Constantino, Mike

From: Sue_Coughlin@chs.net
Sent: Monday, October 04, 2010 2:01 PM
To: Constantino, Mike
Cc: anne.murphy@hklaw.com; jacobmaxel@msn.com; ed_cunningham@chs.net; Tom_Miller@chs.net; Ron_Shafer@chs.net; James_Rayome@chs.net
Subject: Crossroads Community Hospital Project 010-056 written Comments and Supplemental Information
Attachments: CON Project 010-056 Crossroads Community Hospital Written Comments Supplemental Info 10-04-10.pdf

Mr. Constantino:

Attached please find the Written Comments and Supplemental Information regarding Project 010-056 Crossroads Community Hospital. Should you have any additional questions, please do not hesitate to contact Ed Cunningham at 618-214-5188 or Jack Axel at 847-776-7101. Thank you.

Sue Coughlin | Executive Administrative Assistant
Crossroads Community Hospital | #8 Doctors Park Road | Mt. Vernon, IL 62864 | Tel: 618-241-8505 | Fax: 618-244-5566|
http://www.crossroadscommunityhospital.com

CROSSROADS
COMMUNITY HOSPITAL

"Caring People, Caring for People"

by FedEX and Electronic Mail

October 4, 2010

Mr. Dale Galassie
Acting Chairman
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

RE: Written Comments and Supplemental Information
Project 010-056
Crossroads Community Hospital

Dear Mr. Galassie:

This letter is being written in response to the written comments provided by SSM Healthcare/St. Mary's Good Samaritan Hospital, and to provide supplemental information in support of the application.

Both Crossroads Community Hospital ("Crossroads") and St. Mary's Good Samaritan Hospital ("Good Samaritan") are located in Mt. Vernon. Crossroads is approved to operate 57 beds and Good Samaritan 134 beds.

The above referenced project proposes a $23 Million modernization project for Crossroads Community Hospital, the cornerstone of which is the replacement of the hospital's 50 medical/surgical beds with 40 beds—a reduction of 10 beds—to be located in private rooms. No other IDPH-designated "categories of service" are being addressed through the project. As the Illinois Health Facilities and Services Review Board may be aware, the proposed project represents the first major modernization project addressing Crossroad's medical/surgical units since the facility was converted from a nursing home to a hospital nearly 30 years ago.

Good Samaritan raised a variety of issues, each of which is addressed below.

Good Samaritan noted their plans to invest $240 Million in their campus, their interest in "protecting SSM's financial investment" and their interest in protecting the long-term mission of the hospital. Good Samaritan is the largest hospital in the area, and both hospitals have operated in the community for many years.

Crossroads has no interest in impinging upon Good Samaritan's mission. This project simply proposes the modernization of an outdated hospital facility that was originally constructed as a nursing home. It does not propose the expansion of Crossroads' services, but rather proposes a reduction in the number of hospital beds. In this context, SSM's suggestion that Crossroad's proposed project will hinder any other hospital's ability to fulfill its mission is a stretch, at best. Instead, common sense suggests that Good Samaritan's written opposition (they did not elect to voice their opposition in the open forum of a Public Hearing) is motivated by competitive considerations, and a desire to further increase their market share of inpatient care.

Good Samaritan suggests that the scope of the project is too large, (items 1 and 2 of August 27, 2010 letter) when in actuality the project proposes a reduction from 50 to 40 medical/surgical beds. The reasonableness of the proposed 40 beds is fully addressed in Attachment 15 of the application, including discussions of bed need based on historical utilization, the impact of an aging service area population, beds used by "non-inpatients", additions to the hospital's Medical Staff, and extraordinary census swings. The concern raised that the "new" physicians' patients are "predicated on these physicians pulling market share from like-specialists who already exist in the community" is not contrary to any of the Board's rules, as suggested by Good Samaritan. In addition, it has never been the Board's practice or intent to limit the manner in which physicians practice. We recognize that one of the physicians identified in the application, Dr. Dickler, has subsequent to the application's filing announced his intent to move out of state. A letter from Dr. Shamsham, who has assumed Dr. Dickler's role in the providing of non-invasive cardiology care to Crossroads patients, is attached.

Good Samaritan incorrectly suggests (item 3) that the medical/surgical average daily census (ADC) identified in the application included "observation" patient days, with that assumption apparently being based on 2008 data. In actuality, the historical data used by Crossroads was not 2008 data, but 2009 data, which was absolutely consistent with that provided to the IDPH in the hospital's 2009 Annual Hospital Questionnaire. It should also be noted that the 2009 historical utilization data/ADC did not include "observation" patient days.

Good Samaritan encouraged the State Board and State Agency to include Crossroad's intensive care unit (ICU) beds in the review of the project (item 4), even though ICU beds are not addressed in the proposed project. Good Samaritan should be aware that expanding review parameters beyond a proposed project is contrary to State Agency and State Board practices that have been in place since the Agency's and Board's inception.

Good Samaritan notes that an excess of medical/surgical (and ICU) beds exists in the planning area (item 5). That cannot be disputed. The proposed project, however, does not include the addition of beds, but rather the reduction of Crossroad's medical/surgical bed complement by 10 beds, 20% of its current capacity.

Last, SSM and Good Samaritan (item 6) allege that Crossroads has an "apparent selective admission" practice that "strains the financial ability" of Good Samaritan. Attached are copies of Crossroads' charity care and admissions policies. Contrary to Good Samaritan's allegations, data provided in the table below paints a very different picture, documenting that the two hospitals have similar commitments to these three patient groups. As noted in the table below, even though as an investor-owned hospital Crossroads has no obligation to provide either Medicare, Medicaid or charity care services, it does so.

Comparison of Admissions from Selected Payor Groups

Admissions	Crossroads 2009	Good Samaritan 2008
Medicare	61.0%	53.7%
Medicaid	15.5%	17.6%
Charity Care	2.3%	2.9%

Sources: 2009 IDPH Annual Hospital Questionnaire (for Crossroads)
2008 IDPH Hospital Profile (for Good Samaritan)

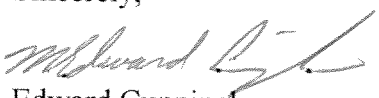
In reviewing the data in the table above, it should be noted that Medicaid may be somewhat skewed for two reasons. First, Crossroads does not provide obstetrics services, which traditionally have a disproportionately high share of Medicaid patients, and 12.8% of Good Samaritan's total admissions were classified as obstetrics. Second, a significant number of Medicaid (and charity care) patients access a hospital through the Emergency Department, and in 2008 Good Samaritan treated 25,411 patients in its ED, compared to 8,237 treated in Crossroads' ED. Crossroads' ED is categorized as "comprehensive" by IDPH and Good Samaritan's is categorized as "basic".

While Good Samaritan seeks to wrap itself in a cloak of charity care and Medicaid provision, the above statistics indicate that Good Samaritan does no more on a percentage basis than does Crossroads. Moreover, the SSM system has a mixed record in Illinois on devotion to charity care and Medicaid service delivery. In 2008 SSM divested itself of St. Francis Hospital in Blue Island, citing continuing operating losses as a primary reason for doing so. During its review of the change of ownership of that hospital, the Board questioned SSM's assertion that operating losses precluded SSM from continuing to operate St. Francis, noting that other near-by hospitals were continuing to operate with higher percentages of Medicaid and charity care patients.

In conclusion, none of the arguments presented in SSM/Good Samaritan's August 27, 2010 letter hold water, and the assertion that CHS/Crossroads does not carry its Medicaid/charity care load in Mt. Vernon is simply untrue.

I look forward to discussing these issues further and as appropriate when I appear before the State Board on October 26th.

Sincerely,



Edward Cunningham
Chief Executive Officer

Attachments

cc M. Constantino

Subject:	Originally Issued	Date of This Revision	Page	No.
CHARITY CARE POLICY			1 of 5	

POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to serve the health care needs of our community, Crossroads Community Hospital will provide charity care to patients without financial means to pay for Inpatient and Emergency Room hospital services.

Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria.

PURPOSE:

To properly identify those patients who are financially indigent or medically indigent, who do not qualify for state and/or government assistance, and to provide assistance with their Inpatient and Emergency Room medical expenses under the guidelines for Charity Care.

ELIGIBILITY FOR CHARITY CARE

1. **FINANCIALLY INDIGENT:**
   A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

   B. To be eligible for charity care as a financially indigent patient, the patient's total household income shall be at or below 100% of the current Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities for the person when determining eligibility.

   C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in

January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 100% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

2. **MEDICALLY INDIGENT:**

A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.

B. To be eligible for charity care as a medically indigent patient, the amount owed by the patient on medical bills for the prior 12 month period, after payment by third party payers, must exceed 50% of the patient's annual gross income and the patient must be unable to pay the remaining bill. The hospital may consider other financial assets and liabilities of the person when determining ability to pay.

