SOUTH COUNTY HOSPITAL

PATIENT FINANCIAL ADVOCACY PROGRAM CHECKLIST

Patient Name: _____ MR # _____ Date _____

SCREENING FOR ELIGIBILITY TYPE:

{ } Yes { } No Does the patient have any type of insurance (including GPA)? Attempt to collect a deposit. If yes, this will be considered a Charity Care APPEAL.

{ } Yes { } No Is the patient a resident of Rhode Island?

{ } Yes { } No Is the Financial Eligibility Screening completed?

- { } Yes { } No If eligible, is the RIteCare/RIteShare application completed?

{ } Yes { } No Does patient meet the DHS Medical Assistance eligibility based on the FPL Guidelines?

- { } Yes { } No Does patient need assistance completing DHS forms?
- { } Yes { } No If eligible for Medical Assistance, is DHS 1 and 2 forms complete?
- { } Yes { } No Are three DHS medical release forms signed by the patient?
- { } Yes { } No Is DHS Physician Examination Disability Form (MA63) signed by patient. Give to Case Management to put in patient's chart.

{ } Yes { } No Is patient disabled?

{ } Yes { } No Was patient screened for Medicare?
Give patient Medicare pamphlet and encourage patient to follow through with SSA.

{ } Yes { } No Can patient prove disability for 24 months before Medicare eligibility ?

{ } Yes { } No Patient should also apply for Medical Assistance as secondary to Medicare

{ } Yes { } No Is patient living in a rehab center or a shelter?

- { } Yes { } No Can patient prove residency at rehab/shelter?
- { } Yes { } No Letter received from rehab/shelter?

CHARITY CARE

{ } Yes { } No Did patient receive approval at Thundermist Health Center?

- { } Yes { } No Does patient have their approval letter? If not, ask health center to fax.

{ } Yes { } No Is SCHHS application signed?

{ } Yes { } No Is application dated at top and/or bottom?

{ } Yes { } No Is proof of permanent RI residence attached?

{ } Yes { } No Is current Federal Income Tax Return attached?

- { } Yes { } No Is IRS Letter #1722 attached proving lack of tax filing?
- { } Yes { } No If neither, did patient's letter indicate why these are not attached?

{ } Yes { } No Are 3 consecutive months of Current Paychecks received?

- { } Yes { } No If neither, did patient's letter indicate why these are not attached?

{ } Yes { } No Are there 3 consecutive months of Bank Statements attached?

- { } Yes { } No If neither, did patient's letter indicate why these are not attached?

{ } Yes { } No Is application completed?

REPORTABLE INCOME:

List all reportable income: $_____ _____
$_____ _____
$ _____ _____
$ _____ _____

What is the average monthly income for the family: $_____ X 12 months = $_____

NO INCOME:

{ } Yes { } No Is letter from unemployment attached or did patient explain if they are collecting or not?
{ } Yes { } No Is letter from person supplying food and lodging attached?
{ } Yes { } No Does patient's letter explain their situation of last employment?
{ } Yes { } No Does letter explain why the patient is no longer employed?
{ } Yes { } No Does letter explain when patient expects to be employed again?

ASSETS:

List all **reportable** assets: $_____ _____
$_____ _____
$ _____ _____
$ _____ _____

ELIGIBILITY DETERMINATION:

{ } Yes { } No Is patient eligible for Charity Care?
{ } Yes { } No Does patient understand that Charity Care is only good for six (6) months? (Patient must reapply after 6 months.)
What is the effective dates of Charity Care _____to _____
{ } Yes { } No Are the dates and percentages entered into B/AR?

PAYMENT PLAN:

{ } Yes { } No If ineligible for any other programs, attempt to set up a payment plan with the patient.
{ } Yes { } No Deducted 40 % self pay discount.
{ } Yes { } No Did patient sign the Payment Plan Agreement?
{ } Yes { } No Is payment agreement approved for:
___ 6 months (up to $999.99) or
___12 months (over $1,000.00) or
___24 months (maximum amount)

{ } Yes { } No Place comments on account of payment arrangement agreed upon.
{ } Yes { } No Contact Self Pay Unit (Medical Bureau) on day that bill drops. They bill patient monthly.

{ } Yes { } No Did you enter a reminder in B/AR?