DEPARTMENT: Business Office/ Patient Financial Services	**ORIGINATION DATE:** 8/15/2018
POLICY/PROCEDURE: Financial Assistance Guidelines	**REVISED DATE:** 08/15/2018
APPROVED BY:	**REVIEWED:**

Purpose:
To establish guidelines and procedures for identifying patients who are under or uninsured by insurance or other third-party payers and who are unable to pay for some or all of their healthcare services due to genuine financial need.

Policy:
Patients who do not have sufficient third party payer coverage, are not eligible for Medicaid or any other funded program and who are unable to pay for services will be considered for indigent/ poverty care. Patients or the patient's guarantor are required to provide documentation to qualify for financial assistance. This designation requires that the patient/guarantor not have sufficient income or assets with which to pay for care. Patients or their guarantors are expected to assist with all such efforts to obtain third-party payments. *Verified dually eligible Medicare and Medicaid patients qualify for indigent care without completing a financial assistance application. These dually eligible accounts are also eligible for inclusion on the Medicare Bad-Debt cost report.*
Medicaid beneficiaries that acquire Medicaid under SLMB and/or have exhausted days automatically qualify for indigent care also known as Medicaid Charity through our health system without completing a financial assistance application.
Medicaid beneficiaries that acquire Family Planning Services should be billed for services rendered outside of family planning services.
Simpson Community Healthcare, Inc. dba Simpson General Hospital (SGH) will not discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

Definitons:

For the purpose of this policy the following terms are defined:

1. "Amount Generally Billed" (AGB):
   The average amount allowed by Medicare/Medicaid and Commercial insurance payers for emergency and other medically necessary care at SGH.
2. Discounted Care

Financial assistance that provides care at a discount on gross charges to eligible patients with annualized family incomes between amounts equal or greater than 100% but less than 250% of the Federal Poverty Guidelines.

3. Federal Poverty Guidelines
   Guidelines issued by the Federal Government that describes poverty levels in the United States based on a person or family's household income. The Guidelines are adjusted according to inflation and published in the Federal Register.

Procedure:

1. Before an application for Financial Assistance can be considered, the patient / guarantor may be asked to apply for Medicaid and present a denial letter with the application.
2. The patient / guarantor will authorize Simpson General Hospital to obtain a consumer credit report.
3. Dually eligible Medicare and Medicaid patient accounts must include the Medicare and the Medicaid remittance advice as evidence the patient is dually eligible and automatically qualifies for an indigent care write off. This includes services that are non-covered by Medicaid. These patients are not required to complete a financial assistance application.
4. An application for financial assistance will be completed with all financial and social information and submitted to the Patient Accounts Collection Representative for review (Social Services may be requested to assist in obtaining emotional, social and psychological factors).
   Documents required:
   a. Medicaid Denial Letter if requested by facility or PFS.
   b. Most recent prior years tax returns including W2s /1099s / Schedule C
   c. Proof of income
      * If working, paycheck stubs for the previous month
      * If unemployed and receiving unemployment check, provide check stub or unemployment compensation determination letter
      * If income is from a retirement fund, pension, rental property, etc. provide proof of the source and amount of income received.
   d. If income has changed since last tax return, provide a written explanation.
   e. Proof of disability / physicians work order restriction.
   f. Outstanding medical bills other than bills at Simpson General Hospital.
   g. Rent or mortgage payment receipt for one month
   h. Utility bills; gas, electric, water and sewage
   i. Three months bank statements (checking and savings)
5. After review, the completed application will be approved or denied. Reduced payment arrangements will also determined.

6. The application must be complete including signatures, dates and all applicable documents attached before the PFS department will accept for processing. If an incomplete application is received, it will be returned to the patient / guarantor.
7. The Financial Application will be returned to Simpson General Hospital within 2 weeks.
8. Financials assistance that provides care at a discount on gross charges to eligible patients with annualized family incomes between amounts equal or greater thna100% but less than 250% of the Federal Poverty Guidelines. This type of financial assistance reduces the patient financial obligation on a sliding scale rate as illustrated below: (see attached exhibit A)
    a. 100-133% federal poverty level will received 75% discounted care
    b. 134-175% federal poverty level will receive 50% discounted care
    c. 176-250% federal poverty level will receive discounted care equivalent to the AGB rate 54%.

    the Patient Account Collection Representative will also review any other liabilities the patient may have to assist in determining indigent care qualifications .
    The patient balance after a partial write off will be subject to the payment arrangements policy unless otherwise determined by the Director of Revenue Cycle Management**.**
9. Notwithstanding the methodology in 8. above, A FAP eligible individual may not be charged more than the Amount Generally Billed (AGB) for emergency or other medically necessary care. In order to calculate the AGB, the hospital used the look-back method--(Treas.Reg.Section1.501(r)-5(b)(3)). The AGB percentage the hospital calculated is 54%. The percentage used was calculated by determining usual and customary hospital charges for services from all insurance payers less adjustments made by insurer.