C. A determination of the patient's ability to pay the remainder of the bill, or portion of the bill, will be based on whether the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.

D. The patient may be eligible for a charity discount for any amount beyond what the patient is expected to pay over a 3-year period.

E. If a determination is made that a patient had the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should there be a change in the patient's financial status.

THE PROCESS

1. **Identification of Charity Cases:**

A. The hospital maintains posted signs, in English, *Exhibit "A"* and Spanish, *Exhibit "B"*, one in each admitting offices and one in the emergency lobby that inform customers that charity care is available and what the charity care criteria

is. (**SIGNS WILL BE POSTED ONLY IF STATE REQUIRES or if hospital has participated in the Hill Burton Program)**

B. All self-pay patients are asked to complete the Financial Assistance form "FA", *Exhibit "C"*, during the registration or financial counseling process.

C. All self-pay accounts will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an "FA" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.

D. The "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager.

E. If the Financial Counselor determines through the application and documented support that the patient qualifies for charity care she/he will give the completed and approved "FA" to the BOM for approval authorization, prior to write off.

F. The following documents will be required to process the application: copies of current monthly expenses/bills, copies of the previous year's income tax return, current copy of employers check stub, proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills. The hospital has the option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to the credit card.

G. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.

H. Once approved for Charity, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self pay.

I. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.

J. Applications that remain incomplete after 30 days of request for information will be denied.

K. The application may be reopened and reconsidered for charity once the require information is received.

L. Once an account has been written off to bad debt, the patient will not be allowed to apply for Charity assistance.

2. FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for charity care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for charity are attached on *Exhibit "D"*. The current Federal Poverty Guidelines are attached as *Exhibit "E"* and they include the definition of the following:

1. Family
2. Income

3. FAILURE TO PROVIDE APPROPRIATE INFORMATION

Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt

4. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

5. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit

purposes. The CEO, CFO, BOM will signify their review and approval of the write-off by signing the bottom of the Charity Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

6. REPORTING OF CHARITY CARE

Information regarding the amount of charity care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

7. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO	Date
Hospital CFO	Date
Corporate VP, Patient Financial Services	Date
Division VP, Finance	Date

Exhibit A
Example of 'Availability of Charity Care" Sign-English Version

CHARITY CARE POLICY

As a condition pf participation in the Medicaid Disproportionate Share Program, this hospital will provide care to persons who are unable to pay for their care.

In order to be eligible for charity care, you must:

Have no other source of payment such as insurance, governmental assistance or savings; or

Have hospital bills beyond your financial resources; and

Provide proof of income and income resources; and

Complete an application and provide information required by the hospital.

Forms and information about applying for charity care are available upon request.

Exhibit B
Example of 'Availability of Charity Care" Sign-Spanish Version

REGLAS PARA SERVICIOS DE CARIDAD

Este hospital participa en un programa de Medicaid, llamado "Disproportionate Share Program". Como condicion a esta participacion, al hospital ofrece servicios grauitos a personas que no pueden pagar por su atencion medica.

Para tener `derecho a servicios caritativos, se necesita tener los siguientes requisitos:

No contra cpn otro medio de pagar, (por ejempio seguor medico, asistencia del gobierno federal, o sus propios ahorros o bien)

Tener cuentes de hospital que esten mas alla de sus recursos economicos.

Tambien hay que:

Presentar pruebas de sus ingresos y recursos economicos

Liener la solicitud de servicio y dar la informacion que le pida al hospital.

A pedido de los interesados, se proveeran formularios e informacion y datos tocante a la solicaticion de servicios caritativos.

Exhibit C
Example of Financial Assistance Form

Crossroads Community Hospital
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other(explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

Approval/Authorization of Charity Write-Off **Amount Approved $**_____

BOM_____ **CEO**_____

CFO_____

Exhibit D
EXAMPLE

Income Guidelines For Determining % of Charity Care Discount
(For Financially Indigent Patients)

Based Current Year's Federal Poverty Income Guidelines

% of Poverty Income	Discount from charges
Equal to or Below Poverty	100%
100-150%	100%
151-200%	75%
201-250%	50%
251-300%	25%

The above sliding scale is intended to provide an example of what a hospital might want to consider and is not the standard income or charity discounts suggested. Hospitals should discuss with their Division VP of Finance.

Exhibit E

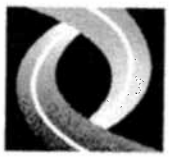
2008 Federal Poverty Income Guideline

The Department of Health and Human Services has issued updated Poverty Guidelines for 2008 (reference: Federal Register: January 23, 2008, Volume 73, Number 15 pp. 3971-3972).

2008 HHS Poverty Guidelines

Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

These guidelines are effective immediately upon publication in the Federal Register. As noted In the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the poverty guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program...to find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.



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COMMUNITY HOSPITAL

2008 Charity Care Sliding Scale

Family Size	100%	75%	50%	25%
1	10,400	13,000	15,600	18,200
2	14,000	17,500	21,000	24,500
3	17,600	22,000	26,400	30,800
4	21,200	26,500	31,800	37,100
5	24,800	31,000	37,200	43,400
6	28,400	35,500	42,600	49,700
7	32,000	40,000	48,000	56,000
8	35,600	44,500	53,400	62,300

Guidelines: Effective date for use 01/24/07: publication date Department of Health and Human Services Poverty Guidelines for 2008
For families with more than eight members, add $3,480.00 for each additional member

Policy/Procedure Title	Non-Discrimination Policy	**Manual Location**	Administration		
Policy/Procedure # **Replaces Policy #**	7381-032010-961 7381-082000-961	**Effective**	03/10	**Page(s)** **Attach**	1 N/A
Department Generating Policy	Administration				
Affected Departments	Hospital Wide				
Prepared By	Sam White, RN, BSN	**Dept/Title**	QRMC		
Administration Approval (If Applicable)	Ed Cunningham	**Date/Title**	02/16/10 /CEO		

POLICY:

- As a recipient of Federal financial assistance, Crossroads Community Hospital, does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Crossroads Community Hospital directly or through a contractor or any other entity with whom Crossroads Community Hospital arranges to carry out its programs and activities.
- This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of the Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed).

PROCEDURE:

Crossroads Community Hospital shall provide care for patients without discrimination, including but not necessarily limited to the following:

- Patients will be treated and/or admitted and assigned rooms without regard to race, color, creed, national origin or handicap.
- Patients will not be asked if they desire or are willing to share a room with a patient of another race or on any other discriminating basis.
- Employees, volunteers, and medical staff will be assigned to patients regardless of race, color, creed or national origin.
- All patients shall receive the same level of care based on their diagnosis, treatment needs, care planning and all other aspects of patient care.

Reviewed:

Date: _____ _____ _____ _____

By: _____ _____ _____ _____

Policy/Procedure Title	EMTALA	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s) Attach**	8 A,B,C, D,E,F
Department Generating Policy	Nursing				
Affected Departments	Nursing				
Prepared By	Stacey Maxey	**Dept/Title**	RN, BSN, CNO/ 04/05/04		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

Introduction

To ensure that all patients presenting on Hospital property and requesting emergency medical services, and patients presenting to a dedicated emergency department requesting medical services and non-emergency services, receive an appropriate medical screening examination and stabilization services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC Section 1395 and all Federal regulations and interpretative guidelines promulgated there under.

POLICY

Each hospital must have written guidelines outlining the requirements for appropriate medical screening and stabilization procedures which comply with applicable federal and state law.

DEFINITIONS

- **Appropriate Transfer** occurs when:
  - The transferring Hospital provides medical treatment within its capacity and capability that minimizes the risks to the individual's health and in the case of a woman in labor, the health of the unborn child.
  - The receiving facility has the appropriate space and qualified personnel for the treatment of the individual and has agreed to accept Transfer of the individual and to provide appropriate medical treatment.
  - The transferring Hospital sends to the receiving Hospital all medical records (or copies thereof) related to the Emergency Medical Condition, including available history, that are available at the time of Transfer pertaining to the

individual's Emergency Medical Condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies and telephone reports of the studies, treatment provided and the informed written consent of certification required, name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; any other records that are not readily available at the time of the Transfer are sent as soon as practicable after the Transfer.

- The Transfer is effected through Qualified Medical Personnel and appropriate transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the Transfer (see Compliance Policy/Procedure: EMTALA-Emergency Transfers).

➢ **Capacity**

- The Hospital's physical space, equipment, supplies, and services (e.g. trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit or psychiatry), including ancillary services that the Hospital provides. Capacity encompasses number and availability of qualified staff, beds, equipment, and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

➢ **Capabilities**

- The ability of the Hospital to accommodate the individual requesting examination or treatment of the Transferred individual. The capabilities of the Hospital's staff mean the level of care that the Hospital's personnel can provide within the training and scope of their professional licenses.

