Boyd Healthcare Services
Boyd Care
May 2010

BOYD CARE

POLICY: Boyd Healthcare Services will promote the health and well being of the citizens of the community by providing patients with charity care that qualify under specific criteria.

PROCEDURE:

1. The facility will notify patients of the available of Boyd Care in person, by mail and by signs in the registration areas.
2. The patient's family income must be equal or less than the Federal Income Poverty Guidelines established by the Department of Health and Human Services in order to be eligible for a 100% Charity Care adjustment. Applicants whose income is higher than 100% of the guidelines but lower than 200% of the guidelines may qualify for discounted services.
3. A guideline for assistance will be formulated and reviewed by the Chief Financial Officer and Chief Executive Officer. The guideline will follow the Federal Income Poverty Guidelines established by the Department of Health and Human Services. This guideline will be updated when the Department of Health and Human Services updated their form.
4. The staff will provide the patient with information on how to apply for assistance from their local State of Illinois, Department of Public Aid/Human Services office, if applicable.
5. The Boyd Care form may be requested at time of service but must be requested within 60 days of the date of service.
6. After receiving the form the patient has 30 days to complete and return the form along with the verification information requested. Documentation to verify income may include but are not limited to:
   a. pay stubs
   b. bank statements
   c. most recent Federal & State Income Tax records
   d. unemployment check stubs
   e. recent bank statements for checking and savings balances and interest received
   f. divorce degree stating alimony and/or child support paid or received
   g. all bills and payments and records of assets. Liens on assets will be filed, if necessary to guarantee payment.
7. Failure to comply with request in providing documentation will result in denial of the Boyd Care application.

8. After the information is reviewed by the Collections or Business Office Supervisor will be forwarded to the Chief Financial Officer for review. If the information is present to support the request, it will be processed by the Collections department. The Collections Supervisor may write off up to $1,000.00 by the guidelines provided.
9. Applications for more than $1,000.00 will then be forwarded to the Administrator for review and a determination will be made within 15 business days of submission of the application.
10. The patient will receive notice as to approval or denial of Boyd Care by first class mail.

Administrator: Deborah Campbell Date: 12-27-10

Board of Trustees: Mary Frances Jameson Date: 12-27-10

Implementation Date June 15, 2010

BOYD HEALTHCARE SERVICES
Discounted/Sliding Fee Application

It is the policy of Boyd Healthcare Services to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the desk to determine if you or members of you family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services; this form must be completed quarterly or as requested. Please feel free to discuss any questions with the registration staff.

Number of persons living in your household:_______________

Total monthly income of all persons living in your household:_______________
Please include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military benefits, unemployment and public aid.

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs and other information verifying income may be required before a discount is approved.

_________________________ _________________________
Name (print) Signature/Date

Office Use Only:

Date of Service:_________________________

Discount given:_________________________

Approved by:_________________________
(Signature)

Boyd Cares Program 2010

Discount	Family Size 1	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 2	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 3	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 4	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 5	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 6	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 7	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Discount	Family Size 8	
100		
90		
80		
70		
60		
50		
40		
30		
20		
10		

Each additional person add 3600

Updated 06/01/2010

150% of poverty guidelines

Effective 07/01/2010