

Policy: Financial Assistance Policy

ORGANIZATIONAL: Affects two or more departments.							
Folder	Organizational Choices: Administrative			Sub-Folder (If Applicable)	Click here to enter text.		
Original Effective Date	6/30/2017	Scope	What departments does this policy apply to? State "All" as is may apply to the entire organization. All				
Approved (Approver/Date)	Board of Directors(6/29/17), Finance Committee (6/27/17), Steve Hass, Chief Financial Officer (6/26/17), Multidisc Policy Committee						
Last Reviewed/ Revised Date	6/27/2019	OSHA Category (If Applicable)	Not Applicable	Standard (If Applicable)	<i>Section 501(R) of Internal Revenue Code</i>	Number of pages	13

PURPOSE:

The purpose of this policy is to establish guidelines pursuant to which SoutheastHEALTH ("SEH") will provide financial assistance to its patients.

Accordingly, this Policy describes the:

- Services eligible for financial assistance
- Criteria used to determine eligibility for financial assistance
- Process by which patients may apply for financial assistance
- Amounts charged to patients eligible for financial assistance
- Communication of the Financial Assistance Policy to Patients Within the Community

SKILL LEVEL: Financial Counselor, Patient Financial Services, & staff qualified to discuss and/or approve financial assistance

GUIDELINES:

SEH is committed to enhancing the health and well-being of the residents in the community and will provide, without exception, care for emergency medical conditions to all patients seeking such care, regardless of ability to pay. In keeping with our mission, SEH has established a Financial Assistance Policy ("FAP") to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

Patients that do not have the means to pay for services provided at SEH may apply for financial assistance. Eligibility for financial assistance will be considered for those individuals, who are uninsured, underinsured, or otherwise unable to pay for emergency or medically necessary care, and meet the criteria set forth in this policy. Patients eligible for financial assistance will

be offered discounts to reduce or eliminate their financial obligations for payment of these services.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with SEH's procedures for obtaining other forms of payment and coverage from public and private payment programs before financial assistance is considered.

PROCEDURE:

A. Definitions

For the purpose of this policy, the following definitions apply:

Financial Assistance: Healthcare services that have been or will be provided for free or at a discount to individuals who meet established criteria under the FAP.

Emergency Care: Care or treatment for an Emergency Medical Condition as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA).

Medically Necessary Care: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Household: A household consists of head of household, spouse, and all "dependents" as defined by federal IRS guidelines.

Household Income: Gross earnings, unemployment compensation, workers' compensation, Social Security, Supplement Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

AGB: Amounts generally billed to individuals who have insurance covering emergency or other medically necessary care. SEH limits the amount charged for emergency and medically necessary care provided to patients who are eligible for financial assistance under this policy to not more than the gross charges for the care multiplied by the AGB percentage.

B. Services Eligible for Financial Assistance

Services eligible for financial assistance include emergency and medically necessary care provided at any SEH facility. Patient care that is cosmetic, experimental or deemed to be non-reimbursable by traditional insurance carriers and governmental payers shall not be considered

eligible for financial assistance. Items that are considered a patient convenience, such as hearing aids, are also not eligible for financial assistance. SEH reserves the right to determine on a case-by-case basis whether the services meet the definition and standard of “medically necessary” for the purpose of eligibility for financial assistance.

C. Eligibility Criteria for Financial Assistance

In order to manage its resources responsibly and to allow SEH to provide the appropriate level of assistance to the greatest number of persons in need, SEH has established the following criteria to determine eligibility of financial assistance:

1. The patient must complete and submit a Financial Assistance Application and provide the requested supporting documentation needed to verify eligibility.
2. The patient must have a household income at or below 300% of the Federal Poverty Level (“FPL”) and have limited assets.
3. The patient must be a documented resident in SEH's service area to be eligible for financial assistance except when a patient requires emergency care while visiting SEH's service area. For purposes of this policy, service area is defined as Cape Girardeau County, Perry County, Bollinger County, Saint Genevieve County, St. Francois County, Scott County, New Madrid County, Ripley County, Reynolds County, Stoddard County, Carter County, Butler County, Iron County, Madison County, Wayne County, Pemiscot County, Dunklin County, and Mississippi County in Missouri along with Union County, Alexander County, Pulaski County, Jackson County, Johnson County, Williamson County, and Randolph County in Illinois.

Patients whose household income exceeds the guidelines based on FPL may be eligible to receive assistance based on their specific circumstances, such as a catastrophic medical event or medical indigence. Requests for assistance under these exceptional circumstances will be evaluated on case-by-case basis and approved at the discretion of SEH.

