documentation and information requested to demonstrate financial hardship. Please complete the attached application and return it with all of the following items. If you are unable to supply one of the documents, please submit a statement explaining why you cannot provide the information.

1. **Proof of Identity** – One of the following:
 - Copy of Social Security Card
 - Copy of state issued driver's license
 - Other photo ID
 - Proof of State of New Mexico legal residency
2. **Proof of Monetary Assets** – All of the following (if applicable):
 - Last two months checking account statements
 - Last two months of savings account statements
 - Documentation about stocks, bonds, and/or CDs
 - Money market accounts
 - Annuities
 - Pensions
3. **Verification of Current Address** – One of the following:
 - Rent receipt
 - Utility bill
4. **A copy of a state Medicaid decision/denial notice.**
5. **Proof of Income**



Attachment B

- If employed, include a copy of prior year tax return, including W-2 or check copies or check stubs from each of the prior three months.
 - If receiving public assistance, include copies of public assistance checks from each of the prior three months or award letter (i.e., disability, unemployment pay stubs, or social security benefits.)
 - If self-employed, include Schedule C of prior year tax return and a quarterly accountant report with a written statement declaring gross income received during the last three months.
 - If not receiving a consistent income, write a brief paragraph on a separate paper stating your financial situation over the last three months. Explain how or from what source you are receiving monies to pay for your basic living expenses such as food and housing.
 - If dependent upon another individual's financial support, include a "letter of financial support."
6. **Proof of Unpaid GRMC Expenses.** Applications must include documentation of unpaid GRMC expenses. Any unpaid GRMC expenses must be documented by a billing invoice and a balance due statement.

By signing below, you indicate you have fully read and understand this application and that you desire to be considered for participation in GRMC's Financial Assistance Program. You also certify, represent and warrant that all the statements made on this Application are true and complete to the best of your knowledge. You also unconditionally grant GRMC authorization to verify the information that was submitted with this Application, to check references and to obtain any additional information necessary including, but not limited to a credit history in order to evaluate this Application for participation in GRMC's Financial Assistance Program. You also understand that if the information you submitted cannot be verified, or the documents GRMC requested were not provided, or this Application is not completed within thirty (30) days from the date of the health care services for which you are requesting financial assistance under this Program, your Application will be denied and you will be responsible for the billing charges.

Signature of Person Responsible for Bill (Guarantor)

Date

For internal GRMC Patient Financial Service Department use only.

- 1) Did patient fully and accurately complete application within thirty (30) days of service? Y ____ N ____.
- 2) Does patient meet Program residency criteria? Y ____ N ____.
- 3) Does patient's healthcare service, for which a discount is requested, meet the Program's medical necessity criteria? Y ____ N ____; and were the healthcare services GRMC inpatient, ER, EMS services? Y ____ N ____.
- 4) Does patient meet the Program's financial eligibility criteria? Y ____ N ____.

If "yes" is answered to **all** questions above (1-4), calculate the discount percentage according to the Program policy and send the patient the Determination Notice of Approval. Apply the Calculated Discount Amount to the patient account. Calculated Discount Amount = _____.

If "no" is answered to any of the questions above (1-4) the patient does NOT qualify for the Program discount. Send the patient the Determination Notice of Denial and determine if the patient qualifies for a self-pay discount? Y ____ N ____.

If "yes", calculate Self Pay Discount and have patient sign Self Payor Discount Form. Calculated amount = _____.

If the patient is a Self Payor was payment plan offered to patient? Y ____ N ____.



Attachment C

Date:

Account Number(s):

Patient Name:

Date(s) of Service:

DETERMINATION NOTICE OF DENIAL OF FINANCIAL ASSISTANCE PROGRAM PARTICIPATION

Dear :

This is to notify you that your application to participate in Gila Regional Medical Center's Financial Assistance Program ("Program") and the residency and/or financial information you have provided Gila Regional Medical Center (GRMC), or other information that has been obtained by GRMC to determine your eligibility status have been carefully evaluated. Based upon this information we have determined that you do not meet the criteria to participate in the Program. This determination is in accordance with GRMC's Program Policy and is based on the following:

(CHECK ALL THAT APPLY)

- Application not completed by applicant within thirty (30) days;
- Unable to verify information provided by applicant;
- Residency Status criteria is not met;
- Medical Necessity criteria are not met;
- Financial Eligibility criteria are not met;
- Self Pay Discount criteria are not met;
- Medical Hardship criteria are not met

You have a right to appeal this decision if you have additional information concerning the criteria noted in the checked boxes that would assist us in reviewing your eligibility status.