➢ **Central Log**

- A log the Hospital maintains of all individuals who present to the Hospital seeking emergency medical assistance and the disposition of such individuals, whether the person refused treatment, was transferred, was admitted and treated, was Stabilized and Transferred, or discharged. The purpose of the Central Log is to track the care provided to each individual who comes to the Hospital seeking care for an Emergency Medical Condition. The Central Log must include patient logs from other areas of the Hospital, including labor and delivery, where a patient might present for emergency services or receive a Medical Screening Examination instead of in the Dedicated Emergency Department (see Compliance Policy/Procedure: EMTALA-Central Log).

➢ **Comes to the Emergency Department**

- With respect to the individual requesting examination and treatment means that the individual is on the Hospital Property (including parking lot, campus, and other departments of the Hospital) or an off campus department of the Hospital which meets the definition of a Dedicated Emergency Department.

➢ **Dedicated Emergency Department**

- A department or a facility of a Hospital that is located on the main Hospital campus or off campus, and meets at least one of the following requirements:

- The department or facility is licensed by the state as an emergency room or department
- The department or facility is held out to the public (by name, signs, advertising, or other means) as a place that provides care for Emergency Medical Conditions on an urgent basis without requiring a previously scheduled appointment.
- The department or facility, based on a representative sample of patient visits within the immediately preceding calendar year, provides at least one-third of all its outpatient visits for the treatment of Emergency Medical Conditions on an urgent basis without requiring a previously scheduled appointment.

➢ **Emergency Medical Treatment and Active Labor Act (EMTALA)**
- Section 1866 and 1867 of the Social Security Act 42 USC Section 1395dd, which obligates the Hospital to provide medical screening, treatment and Transfer of individuals with Emergency Medical Conditions or women in labor. It is also referred to as the "anti-dumping" statue and COBRA.

➢ **Emergency Medical Condition**
- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and unborn child) in serious jeopardy.
  - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.
    - With respect to a pregnant woman who is having contractions
      - There is inadequate time to affect a safe Transfer to another Hospital before delivery.
      - The Transfer may pose a threat to the health or safety of the woman or the unborn child.

➢ **Hospital**
- A Medicare facility certified as a Hospital with its own provider number, including a rural primary care Hospital.

➢ **Hospital Property or Premises**
- The entire main Hospital campus, including the parking lot, sidewalk, and driveway.

➢ **Hospital Owned Facility which is Contiguous**
- Any area within the Hospital (or a Hospital owned facility) on land that touches land where a Hospital's Dedicated Emergency Department is located.

- **Labor**
  - The process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician or Qualified Medical Personnel certifies that, after a reasonable time of observation, the woman is in false labor.

- **Medical Screening Examination**
  - The process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an Emergency Medical Condition exists or a woman is in labor. Such screening must be done within the Hospital's capabilities and available personnel, including on-call physicians. The Medical Screening Examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either Stabilized or appropriately transferred.

- **Non-Emergent**
  - Based on an appropriate Medical Screening Examination, the Qualified Medical Personnel has determined that the patient does not have an Emergency Medical Condition.

- **On-Call List**
  - The list that the Hospital is required to maintain that defines those physicians who are on-call for duty after the initial Medical Screening Examination to provide further evaluation and/or treatment necessary to stabilize an individual with an Emergency Medical Condition. The purpose of the On-Call List is to ensure that the Dedicated Emergency Department is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to stabilize individuals with Emergency Medical Conditions. If a Hospital offers a service to the public, the service should be available through on-call coverage of the Dedicated Emergency Department (see Compliance Policy/Procedure: EMTALA-Provision of On-Call Coverage).

- **Physician**
  - A doctor of medicine or osteopathy.
  - A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his/her license.
  - A doctor of podiatric medicine to the extent that he/she is legally authorized to practice by the State.

- **Physician Certification**
  - Written certification by the treating physician ordering the Transfer and prior to the patient's Transfer, that based on the information available at the time of Transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from effecting the Transfer. The Physician Certification must include a summary of the risks and benefits upon which the Physician Certification is based

and the reason(s) for the Transfer (see Compliance Policy/Procedure: EMTALA-Emergency Transfers, Attachment A).

- **Qualified Medical Personnel**
  - Those individuals defined by the Hospital's Medical Staff Bylaws, Rules and Regulations and approved by the Hospital's governing board to perform the initial Medical Screening Examinations for those individuals who come to the Dedicated Emergency Department and request examination or treatment.

- **Signage**
  - The Hospital's requirement to post signs conspicuously in any Dedicated Emergency Department or in a place or places likely to be noticed by all individuals entering the Dedicated Emergency Department as well as those individuals waiting for examination and treatment in areas other than the traditional Dedicated Emergency Department (e.g. labor and delivery, waiting room, admitting area, entrance, and treatment areas) informing the patients of their rights under federal law with respect to examination and treatment for Emergency Medical Conditions and women in labor. The Signage must also state whether or not the Hospital participates in the State's Medicaid Program (see Compliance Policy/Procedure: EMTALA-Signage).

- **Stabilized/Stabilization**
  - Stable for Discharge
    - When a patient is within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instruction; or, the patient requires no further treatment and the treating physician has provided a written documentation of his/her findings.
  - Stable for Transfer
    - A patient is Stable for Transfer if the treating has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.
    - For the purpose of transferring a patient with a psychiatric condition(s), the patient is considered stabilized when he/she is protected and prevented from injuring him/herself or others. For the purpose of discharging a patient for psychiatric condition(s), the patient is considered stable when he/she is no longer considered to be a threat to themselves or others.
    - Neither Stable for Discharge nor Stable for Transfer requires final resolution of the Emergency Medical Condition.

- If a Hospital has screened a patient and found the patient to have an Emergency Medical Condition, and admits that patient in good faith in order to stabilize the Emergency Medical Condition, the Hospital has satisfied its special responsibilities under EMTALA with respect to the patient. At this point, the Hospital's obligations under EMTALA cease and the Hospital is required to provide care to its inpatients in accordance with the Medicare Conditions of Participation.

- **Transfer**
  - The movement of an individual outside a Hospital's facilities at the direction of any person employed by, affiliated or associated, directly or indirectly, with the Hospital, but does not include such a movement of an individual who has been declared dead or who leaves the Hospital against medical advice or without being seen, or movement of an individual to or from a Hospital owned facility that is operated under the Hospital's provider number, as long as all persons with the same medical condition are moved to this location and there is bona fide medical reason for moving the patient (see Compliance Policy/Procedure: EMTALA-Emergency Transfers).

- **Triage**
  - A sorting process to determine the order in which patients will be provided a Medical Screening Examination by a physician or Qualified Medical Personnel. Triage is not the equivalent to a Medical Screening Examination and does not determine the presence or absence or an Emergency Medical Condition.

MEDICAL SCREENING/STABILIZATION

- **General Requirements**
  - In general, when an individual comes, by himself or herself or with another person, to the Dedicated Emergency Department of the Hospital and a request is made on the individual's behalf for a medical examination or treatment, the Hospital must provide an appropriate Medical Screening Examination within the capability of the Hospital (including ancillary services routinely available in the Dedicated Emergency Department and emergency services offered at outpatient departments or facilities) to determine whether an Emergency Medical Condition exists, or with respect to a pregnant woman having contractions, whether the woman is in active labor; and, if necessary, the Hospital must execute an Appropriate Transfer according to the guidelines of EMTALA and these policies. These same requirements apply if a person comes to areas in the Hospital other than the Dedicated Emergency Department and a prudent layperson believes the individual is in need of an emergency examination or treatment.

- **The Location in which the Medical Screening Examination Should Be Performed**
  - The Medical Screening Examination and other emergency services need not be provided in a location specifically identified as an emergency room or Dedicated Emergency Department. If an individual arrives at a facility and is not technically in the Dedicated Emergency Department, but is on the premises of the Hospital and requests emergency care, he or she is entitled to a Medical Screening Examination. For example, all pregnant women may be directed to the labor and

delivery area of the Hospital, if the Hospital has adopted and approved such a policy. The Hospital may use areas to deliver emergency services which are also used for other inpatient or outpatient services. Medical Screening Examinations or Stabilization may require ancillary services available only in areas or facilities outside of the Dedicated Emergency Department.

