Financial Assistance Program and Collection Policy

OTTAWA COUNTY HEALTH CENTER

Date of Board Approval: 11-28-17

Purpose: To provide financial assistance for emergency and medically necessary healthcare services received as an inpatient or outpatient from the Hospital in a fair, consistent, respectful and objective manner to *indigent, medically indigent, uninsured* or *underinsured* patients. **This policy contains GPHA recommendations**.

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A. **Eligibility Criteria**:

1. The Financial Assistance Program (Program) takes into consideration a patient's household income and is based off of the Federal Poverty Level (FPL) which is updated annually and included on (Appendix A).

2. Eligible patients are people who have received emergency and *medically necessary services*, and are *indigent, medically indigent*, *uninsured* or *underinsured*. The patient's Household income (as defined below) must be less than 200% of the poverty level to receive 100% financial assistance.

3. Financial Assistance determination will be consistent among patients, regardless of sex, race, creed, disability, sexual orientation, national origin, immigration status or religious preference.

4. Financial Assistance is secondary to all other financial resources available to the patient, including employer-based insurance coverage, commercial insurance, government programs, third-party liability and household qualified assets.

B. Application Process:

1. All qualifying applicants will be granted Financial Assistance for *emergency and medically necessary services* in accordance with the qualifications and guidelines herein set forth.
2. An application for financial assistance can be initiated by a patient in person at admissions or at patient financial services; over the phone by calling 785-392-212; through the mail at OTTAWA COUNTY HEALTH CENTER, PO Box 290, MINNEAPOLIS, KS, 67467, or via the Ottawa County Health Center website www.ottawacountyhealthcenter.com. If help is required to complete the application

someone will be available to assist you.

It is ultimately the patient's responsibility to provide the necessary information to qualify for financial assistance. There is no assurance that the patient will qualify for financial assistance.

3. The Financial Assistance process begins at the time of service (during pre-admission, admission or at time of discharge.) A list of covered and non-covered providers is available (Appendix B and C).

4. The application process includes completion of a "Personal Financial Statement for Financial Assistance" and providing verification documents. Verifiable information may include, but is not limited to, the following:

   a. Individual or family income (income tax return with copies of earnings statements – W-2 forms, 1099 forms, etc. for past 2 years)
   b. Copies of most recent 90 days of payroll stubs, Social Security checks, or unemployment checks.
   c. Copies of most recent 60 days of bank statements and investment/broker statements.
   d. Current trust fund statements
   e. Mortgage statements
   f. Documentation of employment status
   g. Household family size
   h. Credit history reports
   i. Previous or current returns from collection agencies with documentation regarding inability to pay
   j. Business Office knowledge of individual or family background

   Note: The object is to document the need for financial assistance. If a patient or the person who has financial responsibility for emergency and *medically necessary services* is unwilling or unable to provide <u>all</u> necessary and pertinent information to make a concise and fair determination of their income then Presumptive Eligibility (PE) can be made.

5. Presumptive Eligibility (PE): Some patients or guarantors are presumed to be eligible for financial assistance based on individual life circumstances, for example, those who are homeless or have qualified for needs-based assistance programs. This is called "presumptive eligibility." These patients or guarantors do not need to complete the financial application if they provide proof that they qualify for certain programs that exist to benefit people who do not have enough resources to pay for services and care. Presumptive eligibility will be used to give a 100 percent discount to patients who are eligible because of one of the following examples:
   a. They are homeless and/or have received care from a homeless clinic or shelter. The patient or guarantor must provide a written statement from a homeless clinic or shelter.

   b. They receive care from and/or part of the Women, Infants and Children's (WIC) program. The patient or guarantor must provide the most recent WIC

voucher issued by the Family Support Division office.

c. They receive Supplemental Nutritional Assistance Program (SNAP) benefits (formerly known as food stamps). The patient or guarantor must provide the most recent SNAP (food stamp) eligibility statement issued by the Family Support Division office.
d. The patient's family is eligible for and receives free or reduced–cost school lunch as a part of the federally funded program. The patient or guarantor must provide the most recent confirmation letter from the Family Support Division to support this
e. The patient's street address is an affordable or subsidized housing program for low-income people, such as HUD Section 8 Housing. The patient or guarantor must provide the subsidized housing application approval issued by the Family Support Division office.
f. The patient's or guarantor's wages are not enough to garnish, as defined by state law. The patient must provide proof, as issued by the state in which he or she lives, exemption from wage garnishment.

6. After the application for Financial Assistance has been completed, account(s) being considered for Financial Assistance will be put in a "hold" status while the application is being reviewed (no longer than 30 days). The hold status will prevent account(s) from proceeding through the collection process, including assignment to a collection agency. Once the Financial Assistance application has been processed and approved/denied, the Hospital will send written notice to the patient and/or person having financial responsibility for the account(s).