10. The PFS Director and the Director of Revenue Cycle Management will review and approve accounts using the most recent annual HHS Poverty Guidelines prior to requesting an indigent write-off of accounts receivable.
11. The financial application is valid for **3 months** after review.
12. The hospital administrator, SGH CFO, or the PFS department reserves the right to grant approval for financial aid based on extraordinary circumstances on a case-by-case basis.
13. A letter will be sent to the guarantor by the PFS representative with a list of accounts and amounts approved / not approved within 15 days of review.
14. Any account that is proven to be indigent eligible should be placed into the Indigent Financial Class.
15. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, SGH could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Presumptive eligibility may be determined on the basis of individual life circumstances that may include**:**

a. State-funded prescription programs;
b. Homeless or received care from a homeless clinic;
c. Participation in Women, Infants and Children programs (WIC);
d. Food stamp eligibility;
e. Subsidized school lunch program eligibility;
f. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
g. Low income/subsidized housing is provided as a valid address; and
h. Patient is deceased with no known estate.

Other Required Disclosures:

The Financial Assistance Policy (FAP) for Medically Indigent Patients, Financial Assistance Application (FAA) or Plain Language Summary are available free of charge at www._____ , in person at any hospital or clinic registration area, or by calling the billing office at (xxx)xxx-xxxx.

Paper copies of the application and plain language summary are available to patients upon request and without charge.

Notices of the existence of this policy are posted in all admitting areas of the Hospital, including the Emergency Department, Registration areas, and all clinics.

Patient statements include a message to notify and inform patients of the availability of financial assistance and where to call for information and application.

Hospital staff will discuss the FAP when appropriate, in person or during billing and customer service phone contacts with patients.

Providers not covered by this policy:

For the most recent list of covered and non-covered providers please see the Hospital FAP covered and non-covered entities and Provider Group list on website at _____. The list is updated quarterly.

Physicians or medical professionals provide care to patients or assist with patient treatment by reading lab work, interpreting medical tests, performing medical tests, and individual patient physician services. The physicians and medical professionals not employed by hospital or its subsidiaries are not covered by this policy.

Financial Aid Application

Patient and/or Guarantor information if patient is a minor:

Name:_____ Date of Birth:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone: (_____) _____

Social Security #:_____ Marital Status:_____

Employer:_____ Position:_____

Annual Salary:_____ Length of Employment:_____

Health Insurance Company:_____ Policy #:_____

Spouse and/or Legal Guardian Information:

Name:_____ Date of Birth:_____

Employer:_____ Social Security #:_____

Annual Salary:_____ Position:_____

Dependent (s) Information:

Number of Dependents:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Use a separate sheet of paper if necessary:

Asset Information Please write yes or no:

Automobile:_____ Rental Property:_____ Farms:_____ Cattle:_____

Do you own a business:_____ Name of business?_____

Checking Account:_____ Bank Name:_____

Balance: $_____

Savings Account:_____ Bank Name:_____

Balance: $_____

Disclaimer and Authorization:
I authorize _____ Hospital to obtain a consumer credit report on my behalf to process my application if necessary. This information will only be used for the purpose it was intended. I also understand that _____ Hospital will not share or disclose the information with any third party vendor unless I give the _____ proper authorization. _____ Hospital will not give me a copy of my credit report; it will stay in the hospital financial record. I also authorize _____ Hospital to verify all the information given by me in order to process my application.

Applicant's Name _____

Applicant's Signature _____ Date: _____

EXHIBIT A
FEDERAL POVERTY GUIDELINES

HHS POVERTY GUIDELINES FOR 2018

The 2019 poverty guidelines are in effect as of January 13, 2019.

See also the Federal Register notice of the 2019 poverty guidelines

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE	133% Poverty	175% Poverty	250% Poverty
	100% Discount	**75% Discount**	**50% Discount**	**AGB 46% Disc**
1	**$12,490**	**$16,612**	**$21,858**	**$31,225**
2	**$16,910**	**$22,490**	**$29,593**	**$42,275**
3	**$21,330**	**$28,369**	**$37,328**	**$53,325**
4	**$25,750**	**$34,248**	**$45,063**	**$64,375**
5	**$30,170**	**$40,126**	**$52,798**	**$75,425**
6	**$34,590**	**$46,005**	**$60,533**	**$86,475**
7	**$39,010**	**$51,883**	**$68,268**	**$97,525**
8	**$43,430**	**$57,762**	**$76,003**	**$108,575**

For families/households with more than 8 persons, add $4,420 for each additional person.

Approval Signature:		Approval Signature:		Approval Signature:	
Service Area:		Service Area:		Service Area:	
Reviewed by:					
Review date:					