- **Medical Screening Examination Requirements**
  - Hospitals are obligated to perform the Medical Screening Examination to determine if an Emergency Medical Condition exists.
  - Medicare participating Hospitals that provide emergency services must provide a Medical Screening Examination to any individual regardless of diagnosis, financial status, race, color, national origin, handicap, or ability to pay.
  - Individuals coming to the Dedicated Emergency Department must be provided a Medical Screening Examination. Triage is not equivalent to the Medical Screening Examination. Triage merely determines the "order" in which patients will be seen, not the presence or absence of an Emergency Medical Condition.
  - The Medical Screening Examination includes both a generalized assessment and a focused assessment based on the patient's chief complaint, with the intent to determine the presence or absence of an Emergency Medical Condition.
  - A Hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with Emergency Medical Conditions who come to the Hospital for examination and treatment.
  - The Medical Screening Examination must be the same Medical Screening Examination that the Hospital would perform on any individual coming to the Hospital's Dedicated Emergency Department wit those signs and symptoms, regardless of the individual's ability to pay for medical care. If the Medical Screening Examination is appropriate, and does not reveal an Emergency Medical Condition, the Hospital has no further obligations under EMTALA or this policy.
  - A Medical Screening Examination is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist. The Hospital must apply, in a non-discriminatory manner and regardless of ability to pay, a screening process that is reasonably calculated to determine whether an Emergency Medical Condition exists.
  - Depending on the patient's presenting symptoms, the Medical Screening Examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as, but not limited to, lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.
  - Medical Screening Examination is not an isolated event. It is an on-going process. The record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or an Appropriate Transfer occurs. There should be evidence of this evaluation prior to discharge or Transfer.
  - All medical screenings do not have to be equally extensive.

- No Hospital may establish, maintain, or enforce a policy that prohibits personnel from leaving the Hospital to examine and/or treat an individual in need of emergency services in the immediate vicinity of the Hospital.
- A Hospital that is not in diversionary status may not refuse or fail to accept a telephone or radio request for Transfer or admission. Such failure or refusal could represent a violation of the Hospital's obligations under EMTALA.

➢ **The Impact of Managed Care on the Medical Screening Examination**

- Every individual who comes to the Hospital's Dedicated Emergency Department and requests a medical examination or treatment must be provided a Medical Screening Examination, which must not be delayed to inquire about the individual's method of payment or insurance status.
- The Medical Screening Examination should be the same appropriate screening the Hospital would perform on any individual coming to the Hospital's Dedicated Emergency Department with those signs and symptoms, regardless of the individual's ability to pay.
- A Hospital may not refuse to screen an enrollee of a managed care plan because the plan refused to authorize treatment or to pay for such screening and treatment.
- It is not appropriate for a Hospital to request prior authorization before the patient has received a Medical Screening Examination to determine the presence or absence of an Emergency Medical Condition or before an existing Emergency Medical Condition has been Stabilized, if such request would delay provision of the medical screening examination.

➢ Facilities must establish processes to ensure that:

- A Dedicated Emergency Department physician on duty is responsible for the general care of all patients presenting themselves to the Dedicated Emergency Department.
- The responsibility remains with the Dedicated Emergency Department physician until the patient's private physician or an on-call specialist assumes that responsibility, or the patient is discharged or an Appropriate Transfer occurs.

➢ **COMPLIANCE PROGRAM POLICY STATEMENT**

- Failure to comply with this policy shall constitute a serious violation of policy and subject an employee to suspension or termination of employment

Reviewed:

Date: 11/21/08 03/30/2010 _____ _____

By: S White, RN QMRC TSpenner, RN _____ _____

Policy/Procedure Title	EMTALA Central Log	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s)** **Attach**	2 N/A
Department Generating Policy	Nursing Administration				
Affected Departments	Emergency Department				
Prepared By	Stacey Maxey, RN, BSN	**Dept/Title**	CNO		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

INTRODUCTION

To track the care provided to each individual who comes to the Hospital seeking care for an Emergency Medical Condition.

POLICY

Each Hospital that provides emergency services will maintain a Central Log to include information on each individual who comes to the Hospital requesting medical treatment, including those patients presenting to labor and delivery, the Dedicated Emergency Department, and other areas where Emergency Medical Conditions are treated.

NOTE

Some states have separate emergency services laws that may apply additional legal requirements to the Medicals Screening Examination, diagnostic testing, or stabilizing emergency medical treatment. Consult with the Hospital's legal counsel to identify and comply with any such additional legal mandates.

PROCEDURE

- Please refer to the EMTALA-Medical Screening/Stabilization Policy for a complete list of definitions pertaining to this policy.
    - Each Hospital must maintain a Central Log to track the care provided to each individual who comes to the Hospital seeking care for an Emergency Medical Condition.
    - The Central Log must include patients presenting to the Dedicated Emergency Department. The Central Log must also incorporate and be consolidated with patient logs from other areas of the Hospital, such as labor and delivery, where

a patient might present for emergency medical services or may have received a Medical Screening Examination instead of in the Dedicated Emergency Department.

- For example, the labor and delivery department log must be physically consolidated with, and made part of, the Dedicated Emergency Department Central Log on a daily basis.

- All logs must be maintained for a period of five (5) years and must be readily available for surveyor review.
- The Central Log must contain:
  - The name of the individual seeking assistance
  - The disposition. Permitted dispositions include:
    - Patient refused treatment.
    - Patient was transferred.
    - Patient was admitted and treated.
    - Patient was stabilized and transferred.
    - Patient presented for outpatient test or treatment only.
    - Patient was discharged.
  - Patient should be entered into the Central Log at the first point of contact.

COMPLIANCE PROGRAM POLICY STATEMENT

Failure to comply with this policy shall constitute a serious violation of policy and subject an employee to suspension or termination of employment.

Reviewed	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____

TO BE UTILIZED FOR ALL PATIENT TRANSFERS – EMERGENCY AND NON-EMERGENCY
COMPLETE SECTIONS A AND B FOR ALL PATIENT TRANSFERS. COMPLETE SECTION C ONLY FOR EMERGENCY TRANSFERS.

TRANSFERRING NURSE TO COMPLETE

1. a. Appropriate medical records of the examination and treatment of the patient provided to the receiving facility at the time of transfer: (CHECK ALL THAT APPLY)

❑ History/Physical ❑ Progress Notes ❑ Medication Records ❑ X-Rays ❑ ER Records
❑ Lab Tests ❑ Consultation Reports ❑ EKG ❑ Face Sheets ❑ Nurse's Notes
❑ Advance Directive ❑ Other

b. Additional reports needed by receiving facility should be requested through the HIM department.

2. Receiving facility has agreed to accept patient transfer, provide appropriate personnel and treatment, and has available space.

Name of Receiving Facility _____ Address _____ Telephone # _____

Full Name of Person Accepting Transfer _____ Title _____ Time Contacted _____ Time Accepted _____

Equipment Needs During Transfer _____

Personnel Needed During Transfer _____

Accepting Physician _____

TRANSFERRING PHYSICIAN TO DETERMINE IN ALL CASES

1. Mode of Transfer:

❑ Ambulance with Basic EMT (Basic Life Support) ❑ Ambulance with Paramedic (Advanced Life Support)
❑ Ambulance with RN (Critical Care Ground) ❑ Helicopter or fixed wing aircraft with RN (Critical Care Air)
❑ Law Enforcement

Transferring Healthcare Professional's Printed Name _____ Date _____

Physician Signature _____ Time _____

SECTION B

PATIENT OR PATIENT'S LEGAL GUARDIAN TO COMPLETE

Risks related to transfer acknowledgment:
I realize that there are risks involved in transfer from one facility to another regardless of the reason for the transfer. Such risks include those inherent in the Transfer such as traffic delays, inclement weather, accidents during transport, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle. I also understand that my medical condition may worsen.

I understand that every effort will be made to ensure a safe transfer. However I acknowledge I have been informed of the above and agree to transfer by the mode determined by the physician:

Signature of patient or legally responsible individual _____ Print patient's full name _____

Relationship to patient _____ Date _____ Time _____

1. Physician initiated transfer - Acceptance
I have been informed by the physician that the medical benefits of transfer outweigh the risks.

a. I accept those risks and consent to be transferred. I understand that a copy of my medical records and reports that are available at the time of transfer, as appropriate, will be sent to the receiving facility.

Signature of patient or legally responsible individual: _____ Print Name _____

Relationship to patient _____ Date _____ Time _____

EMERGENCY SERVICES

PATIENT TRANSFER FORM

ER-3401-2 (02/05)

Addressograph

White - Facility Copy

Yellow - Receiving Facility

SECTION B (CONTINUED)

2. Physician initiated transfer - Refusal to Consent To Transfer
   b. I understand that the physician has recommended that I be transferred to another facility for continued care and treatment. However, I decline to be transferred and request to remain at this facility.

Signature of patient or legally responsible individual: _____ Print Name _____

Relationship to patient _____ Date _____ Time _____

3. Patient Initiated Request.

I have been informed by the physician that based on the information available to the physician at the time of transfer, the risks of transfer outweigh the medical benefits.

