Flagstaff Medical Center Northern Arizona Healthcare	**CORPORATE POLICY**	**NUMBER:** CP 606
		DATE OF ORIGIN: 02/27/2013

TITLE:

NAH LODGING AND TRANSPORTATION FINANCIAL ASSISTANCE PROGRAMS – SCHEDULED AND RECURRING APPOINTMENTS

POLICY:

Northern Arizona Healthcare hospitals [and clinics] (NAH) periodically encounter situations in which patients do not receive medically necessary services because they cannot afford or do not have access to lodging or transportation necessary to make their scheduled and recurring NAH appointment(s). In certain circumstances, NAH may provide reduced cost lodging or transportation services to these patients. The purpose of this policy is to establish the circumstances in which NAH may provide reduced cost lodging or transportation to its patients in compliance with applicable laws.

PROCEDURE:

1. NAH may offer or provide reduced cost lodging or transportation to patients that have scheduled and recurring appointments for services with NAH and meet one or more of the following criteria:

    a. Lodging:

        i. Financial need: the patient attests that he/she does not have access to private lodging (*e.g.*, friends/relatives), the patient attests that the cost of lodging would pose a financial hardship, *and* the patient lives at least 50 miles away from the hospital in which he/she will receive scheduled outpatient services.

        ii. Unlikely to obtain medically necessary care without lodging: the patient attests that he/she does not have access to private lodging (*e.g.*, friends/relatives), the patient lives at least 50 miles away from the hospital in which he/she will receive scheduled outpatient patients, the patient is unlikely or unwilling to receive the necessary medical services without reduced cost lodging, and there could be a serious risk to the patient if he/she does not receive NAH's services.

        iii. Unusual circumstances: the patient qualifies for reduced cost lodging based on unusual, patient-specific circumstances, as determined on a case-by-case basis and approved by the Department Director or designee (*e.g.*, the patient has been discharged late at night and no other lodging alternatives are available).

APPROVED BY/TITLE: John J. Dempsey Chief Integration Officer	**DATE REVIEWED: NEW** **DATE REVISED:**

b. Transportation:

i. Financial need: the patient attests that he/she does not have access to private transportation, the patient attests that the cost of public transportation would pose a financial hardship, and the patient lives at least 50 miles away from the hospital in which he/she will receive inpatient or outpatient services.

ii. Unlikely to obtain medically necessary care without transportation: (1) the patient attests that he/she does not have access to private transportation, (2) the patient lives in an area that does not have a reliable or efficient means of public transportation between the patient's home and hospital or the patient has a physical condition that makes public transportation impractical, and (3) the patient is unlikely or unwilling to receive the necessary medical services without transportation and there could be a serious risk to the patient if he/she does not receive NAH's services.

iii. Unusual circumstances: the patient qualifies for free transportation based on unusual, patient-specific circumstances, as determined on a case-by-case basis by the Department Director or designee (*e.g.*, the patient has been discharged late at night and no other transportation alternatives are available).

2. Financial Assistance Programs

i. Patients with complex needs who are discharging from the Emergency Department or acute care, who are uninsured, have insurance which does not cover costs associated with the patient's transition from hospital to home or to a provider for continuing care, and who do not have sufficient cash resources to pay for needed services and supports that that are needed for a timely and safe transition may receive lodging, transportation, pharmancy, and/or durable medical equipment assistance through the Patient Assistance Fund. See FMC Policy HP500-10 Patient Assistance Fund.

3. NAH's reduced cost lodging, transportation programs are available on a first come, first served basis to all patients. Lodging assistance is available for up to a maximum of 30 patients at a time who meet the above criteria regardless of the patient's insurance status, payment source, diagnosis, or NAH services referred or scheduled. Transportation assistance is available for up to 30 patients at a time who meet the above criteria regardless of the patient's insurance status, payment source, diagnosis, or NAH services referred or scheduled. Patients eligible to participate in NAH's reduced cost programs will generally be identified through the hospital's scheduling, case management, and clinical resources departments.

4. Patients must live within the *primary service area* of the hospital from which they will receive services or in an area for which the NAH facility is the nearest facility which offers the required services. For information on which areas are included in the hospital's primary service area, see attached service area descriptions.

5. Qualifying patients must complete the applicable contract (lodging program) or patient attestation (transportation program) in order to qualify for NAH's reduced cost programs.

6. NAH will not advertise the existence of its reduced cost lodging or transportation program in advance to referring physicians, the public, or to prospective patients who have not yet been referred to, or have scheduled services with, NAH.

7. NAH will not actively promote, or arrange to actively promote, its services to patients during the provision of its lodging or transport services. NAH may passively promote its services by the placement of health care articles, brochures, and newsletters at the Taylor House or within transportation vehicles owned or operated by NAH.

8. Transportation will be provided only to and from the patient's location and NAH at the time services are scheduled or rendered. For patients who are receiving a course of treatment (*e.g.*, radiation oncology), lodging and transportation services will be available Mondays-Fridays beginning on the date of the patient's first appointment extending through the last scheduled appointment date.

