SURPRISE VALLEY HEALTH CARE DISTRICT

CHARITY/DISCOUNT POLICY

POLICY STATEMENT

Surprise Valley Community Hospital strives to provide quality services in a caring environment and to make a positive, measurable difference in the health of individuals we serve. Helping to meet the needs of the low-income uninsured and underinsured is an important element of our commitment to the community. The hospital's financial assistance policy provides the means for Surprise Valley Community Hospital to demonstrate its commitment to achieving its mission and values.

The criteria that Surprise Valley Community Hospital will follow qualifying patients for programs for financial assistance purposes are provided in this policy. The financial assistance policy has been developed in written form to effectively communicate how our commitment will be applied consistently to all patients.

Patients who receive medically necessary care at Surprise Valley Community Hospital and who do not have third party insurance coverage for the hospital bill, and who have difficulty paying their hospital bills because of financial hardship, may be covered under the terms of the financial assistance policy.

The differentiation between charity service and bad debts is clearly defined for the Hospital. Bad debts and those accounts which become uncollectible because the patient refused to pay although they have resources and income sufficient to make payments even if the payments extend over a long period of time. Charity care are those accounts in which there is a demonstrated inability of the patient to pay. Should the patient's financial position change after discharge or during the payment process, the consideration of charity may be needed by patients qualifying under the charity care policy.

SURPRISE VALLEY HEALTH CARE DISTRICT

CHARITY CARE DETERMINATION FORM

TO: Business Office Manager

I have reviewed the attached completed charity care application form for ______________________ for a total of __________. I make the following recommendation:

____

____

____

Signature ______________________________ Date________

TO: Accounting Department

Year to date Charity Write-Off $____________ (including above).

Additional Comments:______________________________

____

Signature ______________________________ Date ________

TO: Administrator

I have reviewed the attached completed charity care application and I approve________ Disapprove __________. Reason for Disapproval:

____

____

Signature ______________________________ Date________

TO: Board of Directors

I have reviewed the attached completed charity care application and Approve_________ Disapprove __________Reason for Disapproval:

____

____

____

Signature ______________________________ Date________

Revised 9/0_ Reviewed 04/09

FINANCIAL EVALUATION FORM

Schedule of Current Income and Expenditures

Patient: ______________________ Spouse: ______________________

Address: ____

____

Phone: ______________________

Social Security number: ______________ ______________
(patient) *(spouse)*

FAMILY STATUS

List all dependents you support

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer: ______________________ Position: ______________________

Contact person: ______________________ Phone: ______________________

If self-employed, give name of business: ______________________

Spouse's employer: ______________________ Position: ______________________

Contact person: ______________________ Phone: ______________________

If self-employed, give name of business: ______________________

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross pay from employment (before deductions)	$______	$______
Income from operating business (If self employed)	$______	$______
Other income:		
Interest and dividends	$______	$______
From real estate or personal property	$______	$______
Social Security	$______	$______
Other—specify:______________________	$______	$______
Alimony, support payments	$______	$______
Total current monthly income (add all figures from above)	$______	$______

MONTHLY EXPENSES

Rent or house payment	$__________
Food	$__________
Utilities (electricity, water, etc.)	$__________
Automobile payment	$__________
Other transportation expense (gasoline, bus, etc.)	$__________
Telephone	$__________
Insurance (home, automobile, life, etc.)	$__________
Credit cards/other debt	$__________
Other	$__________

UNUSUAL EXPENSES OR INCOME

Please provide information on any unusual expenses or income such as previous medical bills, a recent bankruptcy, court judgments or one-time earnings. You may write on the back of this page or attach a separate listing.

4. FAMILY SIZE:

Name	Relationship

5. PUBLIC ASSISTANCE HAS BEEN APPLIED FOR? YES______ NO______

PLEASE ATTACH NOTICE OF DETERMINATION OF ELIGIBILITY FROM YOUR SOCIAL SERVICES DEPARTMENT, OR A COPY OF NOTICE.

I affirm that the above information is true and correct to the best of my knowledge.

______________________ Date

______________________________ Signature (person making request)

Date Application Received at Surprise Valley Community Hospital

____

REVIEWED 04/09

REVISED ______________

ASSETS AND DEBTS

Please provide your best estimate of the value of any homes, cars or similar assets. Also, indicate how much debt you currently have.

Assets:

a. Home and property $__________

b. Automobiles $__________

c. Retirement plan $__________

d. Investments/other (specify) $__________

Debts:

a. Amount owed on mortgages $__________

b. Amount owed on automobiles $__________

c. Amount owed on credit cards $__________

d. Other (specify) $__________

My/our signature(s) on this form gives Sample Hospital authorization to verify the information on the form including permission to contact employers and to check my/our credit history.

______________________ (Date)

______________________________________ (Signature of Patient or Guarantor)

______________________ (Date)

______________________________________ (Signature Spouse)