I am aware that the Hospital has a legal obligation as well as the willingness, capacity and capability to provide the appropriate care for my medical condition.

However, I refuse to consent to further medical treatment and request transfer to _____

Signature of patient or legally responsible individual: _____ Printed Name _____

Relationship to patient _____ Date _____ Time _____

SECTION C

ADDITIONAL PHYSICIAN DOCUMENTATION
TO BE COMPLETED FOR TRANSFERS FROM THE EMERGENCY ROOM ONLY

The patient presented to the Hospital requesting emergency medical treatment and the Hospital has provided a medical screening examination and stabilization services to the extent possible, given the Hospital's current capacity and/or capabilities. Transfer of the patient to a hospital with additional capacity and/or capabilities is medically indicated, or has been requested by the patient or the patient's legal guardian.

Check only one:

- ❑ The patient is being transferred to a hospital that provides a different level of care and/or services which this hospital does not provide, for the purpose of stabilizing and/or treating the patient's Emergency Medical Condition, including psychiatric emergencies.
- ❑ The patient is being transferred, at the patient's request, following a disclosure by the Hospital of its obligations to provide Emergency Medical Screening and treatment, and after informing the patient of the risks and benefits of the Transfer.
- ❑ The patient is being transferred because of failure, refusal, or inability of an on-call physician to respond.

On-Call Physician's Name _____ Address _____ Phone Number _____

PHYSICIAN CERTIFICATION

EMERGENCY MEDICINE PHYSICIAN TO COMPLETE:

The patient has an emergency medical condition that this hospital has attempted to stabilize and/or treat to the extent possible given the Hospital's capacity and capabilities. However, based on the information available to me at the time of transfer, I certify that the medical benefits expected from the provision of appropriate medical care at another facility outweigh the increased risks to the individual and, in the case of a patient in labor, to the unborn child associated with the transfer of the patient to the receiving facility. For psychiatric conditions, the patient is protected from harming him/herself or others. All transfers have the inherent risk that the patient's medical condition could worsen. There are also risks of traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle. In addition, regarding this patient, additional risks and benefits include:

Expected Benefits of Transfer _____

Specific Risks of Transfer _____

Transferring Physician/Qualified Medical Personnel Signature _____ Physician Countersignature (if patient was transferred purusant to a verbal order due to urgent need to transfer) _____

Patient _____ Date _____ Time _____

Facility _____ Department _____

EMERGENCY SERVICES

PATIENT TRANSFER FORM

ER-3401-2 (02/05)

Addressograph

White - Facility Copy

Yellow - Receiving Facility

Policy/Procedure Title	EMTALA On-Call Coverage	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s)** **Attach**	2 N/A
Department Generating Policy	Nursing Administration				
Affected Departments	Emergency Department				
Prepared By	Stacey Maxey, RN, BSN	**Dept/Title**	CNO		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

INTRODUCTION

To ensure that the Hospital's Dedicated Emergency Department staff are at all times aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to Stabilize individual with Emergency Medical Conditions and to ensure that the Hospital has developed an On-Call List of physicians which best meets the needs of its patients in accordance with available resources.

POLICY

All Hospitals with a Dedicated Emergency Department shall have a documented system for providing on-call coverage for all services offered by the Hospital that best meets the needs of its patients in accordance with the resources available to the Hospital.

PROCEDURE

- Please refer to the EMTALA-Medical Screening/Stabilization Policy for a complete list of definitions pertaining to this policy.
    1. Each Hospital should have a documented system for providing on-call coverage, so that the Dedicated Emergency Department is at all times aware of which physicians, including specialists and sub-specialists, are available to provide screening and treatment necessary to stabilize individuals with Emergency Medical Conditions.
    2. If a Hospital offers a service to the public, the service should be available through on-call coverage of the Dedicated Emergency Department and should be reflected on the On-Call List. There is no requirement for a sole practitioner to be on-call at all times. However, the Hospital must have policies and

procedures to be followed when a particular specialty is not available (see attached sample recommended policy).

3. Each Hospital must establish a process for identifying those physicians "on-call" for a given specialty (see sample "On-Call Schedule"). On-call physicians, after being called, must respond to the Dedicated Emergency Department within a reasonable timeframe as specified in the Hospital's Medical Staff Bylaws.
4. The Hospital's Medical Staff Bylaws or appropriate policy and procedure should define:
   - The responsibility of on-call physicians to respond within a defined time period to examine and treat patients with Emergency Medical Conditions.
   - Actions to be taken when a practitioner fails to respond due to circumstances beyond his/her control, including initiation of his chain of command.
5. The Hospital must document on the transfer summary form the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment, and must report such information to Hospital administration as soon as practicable.
6. The Hospital must keep a record of individual's on-call for at least five (5) years. Each Hospital must develop a mechanism for maintaining accurate On-Call Lists to be retained.

COMPLIANCE PROGRAM POLICY STATEMENT

Failure to comply with this policy shall constitute a serious violation of policy and subject an employee to suspension or termination of employment.

Reviewed	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____

Policy/Procedure Title	EMTALA Signage	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s)** **Attach**	2 N/A
Department Generating Policy	Nursing Administration				
Affected Departments	Emergency Department				
Prepared By	Stacey Maxey, RN, BSN	**Dept/Title**	CNO		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

INTRODUCTION

To comply with the legal requirement that patients have the opportunity to review their right to a Medical Screening Examination and stabilization for an Emergency Medical Condition.

POLICY

All Hospitals with a Dedicated Emergency Department must post appropriate Signage notifying patients of their right to a Medical Screening Examination and stabilization treatment as specified under EMTALA.

NOTE

Some states have separate emergency services laws that may apply additional legal requirements to the Medical Screening Examination, diagnostic testing, or stabilizing emergency medical treatment. Consult with Hospital's legal counsel to identify and comply with any such additional legal mandates.

PROCEDURE

- Please refer to the EMTALA-Medical Screening/Stabilization Policy for a complete list of definitions pertaining to this policy.
    - Each Hospital with a Dedicated Emergency Department must post one or more signs in a place or places likely to be noticed by all individuals entering the Dedicated Emergency Department, as well as those individuals waiting for examination and treatment in areas other than traditional Dedicated Emergency Departments (for example, entrance, admitting area, waiting room, treatment area, and ambulance bay). In general, the Signage should be visible from anywhere in the area or a distance of twenty (20) feet, whichever is less.

- The Signage must provide, at a minimum, the following:
  - Identification that the Hospital participates in Medicaid or that it does not.
  - Specific rights of patients with Emergency Medical Conditions and women in labor.
  - Clear wording in simple terms and language(s) that are understandable by the population served by the Hospital (e.g., a Hospital which serves a large number of Spanish speaking people should have a sign in Spanish).
  - The content of the Signage must contain the following language:

IT'S THE LAW!

If you have a medical emergency or are in labor, you have the right to receive,
within the capabilities of this Hospital's staff and facilities:

- **An appropriate medical screening examination**
- **Necessary stabilizing treatment (including treatment for and unborn child) and, if necessary**
- **An Appropriate Transfer to another Hospital, even if you cannot pay or do not have medical insurance or you are not eligible to receive Medicare or Medicaid.**

This Hospital participates in the Medicaid program.

COMPLIANCE PROGRAM POLICY STATEMENT

Failure to comply with this policy shall constitute a serious violation of policy and subject an employee to suspension or termination of employment.

Reviewed	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____

Policy/Procedure Title	EMTALA Emergency Transfers	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s)** **Attach**	4 N/A
Department Generating Policy	Nursing Administration				
Affected Departments	Emergency Department				
Prepared By	Stacey Maxey, RN, BSN	**Dept/Title**	CNO		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

INTRODUCTION

To ensure that an emergency patient who requests a transfer to another Hospital for further medical care and follow-up is appropriately transferred, and to provide for transfers of emergency patients when the needs of the patient for stabilizing medical treatment are greater than the capabilities of the Hospital.

POLICY

Each Hospital must have written guidelines outlining the requirements for an Appropriate Transfer to another Hospital in accordance with federal and state laws. Any Transfer of an individual with an Emergency Medical Condition must be initiated either by the written request from the patient or the legally responsible person acting on the patient's behalf for such Transfer, or by a physician's order with the appropriate Physician Certification (see Attachment A, Part Three).

The Transfer of a patient shall not be predicated upon arbitrary or capricious reasons, or upon discrimination based upon race, religion, national origin, age, sex, physical condition or economic status.

NOTE

Some states have separate emergency services laws that may apply additional legal requirements to the Medicals Screening Examination, diagnostic testing, or stabilizing emergency medical treatment. Consult with the Hospital's legal counsel to identify and comply with any such additional legal mandates.

