

**COASTAL MISSISSIPPI
HEALTHCARE FUND, INC**
A Charity Affiliated with Singing River Health System

**Coastal Mississippi Healthcare Fund
Underinsured Assistance Program**

I Purpose: Singing River Hospital and Ocean Springs Hospital have patients experiencing lengthy inpatient stays because the hospital is unable to transfer the patient to another healthcare facility because of the patient's health insurance status. Healthcare facilities, such as skilled nursing facilities, rehabilitation services or assisted living facilities, will not accept patients who have no health insurance, are medically underinsured, or the status of their health insurance is unknown. However, these patients have no medical reason to stay in the hospital and may be better served by being transferred to and rehabilitated in another healthcare facility. Singing River Health System (SRHS) and the Coastal Mississippi Healthcare Fund (CMHF) have partnered to identify eligible patients, assist them with finding health insurance or other programs for which they qualify, to transfer these patients to another healthcare facility more appropriate for the level of care needed, and to compensate the skilled nursing facility for services rendered to the patient for a predetermined number of inpatient days during the period it takes to find them some type of medical insurance or assistance.

II Eligibility:

- a. Be medically appropriate, as deemed by their physician, for transfer to another healthcare facility.
- b. Agree to be transferred to another healthcare facility more appropriate for the level of care needed by the patient.

III Process:

- a. Upon admission to Singing River Hospital or Ocean Springs Hospital, Financial Services personnel will coordinate a referral of the patient to Med-Standard to assist the patient with identifying potential resources, such as health insurance, disability insurance, or other programs, for which the patient is eligible. Med-Standard is a company contracted by Singing River Health System to assist patients with finding health insurance or disability insurance.
- b. Case Manager/Social Worker from the Patient Resource Management Department will identify patients who have exceeded their normally expected inpatient stay at the hospital. Once a Case Manager/Social Worker has identified a patient who is medically eligible for transfer to another healthcare facility the Case Manager/Social Worker will have the patient complete an "Underinsured Assistance" application. The completed application will be faxed or e-mailed to the Director, Financial Services and the Executive Director, CMHF.

- c. The Director, Financial Services will review the Underinsured Assistance application and determine if the patient meets the SRHS Charity Care guidelines. Once that determination has been made, the Director of Financial Services will notify the Case Manager/Social Worker and the Executive Director, CMHF, of the determination.
- d. Providing the patient is medically eligible for transfer and meets the criteria for Underinsured Assistance, the Case Manager/Social Worker-- in consultation with the patient, the patient's family members as appropriate, the patient's physician and the Executive Director, CMHF-- will identify another healthcare facility which can meet the medical needs of the patient.
- e. The Executive Director, CMHF will review the application and make financial arrangements with a previously contracted healthcare facility to ensure payments for the care of the patient are received by the facility in a timely manner.
- f. The Case Manager/Social Worker will arrange for the discharge of the patient, transportation of the patient from Singing River Hospital or Ocean Springs Hospital to the healthcare facility, and the transfer of the proper documentation. The patient is eligible for assistance, as described for in this policy, for a total of sixty (60) days within a calendar year.
- g. The Executive Director, CMHF, is responsible for documenting all assistance provided to the patient by CMHF, as determined in this policy, and reporting this information to the CMHF Board of Directors on a monthly basis as appropriate and to the SRHS Board of Trustees on a quarterly basis or as requested.



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Please submit the following information with your application. We will review your documentation in an effort to determine your eligibility for assistance.

BRING THE FOLLOWING TO SHOW PROOF OF RESIDENCY:

- _____ PROPERTY VALUE (If you or your spouse own real property). This can be a tax statement or current appraisal
- _____ LEASE - Copy of Lease if renting or current rent receipt with landlord's contact information.
- _____ SECTION VIII - Copy of Section VIII agreement if applicable.
- _____ AFFADAVIT OF CO-RESIDENCY – Notarized statement from the person or persons with whom you reside if applicable. This statement should include the total rents paid, the amount paid by each party and to whom they are paid.

BRING THE FOLLOWING TO SHOW PROOF OF INCOME:

- _____ Check stubs (household) for last six months*, food stamps, rental receipts, etc.
- *If not employed in the last six months, provide notarized affidavits from two different people to verify this information.
- *If self-employed, provide quarterly tax forms for the last six months.
- _____ Bank statements (checking, savings or other investment accounts)
- _____ Most recent accounts payable list

Your application for assistance is not complete and cannot be processed until all supporting documents are provided.

AFFADAVIT OF RESIDENCY

I, _____, reside at _____.
I have lived at this location for a period of _____ years _____ months. The mortgage/rent amount is _____ per month, payable to _____.

Members of Household:	Monthly Contribution to Housing
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

AFFADAVIT OF INCOME

I, _____, am currently employed by _____.
I have been an employee of this company/organization for a period of _____ years _____ months.