D. Application Process for Financial Assistance

All patients requesting financial assistance will be required to complete a Financial Assistance Application and are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need.

Documents required for the application process include, but are not limited to:

1. Completed application
2. Proof of residence
3. Proof of income
4. Bank statements- current and previous month

Patients will be notified of any required information that is missing resulting in an incomplete application. An incomplete application will be cancelled if the patient fails to submit all required documentation within 30 days of notification to the patient of the incomplete application.

Patients may apply for financial assistance at any time – before, during, after care, up to 240 days after the patient’s initial bill. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than 12 months prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

SEH shall make a determination on the eligibility for financial assistance within 30 days of receipt of a completed application. SEH will notify the patient in writing of its determination to approve or deny the financial assistance application.

If a patient is determined to be ineligible under this Policy, the denied application and the reason(s) for the denial, including but not limited to failure to cooperate in the application process, will be noted in the patient’s financial file. The patient will be notified that he/she is permitted to request reconsideration of his/her application.

Any applicant fraudulently misrepresenting her or her income level will be immediately disqualified for consideration of financial assistance.

E. Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance application 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 financial assistance. In the event there is no evidence to support a patient’s eligibility for financial assistance, SEH could use outside agencies in determining eligibility under this policy. Presumptive eligibility may be determined on the basis of individual life circumstance that may include:

1. Homeless: A homeless person is an individual who has no home or place of residence. Such individuals will be eligible for Indigent Care, even if they are unable to provide all the documentation required for the application
2. Patient is deceased with no known estate
3. Incarcerated patients found to be uninsured and/or without resources
4. Patients who have qualified for other financial assistance programs such as food stamps or WIC

F. Amounts Charged to Patients Eligible for Financial Assistance

Services eligible under this policy will be made available to the patient, in accordance with financial need, as determined in reference to Federal Poverty Levels in effect at the time of the determination. Once a patient has been determined by SEH to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts SEH will charge patients qualifying for financial assistance is as follows:

1. Patients with an annual household income at or below 200% of the FPL or approved under Presumptive Eligibility will receive a 100% discount.
2. Patients with an annual household income between 201% and 300% of the FPL will receive a 75% discount.
3. Patients with an annual household income above 300% of the FPL but have been approved for assistance under Exceptional Circumstances will be reviewed on a case-by-case basis based on their specific circumstances.

Under no circumstance will a patient eligible for financial assistance under this policy be charged more than amounts generally billed (AGB) for such care. If the balance due is more than the AGB, an additional discount will be applied to the balance to reduce it to the AGB amount.

SEH utilizes the “look-back” method to calculate amounts generally billed to individuals who have insurance covering emergency or medically necessary care. Under this method, the AGB is calculated using all claims paid in a 12-month period by both private pay insurers and Medicare for both inpatient and outpatient services divided by the total charges for those claims. If the claim has not been finalized by the date the analysis is performed, the claim is not included in the calculation. The current AGB percentage is listed in the table below.

Hospital Name	AGB %
Southeast Hospital	26.2%
Southeast Health Center of Stoddard	29.3%

G. Communication of the Financial Assistance Policy to Patients within the Community

Notification to patients and the community of the FAP shall be disseminated by SEH by various means which may include, but are not limited to, providing written notices on patient billing statements, posting notices in the emergency department, admitting and registration areas, & patient financial services office, and posting information on the SEH website. SEH's Financial Assistance Policy, a plain language summary, the Financial Assistance Application, and a list of physicians who are covered under this policy can accessed from the SEH website or hard copies

can be provided in-person or mailed to the patient upon request. Referral of patients for financial assistance may be made by any member of the SEH hospital staff or medical staff, including physicians, nurses, financial counselor, social workers, and case managers.

The documents included in the FAP will be available in English and any other language that constitutes the primary language of at least 5% or the 1000 person threshold of the population in the community where the facility is located.

H. Relationship to Collection Policies

SEH has developed policies and procedures for internal and external collection practices (including actions and reporting to credit agencies) that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a government program, and a patient's good faith effort to comply with his or her payment agreements with SEH. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills:

1. SEH may offer extended payment plans
2. SEH will not impose extraordinary collections actions such as wage garnishments; liens on primary residences or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for assistance under the FAP. Reasonable efforts shall include:
 - Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by SEH
 - Documentation that SEH has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with SEH's application requirements;
 - Documentation that the patient has been offered a payment plan and has not honored the terms of that plan.