9. Lodging and transportation will be provided in a reasonable, low-cost manner (*e.g.*, Taylor House, reasonable hotel room, taxi or shuttle van). For NAH's lodging assistance program, only the Taylor House and hotels that have reduced-rate contracts with NAH may be used.

10. NAH will not seek reimbursement for the costs of its lodging or transportation services on its hospitals' Medicare cost reports.

Forms: NAH Lodging Financial Assistance Program: Application and Agreement
NAH Transportation Assistance Program: Patient Attestation Form
Primary Service Area Descriptions

References: HP 500-10 Patient Assistance Fund
Federal anti-kickback law; laws prohibiting beneficiary inducement

NAH LODGING FINANCIAL ASSISTANCE PROGRAM
APPLICATION AND AGREEMENT FOR FINANCIAL ASSISTANCE

Northern Arizona Healthcare (NAH) offers a financial assistance program for lodging near the NAH facility on a first come, first served basis for qualifying patients and their caregiver(s). In order to determine your eligibility for this program, you must read, complete, and sign this Application and Agreement for Financial Assistance. An NAH case manager or social worker will review the information provided and determine whether you qualify for this program.

I. APPLICATION

Name: _____ Date: _____

Address: _____

Telephone # _____ Cell Phone #: _____ Other Contact #: _____

Treatment Start Date: _____ Length of Treatment (days): _____

Name of Caregiver staying with you (if any): _____ Patient Phone #: _____

Smoker/Tobacco Use *[circle one]*: Yes No

Reason for Application *[check all that apply]*:

☐ Financial need: (1) I do not have access to private lodging (*e.g.*, friends/relatives), (2) the cost of lodging would pose a financial hardship, and (3) I live at least 50 miles away from the hospital in which I am scheduled to receive outpatient services.

☐ Unlikely to obtain medically necessary care without lodging: (1) I do not have access to private lodging (*e.g.*, friends/relatives), (2) I live at least 50 (minimum) miles away from the facility in which I will receive scheduled services, and (3) **I** am unlikely or unwilling to receive the necessary medical services without reduced cost lodging. *Please explain:*

_____

_____

_____

☐ Unusual circumstances *(requires NAH prior authorization)*.

_____

_____

_____

List any Friends/Family in the Flagstaff Area (or "none"): _____

Distance Traveled One Way to the NAH Facility: _____

Patient Employment Status *[check one]*:

Employed	☐		
Unemployed	☐	Student	☐
Disabled	☐	Other	☐

Spouse Employment Status *[check one]*:

Employed	☐		
Unemployed	☐	Student	☐
Disabled	☐	Other	☐

Source of Income *[circle all that apply]*: Employment (Patient or Spouse) Pension Savings

Govt. Assistance Social Security (SSI SSDI Regular Social Security)

Number of Individuals in the Household: Monthly Household Income: _____

What options do you have if not approved for NAH's lodging assistance program? _____

_____

II. AGREEMENT

1. I understand that NAH is relying on the accuracy of the information provided in this Application and Agreement in its determination of whether I qualify for NAH's lodging financial assistance program. I understand that if NAH later determines that the information that I have provided in this application is false, I may be required to refund any amounts NAH incurred in the provision of lodging assistance services.
2. I understand that the completion of this application does not constitute acceptance into NAH's lodging assistance program.
3. I understand that lodging services will only be provided Monday through Friday and only for the minimum time necessary to receive medically necessary services.
4. I understand that NAH personnel decision to provide lodging at Taylor House or a commercial hotel is entirely a matter of NAH discretion.
5. I understand that NAH is not liable for any personal injury or damage caused by the use of any hotel or lodging facility not owned or operated by NAH. I agree to release and hold harmless NAH and its affiliates from any claims, damages, actions, and liabilities of any sort arising out of or related to the use of any such commercial lodging services.
6. I understand that I have a choice of health care providers and that I am under no obligation to select NAH for these or any future health care services.
7. I understand that lodging will be provided only for the patient and one other designated person to assist with providing care to the patient. Children are not allowed at any time unless previously approved by NAH. If additional family members would like to visit, they are responsible for their own lodging and may not stay in the same room.
8. If assigned to the Taylor House, I agree to abide by the Taylor House rules, which will be provided at the time of check in. I understand that if I do not follow these rules, I may be asked to leave the Taylor House immediately and to find my own lodging, at my own expense.

If you agree to the above requirements and expectations, please sign below and enjoy your place to stay while under treatment. Remember, if you violate any of the above terms, we will interpret that as your choice to no longer participate in the lodging assistance program and you will need to find another location at your own expense.