PROCEDURE

- The Hospital must develop written guidelines for transferring a patient with an Emergency Medical Condition to another Hospital in accordance with federal and state laws.
- If a patient comes to the Hospital and is determined to have an Emergency Medical Condition following a Medical Screening Examination, the Hospital must provide either:
    - Further medical examination and treatment, including hospitalization if necessary, as required to Stabilize the Emergency Medical Condition within the capabilities of the staff and facilities available at the Hospital.
    - A Transfer to another more appropriate or specialized Hospital.
- The Hospital shall take reasonable steps to Transfer the patient if the physician determines that the Hospital has exhausted all of its capabilities in trying to Stabilize the patient's Emergency Medial Condition, and that the benefits of such Transfer outweigh the risks.
- Patient Refuses Transfer
    - If a Hospital offers to Transfer a patient to another Hospital and informs the patient or the legally responsible person of the risks and benefits of the Transfer but the patient or the person acting on the patient's behalf refused to consent to the Transfer, the Hospital must take all reasonable steps to secure a written refusal from the patient or the person acting on the patient's behalf, or the staff shall note the refusal in the patient's medical record. The written refusal should indicate the person has been informed of the risks and benefits of the Transfer and state the reasons for such refusal. The patient's medical record must contain a description of the proposed Transfer that was refused by the patient or the person acting on the patient's behalf (see Attachment A-Part 4).
- Emergency Transfer
    - A Hospital may not Transfer a patient with an Emergency Medical Condition unless:
        - The Transfer is pursuant to a physician's order with an appropriate Physician Certification, more fully described in paragraph 6 below.
        - The patient, or a legally responsible person acting on the patient's behalf, requests the Transfer, after being informed of the Hospital's obligations under EMTALA and of the risks and benefits of the Transfer. The request must be in writing and must include the following:
            - The request must contain a statement of the Hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request.
            - Any Transfer of a patient with an Emergency Medical Condition must be initiated by either a written request for Transfer or a Physician Certification. If both are provided, as is often the case, the individual must still be informed of the risks versus benefits of the Transfer.
            - The request must be made part of the individual's medical record, and a copy of the request should be sent to the receiving Hospital when the patient is transferred.

- The request for Transfer should not be made through coercion or by misrepresenting the Hospital's obligations to provide a Medical Screening Examination and treatment for an emergency condition or labor.

An emergency transfer to another Hospital will be appropriate only in those cases in which:

- The transferring Hospital provided medical treatment within its capabilities that minimized the risks to the individual's health and, in the case of a woman in labor, the health of the woman and unborn child.
- The receiving Hospital has available space and Qualified Medical Personnel for the treatment of the individual and has agreed to accept Transfer of the individual and to provide appropriate treatment.
- The transferring Hospital sends to the receiving Hospital all medical records (or copies thereof) related to the Emergency Medical Condition which the individual has presented that are available at the time of Transfer, including available history, records related to the individual's Emergency Medical Condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies and telephone reports of the studies, treatments provided, results of any tests and the informed written consent or written Physician Certification as required in paragraph 6 or 8 above. This documentation must also include the name and address of any on-call practitioner who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records, including test results not yet available from the transferring Hospital at the time of the patient Transfer, must be sent as soon as practicable after such transfer. Records must accompany the patient whether or not the patient's Emergency Medical Condition is Stabilized.
- The Transfer is affected through Qualified Medical Personnel and appropriate transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the Transfer.
- Appropriate Transfer documentation, as outlined above, must be included in the patient's medical record.
- The Hospital, through its designated personnel and/or emergency department physicians, must obtain the consent of the receiving or recipient Hospital before the Transfer of the patient and must make the appropriate arrangements for the patient Transfer with an authorized representative of the receiving Hospital.
- The physician at the transferring Hospital has the responsibility to determine and document the appropriate mode of transportation, appropriate equipment, attendants to be available

Crossroads Community Hospital

Policy/Procedure Title	ILLINOIS UNINSURED/SELF PAY DISCOUNT POLICY	**Manual Location**			
Policy/Procedure #		**Effective** **Revised**	2/1/2008 4/1/09, 2/1/10	**Page**	1 of 10
Department Generating Policy	Patient Financial Services				
Affected Departments	Business Office				
Prepared By	Rhonda Hudnall	**Dept/Title**	Business Office Director		
Chief Executive Officer		**Date/Title**			
Chief Financial Officer		**Date/Title**			
Business Office Director		**Date/Title**			

POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to comply with Illinois Public Act 95-0965, and to serve the health care needs of our community, Crossroads Community Hospital will provide discount care to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or government assistance with their health care bills.

Discount care will be provided to all uninsured patients without regard to race, creed, color, religious beliefs or national origin.

Patients may apply for the discount within 60 days of service.

All Illinois CHS hospitals will charge Illinois residents no more than 135% of cost based on their most recently filed Medicare cost report. Where a prior agreement such as an Asset Purchase Agreement requires the hospital to apply an existing policy, hospital will charge the patient the lesser of the APA agreement or 135% of Medicare cost. Non Illinois residents will receive the minimum uninsured discount without proof of income and/or residency.

PURPOSE:

To properly identify those patients who do not have insurance and do not qualify for third party coverage, state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for the Uninsured/Self Pay Discount Policy.

ELIGIBILITY FOR DISCOUNT CARE

during transfer, and documents necessary to affect a Transfer to a receiving or recipient Hospital.

- Receiving or Recipient Hospital Responsibilities
  - A Hospital that has specialized capabilities or facilities (e.g., burn unit, shock-trauma units, neonatal intensive care units, or with respect to rural areas, regional referral centers) **may not** refuse to accept from a referring Hospital an appropriate Transfer of an individual requiring such specialized capabilities or facilities, if the receiving or recipient Hospital has the capacity to treat the individual.
- Physician Certification
  - For a patient who has not been Stabilized, a physician must have signed a certification that, based on the information available at the time of Transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another Hospital outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman and the unborn child, from effecting the Transfer. The certification must contain a summary of the risks and benefits upon which it is based.
    - An express written Physician Certification is required. A Physician Certification cannot be implied from the findings in the patient medical record and the fact that the patient was transferred.
    - The Physician Certification must state the reason(s) for Transfer.
    - This rationale may be documented on the Physician Certification form or elsewhere in the medical record.
    - The Physician Certification that the benefits reasonably expected from the provision of appropriate medical treatment at another Hospital outweigh the risk of the Transfer is not required for Transfer of individuals who no longer have an Emergency Medical Condition, unless otherwise required by state law.
    - The Physician Certification form must contain a complete picture of the benefits to be expected from appropriate care at the receiving Hospital and risks associated with the Transfer, including the time away from an acute care setting necessary to affect the Transfer.

COMPLIANCE PROGRAM POLICY STATEMENT

Failure to comply with this policy shall constitute a serious violation of policy and subject an employee to suspension or termination of employment.

Reviewed	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____

1. To be eligible for a reduction in the patient balance through the Discount Policy, the patient must be uninsured and the hospital services are not covered in whole or part, by any other third party source.

2. For the purposes of Illinois Public Act 95-0965, the services provided must be on or after 4/1/09, otherwise, the minimum uninsured discount will apply.

3. The household income must be 300% of the Federal Poverty Income, or less at Critical Access or Rural Area Hospitals or 600% of the Federal Poverty Income or less at Urban Area Hospitals. Crossroads Community Hospital is classified as a Rural Area Hospital.

4. Patients who do not apply for Charity Care and/or does not provide the documents required to make a determination for Charity or a determination of income for the purpose of Illinois Public Act 95-0965, will only be eligible for the minimum discount of 25% and have 60 days from discharge/service date to provide the documents required in order to receive an additional discount.

5. The services the patient receives must be medically necessary based on Medicare Medical Necessity criteria.

6. Must be an Illinois Resident and provide acceptable family income verification. Acceptable forms of verification of Illinois residency includes one of the following:

   -Any document listed on acceptable family income verification
   -A valid state issued identification card
   -A recent residential utility bill
   -A lease agreement
   -A vehicle registration card
   -A voter registration card
   -Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
   -A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency
   -A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

THE AMOUNT OF THE DISCOUNT PROVIDED

Patients who do not provide proof of income; who are not eligible for the self pay discount or whose charges for an inpatient or outpatient encounter is less than $500.00: these patients are eligible for a minimum discount of 25% off billed charges.

Patients who provide proof of Illinois Residency, who are eligible for a self pay discount and whose charges for an inpatient or outpatient encounter is more than $500.00: a discount of 74% will be provided. The discount is based on 135% of the hospital cost based on the most recently filed Medicare Cost Report.

However, the maximum amount collected in a 12-month period from eligible patients is 25% of the family's annual gross income, excluding patients with substantial assets as described in Appendix 1.