SEH's Billing and Collection policy can be accessed from the SEH website or hard copies can be provided in-person or mailed to the patient upon request.

I. Regulatory Requirements

In implementing this Policy, SEH management and facilities shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

J. Approval

If a patient is considered to be eligible under this Policy, the following approval will be obtained based on the level of Financial Assistance that is being proposed.

1. Up to \$10,000 will be approved by Manager – Business Office
2. From \$10,001 - \$50,000 will be approved by the Director – Revenue Cycle
3. Greater than \$50,001 will be approved by CFO

REFERENCES:

Section 501(r) of the Internal Revenue Code

HFMA Sample 501(c)(3) Hospital Charity and Financial Assistance Policy and Procedures

Connance 501(r) Compliance Checklist

Federal Register Vol. 82, No. 19

Attachments:

Appendix A: Plain Language Summary

Appendix B: Financial Assistance Discount Guidelines

Appendix C: Approval Letter Template

Appendix D: Denial Letter Template

Appendix E: Financial Assistance Application

Appendix A: Plain Language Summary

SoutheastHEALTH ("SEH") is committed to enhancing the health and well-being of the residents in the community. In keeping with our mission, SEH provides free or discounted emergency and other medically necessary care to patients who are either uninsured or underinsured and who qualify for assistance under its Financial Assistance Policy. Financial assistance does not apply to elective services.

Eligibility Requirements and Assistance Offered Under the Financial Assistance Policy

Patients who qualify for assistance are eligible for discounts for emergency and other medically necessary care based on multiple factors including, income, household size, and other available assets. In general:

- **Patients whose household income is at or below 200% of the Federal Poverty Level are generally eligible for free emergency and medically necessary care.**
- **Patients whose household income is between 200% and 300% of the Federal Poverty Level are generally eligible for a 75% discount for emergency and other medically necessary care.**

A patient who qualifies for assistance under SEH's Financial Assistance Policy will not be charged more than amounts generally billed to patients with insurance, for emergency or medically necessary care.

How to Apply for Financial Assistance

To apply for financial assistance, please submit a completed Financial Assistance Application & supporting documentation to Patient Financial Services, 1200 N. One Mile Rd, Dexter, MO 63841. To be considered complete, an application must include:

- Completed Financial Assistance Application
- Approval/Denial letter from Medicaid
- Copies of most recent Federal Tax Return, including all schedules
- Two months of complete bank statements, both checking and savings accounts
- Verification of current income, if applicable: examples include the two most recent pay stubs, pension and retirement income, Social Security income, unemployment compensation, workers' compensation, veterans' payments, etc.
- Proof of income from interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, and any other misc. income sources

Other documentation may be requested to verify information on the Financial Assistance Application.

How to Obtain Copies of the Financial Assistance Policy and Financial Assistance Application

Copies of the Financial Assistance Policy, this plain language summary, and the Financial Assistance Application are available free of charge upon written request to Patient Financial Services, 1200 N. One Mile Rd, Dexter MO 63841. Copies can also be found in the admitting/registration areas of the hospital or online at www.sehealth.org.

Further information and complete details about the Financial Assistance Policy may be obtained by calling 573-624-5566, visiting our website at www.sehealth.org/patients-and-visitors/billing or in-person at the address above.

Appendix B: Financial Assistance Discount Guidelines

The following table shows the financial assistance level that patients may qualify for under the FAP.

Financial Assistance Level		100%	75%
Federal Poverty Level	Household Size	At or below 200% FPL	201-300% FPL
\$12,490	1 Person	\$24,980	\$37,470
\$16,910	2 People	\$33,820	\$50,730
\$21,330	3 People	\$42,660	\$63,990
\$25,750	4 People	\$51,500	\$77,250
\$30,170	5 People	\$60,340	\$90,510
\$34,590	6 People	\$69,180	\$103,770
\$39,010	7 People	\$78,020	\$117,030
\$43,430	8 People	\$86,860	\$130,290
<ul style="list-style-type: none"> • For households with more than 8 persons, add \$4,420 for each person. • Federal Poverty Level (“FPL”) is determined annually by the U.S. Department of Health and Human Services. 			

Appendix C: Approval Letter Template

Date

Re: Acct #:

Patient Name:

Dear _____,

We have reviewed your application for Financial Assistance and have determined that you meet our established guidelines for reduced rates under our Financial Assistance Policy. Your allowance for Financial Assistance is _____% based on your current financial assistance application information. If your financial situation changes, it will be your responsibility to contact Patient Financial Services at 573-624-5566. This Financial Assistance is only allowed for emergent and/or medically necessary services. Elective services do not qualify for this program.