Patient Signature: _____ Date: _____

Name and Relationship of Person Completing Application (if not the patient):

_____

Name of Caregiver (if known): _____

For NAH personnel use only:

1. *Confirm that the patient lives within the **primary** service area of the facility from which the patient will receive services (see attached hospital service area description) and at least 50 miles away from the facility to qualify for services.*

2. *If the patient attests that he/she is unlikely to obtain medically necessary services without lodging, provide support for position that there could be a serious risk to this patient if he/she does not receive the requested services (e.g., patient's attending/referring physician confirmation):*

_____

_____

3. *If the patient qualifies for lodging assistance based on <u>unusual circumstances</u>, document the circumstances here. Qualification for lodging assistance based on unusual circumstances requires **Director or VP** approval.*

_____

_____

Director/VP Approval (name/title): _____

Signature:_____Date:_____

1. ***APPROVED**:* ☐

Patient qualifies for NAH's transportation assistance program for the following date(s) of service:

_____

Facility Assigned for Lodging: _____

DENIED: ☐

Reason for Denial:

(Note: NAH may not deny services to patients who meet the above criteria based on other factors, such as the patient's insurance status, payment source, diagnosis, or NAH services referred or scheduled).

- ☐ Patient does not meet criteria (based on information provided by patient or information otherwise available to NAH staff)
- ☐ Hotel/lodging not available on the date(s) requested
- ☐ Patient requests on the date(s) requested exceed hospital lodging limits
- ☐ Other *[explain]*: _____

Name of NAH Staff Approving Lodging Request: _____

NAH Staff Signature: _____ Date: _____

NAH TRANSPORTATION ASSISTANCE PROGRAM
PATIENT ATTESTATION FORM

I, _____, attest that I qualify for Northern Arizona Healthcare transportation assistance program because I meet one or more of the following criteria [*check all that apply*]:

☐ Financial need: I (1) do not have access to private transportation to/from the NAH facility for my scheduled appointment(s) or other clinical services, (2) the cost of public transportation would pose a financial hardship, and (3) I live at least 50 miles away from the hospital or clinic.

☐ Unlikely to obtain medically necessary care without transportation: I (1) am unlikely or unwilling to receive NAH's services without transportation assistance, (2) do not have access to private transportation, and (3) live in an area that does not have a reliable or efficient means of public transportation between my home and the NAH facility or my physical condition is such that public transportation is not practical. *Please explain:*

_____

☐ Unusual circumstances (*requires NAH prior authorization*).

_____

I understand that NAH is relying on this attestation in its provision of transportation services. I understand that transportation services will only be provided to and from the NAH facility and my home or community.

I also understand that if NAH later determines that the information that I have provided in this attestation is false, that I may be required to refund any amounts NAH incurred in the provision of transportation services.

I understand that NAH is not liable for any personal injury or damage caused by the use of any transportation service not owned or operated by NAH. I agree to release and hold harmless NAH and its affiliates from any claims, damages, actions, and liabilities of any sort arising out of or related to the use of any such commercial transportation services.

Finally, I understand that I have a choice of health care providers and that I am under no obligation to select NAH for these or any future health care services.

_____ _____
Patient Signature Date

_____ _____
Address City, State, Zip Code

For NAH personnel use only:

1. *Confirm that the patient lives within the service area of the facility from which the patient will receive services and at least 50 miles away from the NAH facility when required to qualify for services.*

2. *If the patient attests that he/she is unlikely to obtain medically necessary services without transportation, provide support for position that there could be a serious risk to this patient if he/she does not receive the requested services (e.g., patient's attending/referring physician confirmation):*

   _____

   _____

3. *If the patient qualifies for transportation assistance based on unusual circumstances, document the circumstances here. Qualification for free [or reduced cost] transportation based on unusual circumstances requires Director or VP approval.*

   _____

   _____

   Approval granted by (name/title): _____

   Signature: _____Date: _____

4. This patient qualifies for NAH's transportation assistance program for the following date(s) of service:

   _____

FMC and VVMC PRIMARY SERVICE AREA DESCRIPTIONS

FMC Primary Service Area

Zip Code	City
86001 Flagstaff	Flagstaff, AZ
86002 Flagstaff	Flagstaff, AZ
86003 Flagstaff	Flagstaff, AZ
86004 Flagstaff	Flagstaff, AZ
86011 Flagstaff	Flagstaff, AZ
86015 Bellemont	Bellemont, AZ
86017 Munds Park	Munds Park,AZ
86018 Parks	Parks, AZ
86023 Grand Canyon	Grand Canyon,
86024 Happy Jack	Happy Jack, AZ
86038 Mormon Lake	Mormon Lake,
86046 Williams	Williams, AZ
86320 Ash Fork	Ash Fork, AZ
86337 Seligman	Seligman, AZ

VVMC Primary Area

Zip Code		City
86322	86322	Camp Verde
86324	86324	Clarkdale
86325	86325	Cornville
86326	86326	Cottonwood
86331	86331	Jerome
86335	86335	Rimrock
86336	86336	Sedona
86339	86339	Sedona
86340	86340	Sedona
86341	86341	Sedona
86342	86342	Lake Montezuma
86351	86351	Sedona