OR

I, _____, am currently unemployed/retired/disabled. My last employer was _____ and my employment ended on _____ (date).
I am unable to work or seek employment at this time due to _____

Applicant or Agent Signature

Print Name

Date

Relationship to applicant

STATE OF _____
COUNTY OF _____

Sworn to and subscribed before me this _____ day of _____, 20____.

Notary Public _____

My Commission Expires _____

SEAL

COASTAL MISSISSIPPI HEALTHCARE FUND, INC.
FINANCIAL EVALUATION FOR CHARITABLE ASSISTANCE

DATE: _____

Patient Name _____ DOS _____ Acct# _____

Social Security Number _____ State _____

Guarantor Name _____ Date of birth _____ No. of dependents _____

Social Security Number _____ State _____

Spouse's Name _____ Date of birth _____

Social Security Number _____ State _____

Patient information

Patient Address: _____ City _____ State _____ Zip _____

How Long at Current address Years _____ Months _____ Home Phone _____ Cell _____

Patient Employer _____ ID# _____ Phone# _____

Address _____ City _____ State _____ Zip _____

How long: Years _____ Months _____ Title / Type of work _____

Gross Pay: Per hour _____ Per Week _____ Per Month _____ Number of dependents _____

Guarantor information

Guarantor Employer _____ ID# _____ Phone # _____

Address _____ City _____ State _____ Zip _____

How long: Years _____ Months _____ Title / Type of work _____

Gross Pay: Per hour _____ Per Week _____ Per Month _____ Number of dependents claimed _____

Spouse Employer if Different than patient or guarantor

Spouse Employer _____ ID# _____ Phone # _____

Address _____ City _____ State _____ Zip _____

How long: Years _____ Months _____ Title / Type of work _____

Gross Pay: Per hour _____ Per Week _____ Per Month _____ Number of dependents claimed _____

Other sources of income: Social Security _____ Pension _____ Welfare _____

Worker's Comp. _____ Food Stamps _____ Unemployment _____

V. A. Benefits _____ Other _____

List dependents of household

Name	Relationship	Age	Name	Relationship	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Guarantor/Patient Bank and or Credit Union Accounts:

Checking Account: Bank/Credit Union _____ Approximate Bal. _____
Savings Account: Bank/Credit Union _____ Approximate Bal. _____
Other bonds, CDs etc: Source _____ Approximate Bal. _____

Other Income

Alimony, child support, or separate maintenance income: Other Income: \$ _____ per _____
Source (s) of other income _____

Marital Status

Applicant: Married _____ Separated _____ Unmarried _____ (including single, divorced, widowed)
Other Party: Married _____ Separated _____ Unmarried _____ (including single, divorced, widowed)

Outstanding Debts (including hospitals, physicians, mortgages, charge accounts, installment contracts, credit cards, rent, etc.)

Creditor	original amount	present balance	monthly payment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total combined monthly Income _____ Total combined monthly expenses _____

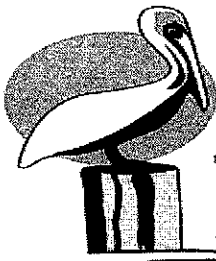
I hereby certify the above information is true and correct. I understand any intentional false statements will be considered an attempt to commit fraud upon the Coastal Mississippi Healthcare Fund as a charitable organization of the State of Mississippi and may result in prosecution to the fullest extent allowed by law. Applicant must provide Coastal Mississippi Healthcare Fund, Inc. with any and all information regarding possible third party coverage, to include but not limited to insurance, liability, worker compensation, voc-rehab or any other coverage resulting from the accounts included in this request for assistance. With the understanding that money received related to accounts included in this request will be due the hospital without regard to reduction.

Signature of Applicant _____ Date _____
Signature of Co-applicant _____ Date _____
Witness _____ Date _____

FOR HOSPITAL SYSTEM ONLY

Comments _____

Approved _____ Denied _____ SRHS Representative _____



**COASTAL MISSISSIPPI
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Application for Assistance

Patient Name:	Amount Requested:
Patient Date of Birth:	Patient SSN:
Patient Address:	Spouse Name (include address if different):
Patient Phone: Work _____ Home _____ Cell _____	Spouse Phone: Work _____ Home _____ Cell _____
Patient Employer (Name and Address): Length of employment _____ years _____ months	Spouse Employer (Name and Address): Length of employment _____ years _____ months
Income: Patient Salary _____ before deductions _____ after deductions per hour per week per month Spouse Salary _____ before deductions _____ after deductions per hour per week per month	Other income (Social Security, VA, Workman's Comp, Retirement, etc.) Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____
Dependents: Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____	Banking information: Checking balance _____ Bank _____ Savings balance _____ Bank _____ Other balance _____ Source _____ Other balance _____ Source _____ Other balance _____ Source _____
Housing Expenses: <input type="checkbox"/> Own Monthly payment \$ _____ <input type="checkbox"/> Rent Mortgage balance \$ _____	Additional Monthly Obligations: Utilities \$ _____ Food \$ _____ Clothing \$ _____ Misc \$ _____
Creditors: Name Monthly payment Balance _____ _____ _____	Total Combined Income: Total Combined Assets: Total Combined Expenses:

Description of Need

Please describe your need in detail and include any supporting documentation. Continue on separate sheet if necessary.