- A 12 month period begins as of the first date of service determined to be eligible for a discount.
- The patient must inform the hospital that he/she has received prior services from the hospital which were eligible for the discount
- Substantial assets do not include primary residence, personal property and amounts held in a pension or retirement plan

EXCLUDED FROM COVERAGE

1. Patient's covered by any insurance, local, state or government health care coverage or other third party coverage. This includes any portion of a hospital bill where the patient's insurance has denied or excluded certain services from coverage.

2. Patient's who qualify and receive a hospital Charity Care Discount.

3. Patient's requesting cosmetic procedures or services not considered medically necessary based on Medicare medical necessity criteria. In the case of elective procedures such as cosmetic procedures or weight reduction procedures, package pricing often applies and a discount is automatically provided within the package pricing. These services should not be provided until the patient has paid for the service in advance. Non-medical services such as social and vocational services are excluded from coverage.

4. Any other patient/account already receiving a discount, such as (but not limited to) Industrial Accounts or Client Accounts.

5. Hospital based physician charges.

THE PROCESS

1. **Identification of Patients Eligible for Discount Policy:**

   A. The hospital will include a statement on each hospital bill or summary of charges of the availability of an Uninsured Discount and how to make application. The statement will include information regarding income requirements.
   B. All patients with no insurance who do not qualify for Charity Care or who do not apply for Charity Care will be eligible for a discount off billed charges (subject to charges exceeding $300 of charges in any one Inpatient and Outpatient encounters). Excluding encounters where charges are $500 or less. No discount will be provided when the total charges for that encounter is $500 or less.

The maximum amount collected in a 12-month period from eligible patients is 25% of the family's annual gross income excluding substantial assets. The 12-month period beings from the date of service in which the patient is eligible for the discount.

   C. During the screening process for the Charity Care and the Discount Programs, the financial counselor or self pay screening vendor will screen for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process a

"FA" will be completed. (Exhibit A) While it is not necessary that a FA be completed in order to receive a discount, when a FA is completed during the screening process, it will be used for the purpose of this policy as well. Patients will be required to cooperate and apply for Medicare, Medicaid, AllKids, SCHIP, or any other public program providing there is reason to believe they would qualify. Proof of denial will be required for the patient to be eligible for the discount above the minimum uninsured discount.

D. All uninsured patients will be screened for existing Medicaid coverage by using the hospital's insurance eligibility software. A copy of the response will be retained as verification that the patient did not have Medicaid coverage.

E. The hospital will view prior accounts for the patient as well as the guarantor to determine if insurance coverage existed on prior hospital records. If so, the hospital will 'verify insurance coverage' and document the call and response.

F. The hospital reserves the right to pull a copy of the patient's credit report for verification of information provided.

G. When it is determined the patient does not qualify for Medicare, Medicaid or any other third party coverage and the patient does not qualify for Charity Care, the patient will immediately qualify for a discount off billed charges.

H. Patients who are not screened for Medicare, Medicaid and other third party coverage, due to the patient not returning calls or providing the necessary information to make a determination of coverage and who do not provide the necessary information to make a Charity Care or Illinois State discount determination will only be eligible for the minimum uninsured discount off billed charges.

I. Proof of Income and/or residency must be provided within 30 days of request.

Acceptable forms of documentation of family income shall include one of the following:

- A copy of the most recent tax return
- A copy of the most recent W-2 and 1099 forms
- Copies of the 2 most recent pay stubs
- Written income verification from an employer, if paid in cash
- One other reasonable form of third party income verification deemed acceptable to the hospital

Acceptable forms of documentation of residency shall include one of the following:

- Any document listed on acceptable family income verification
- A valid state issued identification card
- A recent residential utility bill
- A lease agreement
- A vehicle registration card
- A voter registration card
- Mail addressed to the uninsured patient at an Illinois address from a government or other credible source
- A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency

- A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

2. FAILURE TO PROVIDE ACCURATE INFORMATION

If it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage or met the criteria for the hospital
Charity Care Discount program, any discount provided for under this policy shall be reversed.

If any information provided by the patient/guarantor is later found to be untrue, any discount provided may be forfeited.

3. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

A. For those patients screened by the hospital financial counselor or self pay screening vendor, once the eligibility determination has been made, the results will be documented in the comments section on the patient's account.

B. The discount will be set in the system and will not require hospital authorization.

C. The transaction code used will reflect 'Self Pay Discount' and will not be considered Charity.

D. The 25% discount applied to all self pay accounts will be adjusted with transaction codes **556** for Inpatient, and **557** for Outpatient.

E. If the patient qualifies for the additional discount; the 25% discount shall be reversed and a new 74% discount will be applied using the following codes:

Inpatient Discount – Transaction code **558**

Outpatient Discount – Transaction code **559**

Bad Debt Inpatient Discount – Transaction Code **794**

Bad Debt Outpatient Discount – Transaction Code **795**

4. REPORTING OF DISCOUNT CARE

Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Illinois hospitals must annually file a copy of Worksheet C Part I of their Medicare Cost Report with the Attorney General's office. The first filing is due 2/20/09.

5. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO	Date
Hospital CFO	Date
Corporate VP, Patient Financial Services	Date
Group VP Operations	Date

Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

Due Date if Application is for Illinois Public Act_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____

VA Benefits: $_____

Workers' Comp: $_____

SSI: $_____

Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for **Charity Care/Financial Assistance:**

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones. Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application: _____

Approval/Authorization of Charity Care Write-Off **Amount Approved $**_____

BOM_____ **CEO**_____

CFO_____

Appendix 1

Under Section 10 of the Hospital Uninsured Patient Discount Act, certain personal property is exempt from the determination of assets owned by an eligible uninsured patient as it relates to the maximum collectible amount in a 12 month period (25% of annual income.) Those assets are listed in the Code of Civil Procedure, 735 ILCS 5/12-1001, with reference to a "debtor's" assets. They include the following:

(a) The necessary wearing apparel, bible, school books, and family pictures of the debtor and the debtor's dependents;

(b) The debtor's equity interest, not to exceed $4,000 in value, in any other property;

(c) The debtor's interest, not to exceed $2,400 in value, in any one motor vehicle;

(d) The debtor's equity interest, not to exceed $1,500 in value, in any implements, professional books, or tools of the trade of the debtor;

(e) Professionally prescribed health aids for the debtor or a dependent of the debtor;

(f) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life insurance and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not and whether the insured or the insured's estate is a contingent beneficiary or not;

(g) The debtor's right to receive:

(1) a social security benefit, unemployment compensation, or public assistance benefit;
(2) a veteran's benefit;
(3) a disability, illness, or unemployment benefit; and
(4) alimony, support, or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor.

(h) The debtor's right to receive, or property that is traceable to:

(1) an award under a crime victim's reparation law;
(2) a payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor;
(3) a payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor or a dependent of the debtor;
(4) a payment, not to exceed $15,000 in value, on account of personal bodily injury of the debtor or an individual of whom the debtor was a dependent; and
(5) any restitution payments made to persons pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act,

For purposes of this subsection (h), a debtor's right to receive an award or payment shall be exempt for a maximum of 2 years after the debtor's right to receive the award or payment accrues; property traceable to an award or payment shall be exempt for a maximum of 5 years after the award or payment accrues; and an award or payment and property traceable to an award or payment shall be exempt only to the extent of the amount of the award or payment, without interest or appreciation from the date of the award or payment.

(i) The debtor's right to receive an award under Part 20 of Article II of this Code relating to crime victims' awards.

(j) Moneys held in an account invested in the Illinois College Savings Pool of which the debtor is a participant or donor, except the following non-exempt contributions:

(1) any contribution to such account by the debtor as participant or donor that is made with the actual intent to hinder, delay, or defraud any creditor of the debtor;
(2) any contributions to such account by the debtor as participant during the 365 day period prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986,as amended, in effect at the time of contribution; or
(3) any contributions to such account by the debtor as participant during the period commencing 730 days prior to and ending 366 days prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution.

For purposes of this subsection (j), "account" includes all accounts for a particular designated beneficiary, of which the debtor is a participant or donor. Money due the debtor from the sale of any personal property that was exempt from judgment, attachment, or distress for rent at the time of the sale is exempt from attachment and garnishment to the same extent that the property would be exempt had the same not been sold by the debtor. If a debtor owns property exempt under this Section and he or she purchased that property with the intent of converting nonexempt property into exempt property or in fraud of his or her creditors, that property shall not be exempt from judgment, attachment, or distress for rent. Property acquired within 6 months of the filing of the petition for bankruptcy shall be presumed to have been acquired in contemplation of bankruptcy. The personal property exemptions set forth in this Section shall apply only to individuals and only to personal property that is used for personal rather than business purposes. The personal property exemptions set forth in this Section shall not apply to or be allowed against any money, salary, or wages due or to become due to the debtor that are required to be withheld in a wage deduction proceeding under Part 8 of this Article XII.