I have applied the discounts to your account, and your new balance is \$_____. If applicable, please remit the balance due within 30 days of this letter. If you require a monthly payment arrangement, please contact us as soon as possible to execute that agreement.

If you have any questions, please feel free to contact me between the hours of 8:00AM and 4:30PM, Monday through Friday. I can be reached at 573-624-5566.

Sincerely,

Patient Financial Services
SoutheastHEALTH Center of Stoddard County
573-624-5566

Appendix D: Denial Letter Template

Date

Re: Acct#:

Patient Name:

Dear _____,

We have reviewed your application for Financial Assistance and have determined that you do not meet our established guidelines to receive free or discounted care.

Reason for denial:

_____ Income exceeds qualifications

_____ Potential third party payer source through _____

_____ Application is not complete

_____ Supporting documentation not adequate

If you have additional information or can provide the required documentation, please contact us for reconsideration. Otherwise, please remit your account balance within the next 30 days. If you require monthly payment arrangements, please contact us as soon as possible to execute that agreement. Should your financial situation change, you are invited to complete another application.

If you have any questions, please feel free to contact Patient Financial Services between the hours of 8:00AM and 4:30PM, Monday through Friday at 573-624-5566.

Sincerely,

Patient Financial Services
SoutheastHEALTH Center of Stoddard County
573-624-5566

Appendix E: Financial Assistance Application

SOUTHEAST HEALTH FINANCIAL ASSISTANCE APPLICATION

Completing this application will help SoutheastHEALTH determine if you are eligible to receive free or discounted services or other public programs that can help pay for your healthcare. Complete the application in full and sign the authorization to verify information. Submit completed application and supporting documentation to SoutheastHEALTH, Patient Financial Services, 1200 N. One Mile Road, Dexter, MO 63841. For questions you may contact a Patient Accounts Representative at 573-624-5566.

Section A – Information regarding Applicant

Full Name – (Last, First, Middle) _____
 Current Street Address _____
 City _____ State _____ Zip _____ Primary Phone _____
 Social Security No. _____ / _____ / _____ Birth Date _____
 Present Employer(s) _____ Position(s) _____
 Employers Address _____
 Supervisor _____ Telephone _____
 Present Gross Income (Must include written verification) _____
 Salary or Commission \$ _____ per _____

Section B – Information regarding Spouse or Joint Applicant

Full Name – (Last, First, Middle) _____
 Social Security No. _____ / _____ / _____ Birth Date _____
 Present Employer(s) _____ Position(s) _____
 Employers Address _____
 Supervisor _____ Telephone _____
 Present Gross Income (Must include written verification) _____
 Salary or Commission \$ _____ per _____

*** Does any member of the household receive Alimony and/or Child Support? ___ Yes ___ No
 If Yes, how much? \$ _____ per _____ \$ _____ per _____

Minor Dependent's Name	Date of Birth	Relationship	Minor Dependent's Name	Date of Birth	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Name of Nearest Relative Not Living With You _____
 Relationship _____ Address _____

Do you have a checking account? ___ Yes ___ No If Yes, Bank Name _____
 Do you have a savings account? ___ Yes ___ No If Yes, Bank Name _____

Automobiles:

Make	Model	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list your monthly expenses and any outstanding debt(s) you may have, including: Mortgage, Rent, Utilities, Telephone, Credit Cards, Installment Contracts, Etc (include additional expenses on back).

Creditor	Monthly Payment	Past Due? Yes/No	Creditor	Monthly Payment	Past Due? Yes/No
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

***You must include CURRENT copies of the following, if applicable to you, for your application to be considered: Federal Income Tax Forms, including Schedule C if you are self-employed. Payroll Stubs, W-2's, Social Security Benefits, Disability Benefits, Unemployment Benefits, Medicaid or Illinois Public Aid Rejection or Acceptance Letter or any other forms of income.

Everything that I have stated in this application is correct to the best of my knowledge. I understand that SoutheastHEALTH will retain this application whether or not it is approved. SoutheastHEALTH is authorized to check my credit and employment history. This program will only cover eligible hospital bills and any lab or Physician bills if employed by SoutheastHEALTH. It will not cover any outside doctor services, such as Washington University Pathology or any other physician or independent contractor providing services at the Hospital. Those providers will bill their services separately.

Applicant's Signature _____ Date _____

Joint Applicant's Signature _____ Date _____

Hospital Use Only:

Account #	Balance	Account#	Balance
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____