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Coastal Mississippi Healthcare Fund, Inc. to verify this information. I understand any intentional false statements will be considered an attempt to commit fraud upon the Coastal Mississippi Healthcare Fund, Inc and may result in denial of my request for assistance. Additionally, I authorize Coastal Mississippi Healthcare Fund to disclose any confidential and/or financial information to the Coastal Mississippi Healthcare Fund Board of Directors as it pertains to the above request for assistance.

Signature of applicant: _____

Witness: _____

FOR CMHF/PRM USE ONLY

DATE APPROVED		DATE DISAPPROVED	
LOS	COC	SNF/HOME	
COMMENTS/PHYSICIAN RECOMMENDATION			
SIGNATURE			

Affix Label Here

Discharge Instructions for Home Care Patients (CMHF)

Today's Date

You are being discharged from Ocean Springs Hospital/Singing River Hospital to receive in-home care. Coastal Mississippi Healthcare Fund, Inc. will pay for care given by the organization named below for a period of up to sixty (60) days from the date of your discharge. During the sixty (60) day period, Singing River Health System and the home care organization will attempt to identify and apply for health insurance or disability insurance on your behalf to pay for your care.

Home care information:

Organization: _____

Address: _____

Phone number: _____

Coastal Mississippi Healthcare Fund, Inc. (CMHF) is a not-for-profit, 501(c)(3) charity. CMHF has developed an Underinsured Assistance Program to assist patients and their families who do not have insurance by paying for patient care and applying for insurance for that patient. Once the patient has insurance, disability payments, or the financial resources to provide for his/her own care, responsibility for all payments returns to the patient and CMHF will cease paying for care.

Please contact Coastal Mississippi Healthcare Fund, Inc. if you need additional information. The home care organization will keep your Case Manager and Singing River Health System informed of your progress during this sixty (60) day period.

Case Manager information:

Name: _____

Address: _____

Phone number: _____

Patient Signature

Case Manager (witness) Signature

Date

Date

Affix Label Here

Discharge Instructions for Skilled Nursing Facility Patients (CMHF)

_____ Today's Date

You are being discharged from Ocean springs Hospital/Singing River Hospital to a local skilled nursing facility. Coastal Mississippi Healthcare Fund, Inc. will pay for your care at the skilled nursing facility for a period of up to sixty (60) days from the date of your discharge. During the sixty (60) day period, Singing River Health System and the skilled nursing facility will attempt to identify and apply for health insurance or disability insurance on your behalf to pay for your care.

Skilled nursing facility information:

Facility name: _____

Address: _____

Phone number: _____

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Please contact Coastal Mississippi Healthcare Fund, Inc. if you need additional information. The skilled nursing facility will keep your Case Manager and Singing River Health System informed of your progress during this sixty (60) day period.

Case Manager information:

Name: _____

Address: _____

Phone number: _____

Patient Signature

Case Manager (witness) Signature

Date

Date



SINGING RIVER HEALTH SYSTEM

OCEAN SPRINGS HOSPITAL | SINGING RIVER HOSPITAL

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____

SSN: _____

Date of Birth: _____

MR#: _____

Effective as of April 14, 2003

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:

Singing River Health System, Kare-In-Home, Ocean Springs Nursing Center, Singing River Rehab, Burnham's Drug Store, River Chase, Sunplex Nursing Center, Hospice of Light

2. Persons/organizations authorized to receive the information:

Coastal Mississippi Healthcare Fund, Inc.

3. Specific description of information that may be used or disclosed:

Financial and medical information needed to assess if patient meets CMHF charity guidelines and to transfer patients

4. The information will be used/disclosed for the following purposes:

Financial and medical information needed to assess if patient meets CMHF charity guidelines and to transfer patients

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

6. The person/organization authorized to use/disclose the information will receive compensation for doing so.

Yes No

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing this the information in writing, except to the extent that:

- a. action has been taken in reliance on this authorization; or
- b. if this authorization is obtained as a condition for obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under policy.

9. This authorization expires (upon) _____ (Insert applicable date or event)

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative
or Authority to act for the patient

Relationship to patient

SRHS Employees: A copy of this signed form will be provided to the patient.