HOW TO APPEAL THIS DENIAL: Within THIRTY (30) DAYS from the date of this letter, you must submit a written request to GRMC's Patient Financial Services Office to have the denial appealed/reviewed. Failure to submit a written request for appeal within the thirty (30) day time frame will result in your appeal being denied without review. Following your timely and written request for appeal/review of the denial you may be asked to submit additional information to assist in the determination review. Failure to submit the requested additional information may result in your appeal being denied. GRMC will make reasonable efforts to review your request and provide you with its final decision within thirty (30) days of your request. You will be notified in writing of GRMC's final determination decision.

Although you may not currently qualify for a discount or participation in the Program to cover the above referenced Account, we encourage you to contact GRMC's Patient Financial Services to reapply to the Program if you require further health care services from GRMC, your residency status meet the Program criteria and/or you experience a financial status change.

Given the determination described above you, will not be eligible for a discount or payment assistance under the Program. You are responsible for the current balance on your Account(s) referenced above. Your current balance is \$ [REDACTED]. Although you are responsible payment of this amount you may be eligible for Self Payor discount. Please contact GRMC Patient Financial Services to determine if you are eligible for a Self Payor discount.

You may also contact GRMC Patient Financial Services to make payment arrangements for any outstanding balances. Should you have any questions regarding this letter, your Account(s), your Application, your Financial Assistance Program participation, or billing charges, please direct them to Patient Financial Services at 575-574-4989.

Sincerely,

Michael Metts, CPA, MHA
Chief Financial Officer
Gila Regional Medical Center



Attachment D

Date:

Account Number(s):

Date(s) of Service:

Patient Name:

**DETERMINATION NOTICE OF APPROVAL OF FINANCIAL ASSISTANCE PROGRAM
PARTICIPATION**

Dear :

We are pleased to inform you that upon careful review of your Financial Assistance Program (“Program”) Application, and in accordance with Gila Regional Medical Center’s Program Policy, we have determined that you are eligible to participate in the Program. Your eligibility qualifies you for the below stipulated payment assistance to cover Gila Regional Medical Center (GRMC) charges for services related to the above referenced account. (*See yellow highlighted amount.*)

Please note that this determination in no way obligates GRMC to provide discounts or payment assistance to you in the future. Please also be aware that any payment assistance or discounts do not apply to any charges you may have for:

- Healthcare rendered by non-GRMC employed caregivers, physicians, or other providers;
- Elective services;
- Outpatient services; and/or
- Services not deemed to be medically necessary

Such charges do not qualify for payment assistance under the Program. You may also have additional charges that do not qualify under the program for which you remain financially responsible. Finally, you are required to inform GRMC of any change in your financial status that may affect your financial capacity to pay your account as indicated in your Program application.

You will be responsible for the amount indicated below (*bolded line*):

Total Account(s) Balance: \$

Less Program Payment Assistance: \$

Total Amount Owed by Patient/Guarantor \$

You may contact GRMC Patient Financial Services to make payment arrangements for any outstanding balances. Should you have any questions regarding your Account(s), payment assistance, Program participation, or charges, please direct them to the Patient Financial Services at 575-574-4989.

Sincerely,

Michael Metts, CPA, MHA
Chief Financial Officer
Gila Regional Medical Center

Federal Poverty Guidelines
 New Mexico Affordable Care Eligibility Groups
 Effective April 01, 2016 thru March 31, 2017

Monthly Guidelines

HH SIZE	PERCENT OF POVERTY				
	138%	190%	240%	250%	300%
1	1,367.00	1,881.00	2,376.00	2,475.00	2,970.00
2	1,843.00	2,537.00	3,204.00	3,338.00	4,005.00
3	2,319.00	3,192.00	4,032.00	4,200.00	5,040.00
4	2,795.00	3,848.00	4,860.00	5,063.00	6,075.00
5	3,271.00	4,503.00	5,688.00	5,925.00	7,110.00
6	3,747.00	5,159.00	6,516.00	6,788.00	8,145.00
7	4,224.00	5,816.00	7,346.00	7,653.00	9,183.00
8	4,703.00	6,475.00	8,178.00	8,519.00	10,223.00