Revisions	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date:	04/01/2009	02/01/2010			
By:	R. Hudnall	R. Hudnall			

- A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

2. FAILURE TO PROVIDE ACCURATE INFORMATION

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Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Illinois hospitals must annually file a copy of Worksheet C Part I of their Medicare Cost Report with the Attorney General's office. The first filing is due 2/20/09.

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The below individuals have read and approved this policy:

Hospital CEO	Date
Hospital CFO	Date
Corporate VP, Patient Financial Services	Date
Group VP Operations	Date

Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

Due Date if Application is for Illinois Public Act_____

PATIENT INFORMATION

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work Phone_____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes___ no___
Savings: yes___ no___

Cash on hand: $_____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Appendix 1

Under Section 10 of the Hospital Uninsured Patient Discount Act, certain personal property is exempt from the determination of assets owned by an eligible uninsured patient as it relates to the maximum collectible amount in a 12 month period (25% of annual income.) Those assets are listed in the Code of Civil Procedure, 735 ILCS 5/12-1001, with reference to a "debtor's" assets. They include the following:

(a) The necessary wearing apparel, bible, school books, and family pictures of the debtor and the debtor's dependents;

(b) The debtor's equity interest, not to exceed $4,000 in value, in any other property;

(c) The debtor's interest, not to exceed $2,400 in value, in any one motor vehicle;

(d) The debtor's equity interest, not to exceed $1,500 in value, in any implements, professional books, or tools of the trade of the debtor;

(e) Professionally prescribed health aids for the debtor or a dependent of the debtor;

(f) All proceeds payable because of the death of the insured and the aggregate net cash value of any or all life insurance and endowment policies and annuity contracts payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, whether the power to change the beneficiary is reserved to the insured or not and whether the insured or the insured's estate is a contingent beneficiary or not;

(g) The debtor's right to receive:

(1) a social security benefit, unemployment compensation, or public assistance benefit;
(2) a veteran's benefit;
(3) a disability, illness, or unemployment benefit; and
(4) alimony, support, or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor.

(h) The debtor's right to receive, or property that is traceable to:

(1) an award under a crime victim's reparation law;
(2) a payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor;
(3) a payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor or a dependent of the debtor;
(4) a payment, not to exceed $15,000 in value, on account of personal bodily injury of the debtor or an individual of whom the debtor was a dependent; and
(5) any restitution payments made to persons pursuant to the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act,

For purposes of this subsection (h), a debtor's right to receive an award or payment shall be exempt for a maximum of 2 years after the debtor's right to receive the award or payment accrues; property traceable to an award or payment shall be exempt for a maximum of 5 years after the award or payment accrues; and an award or payment and property traceable to an award or payment shall be exempt only to the extent of the amount of the award or payment, without interest or appreciation from the date of the award or payment.

(i) The debtor's right to receive an award under Part 20 of Article II of this Code relating to crime victims' awards.

(j) Moneys held in an account invested in the Illinois College Savings Pool of which the debtor is a participant or donor, except the following non-exempt contributions:

(1) any contribution to such account by the debtor as participant or donor that is made with the actual intent to hinder, delay, or defraud any creditor of the debtor;
(2) any contributions to such account by the debtor as participant during the 365 day period prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986,as amended, in effect at the time of contribution; or
(3) any contributions to such account by the debtor as participant during the period commencing 730 days prior to and ending 366 days prior to the date of filing of the debtor's petition for bankruptcy that, in the aggregate during such period, exceed the amount of the annual gift tax exclusion under Section 2503(b) of the Internal Revenue code of 1986, as amended, in effect at the time of contribution.

For purposes of this subsection (j), "account" includes all accounts for a particular designated beneficiary, of which the debtor is a participant or donor. Money due the debtor from the sale of any personal property that was exempt from judgment, attachment, or distress for rent at the time of the sale is exempt from attachment and garnishment to the same extent that the property would be exempt had the same not been sold by the debtor. If a debtor owns property exempt under this Section and he or she purchased that property with the intent of converting nonexempt property into exempt property or in fraud of his or her creditors, that property shall not be exempt from judgment, attachment, or distress for rent. Property acquired within 6 months of the filing of the petition for bankruptcy shall be presumed to have been acquired in contemplation of bankruptcy. The personal property exemptions set forth in this Section shall apply only to individuals and only to personal property that is used for personal rather than business purposes. The personal property exemptions set forth in this Section shall not apply to or be allowed against any money, salary, or wages due or to become due to the debtor that are required to be withheld in a wage deduction proceeding under Part 8 of this Article XII.

Revisions	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date:	04/01/2009	02/01/2010			
By:	R. Hudnall	R. Hudnall			

Policy/Procedure Title	EMTALA Reporting	**Manual Location**	Emergency Dept		
Policy/Procedure # **Replaces Policy #**	7381-112003-122	**Effective**	11/03	**Page(s)** **Attach**	3 N/A
Department Generating Policy	Nursing Administration				
Affected Departments	Emergency Department				
Prepared By	Stacey Maxey, RN, BSN	**Dept/Title**	CNO		
Quality Department Approval (If Applicable)		**Date/Title**			
Administration Approval (If Applicable)	G Sims	**Date/Title**	CEO		
Dept / Committee Approval (If Applicable)		**Date/Title**			
Medical Staff Approval (If Applicable)	D Kelley, MD	**Date/Title**			
Board Approval (If Applicable)	C Stowers	**Date/Title**	BOT		

INTRODUCTION

To ensure that all reports related to EMTALA violations are properly made.

POLICY

As required by provisions of EMTALA, each Hospital must report certain types of know or suspected EMTALA violations to CMS and to other appropriate state agencies. Also, it is the policy of Community Health Systems to voluntarily self-report on certain types of actual or potential EMTALA violations.

NOTE

Some states have separate emergency service laws that may apply additional legal requirements to the Medical Screening Examination, diagnostic testing, or stabilizing emergency medical treatment. Consult with Hospital's legal counsel to identify and comply with any such additional legal mandates.

PROCEDURE

- Please refer to the EMTALA-Medical Screening/Stabilization Policy for a complete list of definitions pertaining to this policy.
    - The Hospital's medical staff members and employees have the following reporting obligations:
        - Violations By Another Hospital
            - The Hospital's medical staff members and employees, who know of an apparent violation of the EMTALA transfer laws on the part of another Hospital, in its capacity as either a transferring or receiving Hospital, will immediately report such

violation to Hospital administration. Hospital administration will report the suspected violation to the Corporate Director of Survey Management (The Corporate Director of Survey Management will involve the Legal Department and the Group as necessary).

- Such violations typically involve a situation where the hospital has reason to believe it may have received an individual who has been transferred in violation of the EMTALA transfer requirements, (i.e., without doing any one of the following:
    - Providing treatment within its capacity to minimize the risks of the transfer.
    - Contacting the receiving Hospital and confirming that it has the capacity to treat the patient and accepts the patient.
    - Transporting the patient by appropriate means and with qualified personnel.
    - Sending a copy of the patient's medical record).

  The Hospital must report the suspected violation to CMS or to the state survey agency. Such reports will be coordinated with the Corporate Director of Survey Management.

- Violations By the Hospital
    - The Hospital's medical staff members and employees, who know of an apparent violation of EMTALA transfer laws on the part of the Hospital, in its capacity as either a transferring or receiving Hospital, will immediately report such violation to Hospital administration. Where the Hospital believes that the apparent violation may be reported to a federal or state survey agency, either by another Hospital, a patient, Hospital staff, or the matter should be reported by the Hospital itself, in concert with the Corporate Director of Survey Management. (Any violation, which also involves harm to the patient, must be immediately reported to Corporate Risk Management by the Corporate Director of Survey Management. Also, the Corporate Director of Survey Management will involve the Legal Department and Group as needed.)
- An on-call physician who fails or refuses to come to the Hospital within a reasonable period of time, as requested, to evaluate or stabilize the patient, must be reported to Hospital administration. The Hospital is not required to self-report other suspected violations of the EMTALA transfer laws; however, in such situations, voluntary self-reports may be deemed appropriate. All such self-reports should be reviewed and approved by the Corporate Director of Survey Management, Group VP, and the Hospital's legal counsel prior to filing with the appropriate federal or state agency.

- It is expected that any Hospital Medical Staff member or employee who knows of or suspects an EMTALA violation will report it immediately to Hospital administration.

COMPLIANCE PROGRAM POLICY STATEMENT

Failure to comply with this policy constitutes a serious violation of policy and subject an employee to suspension or termination of employment.

Reviewed	**1st**	**2nd**	**3rd**	**4th**	**5th**
Date	_____	_____	_____	_____	_____
By	_____	_____	_____	_____	_____