- 138%: 100 Other Adult age 19 up to 65
 190%: 403 Children ages 6 up to 19 (Medicaid)
 240%: 402 Children ages 0 up to 6 (Medicaid); 421 ages 6 up to 19 (CHIP)
 250%: 301 Pregnancy Related Services Only
 300%: 420 Children ages 0 up to 6 (CHIP)



MEDICAL ASSISTANCE
DIVISION

Federal Poverty Guidelines
 New Mexico Affordable Care Eligibility Groups
 Effective April 01, 2016 thru March 31, 2017

Annual Guidelines

HH SIZE	PERCENT OF POVERTY				
	138%	190%	240%	250%	300%
1	16,404.00	22,572.00	28,512.00	29,700.00	35,640.00
2	22,116.00	30,444.00	38,448.00	40,056.00	48,060.00
3	27,828.00	38,304.00	48,384.00	50,400.00	60,480.00
4	33,540.00	46,176.00	58,320.00	60,756.00	72,900.00
5	39,252.00	54,036.00	68,256.00	71,100.00	85,320.00
6	44,964.00	61,908.00	78,192.00	81,456.00	97,740.00
7	50,688.00	69,792.00	88,152.00	91,836.00	110,196.00
8	56,436.00	77,700.00	98,136.00	102,228.00	122,676.00

- 138%: 100 Other Adult age 19 up to 65
 190%: 403 Children ages 6 up to 19 (Medicaid)
 240%: 402 Children ages 0 up to 6 (Medicaid); 421 ages 6 up to 19 (CHIP)
 250%: 301 Pregnancy Related Services Only
 300%: 420 Children ages 0 up to 6 (CHIP)



MEDICAL ASSISTANCE
DIVISION

GILA REGIONAL MEDICAL CENTER
1313 E. 32nd Street
Silver City, NM
575-538-4000

ATTACHMENT F

Patient	Account #	Service/Location	Status	Date	Unit # (Med Rec #)			
PATIENT								
Soc Sec No	DOB	Age	Sex	MS	Race Religion			
Address:								
Home Ph:	County:	PATIENT EMPLOYER						
GUARANTOR	SS#:	Work Phone:	Occupation:	GUARANTOR EMPLOYER				
Address:								
Home Ph:	County:	Work Phone:						
Relationship to Patient:		Occupation:						
OTHER / ALT ADDRESS								
Address:								
Home Ph:	County:	Other Phone:						
Relationship to Patient:		Relationship to Patient:	NEXT OF KIN					
Home Phone:	Work Phone:	Home Phone:	Work Phone:					
Relationship to Patient:		Relationship to Patient:						
TOTAL CHARGES, if available								
Discount Policy								
<ol style="list-style-type: none"> <input type="checkbox"/> a fifty percent (50%) discount if fifty percent (50%) of the estimated charges are paid at the time of service; or <input type="checkbox"/> a forty percent (40%) discount if they pay sixty percent (60%) of actual charges within thirty (30) days from the date of billing; or <input type="checkbox"/> a thirty percent (30%) discount if they pay seventy percent (70%) of actual charges within ninety (90) days of billing; or <input type="checkbox"/> a twenty percent (20%) discount off actual charges if the terms of a mutually agreed upon payment arrangement are fulfilled and paid in full within the time frames agreed upon in the payment arrangement <input type="checkbox"/> I choose not to accept a discount option at this time. 								
Deposit for ER or Outpatient Ancillary services are \$500.00. Deposit for Outpatient Surgery is \$1000.00.								
<p>Please initial the option selected above. By signing below, I indicate I have selected the option initialed. I agree that insurance will not be billed either by myself or the hospital.</p>								
Signature: _____ Date: _____								
<table border="1"> <tr> <td>Financial Counselor: Sylvia</td> <td>at 575-538-4004</td> <td></td> </tr> </table>						Financial Counselor: Sylvia	at 575-538-4004	
Financial Counselor: Sylvia	at 575-538-4004							

Adm Priority	Last Hospitalization	Admission Comment	Financial Class
Attending Physician	PHYSICIANS	Emergency Room Physician	
Prim Care Physician	Admitting Physician	Other Physician	
Date	Time	ADMISSION / REGISTRATION	Admitted By
Rm/Bed	Arrival	Stated Reason for Visit	