7. The application period for completion of a financial assistance application is available for a minimum of 240 days from the date Ottawa County Health Center provides the patient with the first post discharge billing statement for patient services.

8. If the Hospital determines an individual is eligible for FAP the Hospital will do the following:
   a. If the patient or guarantor has made payments to the hospital facility (or any other party) for the care as an FAP eligible individual, refunds of those excess payments shall be made.

   b. Takes all reasonably available measures to reverse any ECA taken against the individual to collect the debt as issue; such measures shall include but not be limited to: vacating any judgments, lifting any liens or levy's on the individuals property and remove from the individuals credit report any adverse information that was reported to a reporting agency or credit bureau.

9. The Hospital Business Office will continue to work with the patient or *guarantor* to resolve remaining account balances. Patients or *guarantors* are responsible to make mutually acceptable payment plan arrangements with the Hospital within 30 days of receiving a written notice of determination regarding their Financial Assistance application.

10. If the patient or *guarantor* fails to initiate or complete the Financial Assistance process, the Hospital may elect to begin collection activity, including possible transfer of account(s) to a collection agency.

C. Financial Assistance Determination:

1. To obtain Financial Assistance, the patient or *guarantor* must establish that the household income is below 200% of the most recent *Federal Poverty Level (FPL)* at the date of service to receive 100% financial assistance. For current (FPL) see (Appendix A).

2. Allowances may be made for extenuating circumstances based on each person's unique life circumstances and mitigating factors. The amount of assistance provided by the Hospital may be more than outlined in the guidelines, but never less.

3. "Household Income" includes all pre-tax income, however derived, for all persons 18 years old and over who reside in the household. A household consists of one or more persons living in the same house, condominium or apartment.

4. Incomplete Financial Assistance applications, or undocumented information within the application, may cause the Hospital to deny the assistance until the completed application or documentation is provided. The Hospital will retain the incomplete application and send written documentation outlining the information needed, and instructions on submitting the necessary paperwork.

5. The Hospital's Business Office Manager or his/her designee will process the Financial Assistance application and determine the appropriate discount.

6. The Hospital's Business Office will send a written notice of determination to the patient or *guarantor* within 30 days of receiving the completed application (including all required documentation).

7. Patients or their representatives can appeal a denial of Financial Assistance by providing additional information regarding eligibility determination or an explanation of extenuating circumstances, to the Business Office Manager of the Hospital within 30 days of receiving the written denial notification. The party making the appeal will be notified in writing of the final decision made by the Business Office Manager **and** Administrator.

8. No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care.

NOTE: The hospital is using the prospective Medicare method for the amounts generally billed (AGB).

D. Approval & Authorization:

1. Approval and authorization of Financial Assistance discounts will be based on the following: (or the Hospital's alternative Board of Trustee's adopted policy)

a.	$ 0 to $ 750	Business Office Manager or designated Representative
b.	$ 750 to $2,000	Business Office Manager
c.	$2,001 to $4,000	Administrator
d.	$4,001 to $5,000	Vice President of Regional Operations or Representative
e.	$5,000 or higher	Board of Trustees or Representative for Managed Hospitals; GPHA CFO for Leased Hospitals

E. Terms & Definitions:

1. *Federal Poverty Level (FPL):* Poverty thresholds that are issued each year in the Federal Register by the Department of Health and Human Services (HHS). http://aspe.hhs.gov/poverty
2. *Guarantor:* Refers to person financially responsible for patient's account balance(s).
3. *Indigent:* Refers to patient that has no financial resources to pay obligation.
4. *Medically Indigent:* Refers to situation where payment of obligation will create financial hardship.
5. *Medically Necessary Services:* Refers to inpatient or outpatient healthcare services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which if left untreated, would pose a threat to the patients ongoing health status.
6. *Uninsured*: The patient has no insurance or coverage under governmental programs and not eligible for any third party payment such as worker's compensation or third party liability.

7. *Underinsured*: The patient has limited insurance coverage that does not provide coverage for the medically necessary care rendered or the maximum liability under insurance coverage has been exceeded.

F. Collection Actions – Ottawa County Health Center will engage in reasonable efforts to determine whether an individual is eligible for assistance under this policy before engaging in extraordinary collection actions ("ECA").

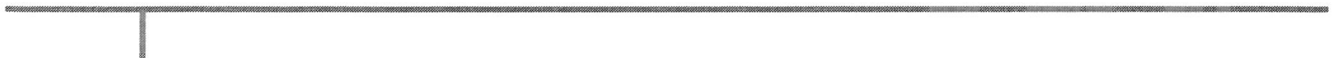
1. ECA includes any actions taken that require a legal or judicial process in an attempt to collect payment from an individual covered under this policy. "ECAs that require legal or judicial process include, but are not limited to:
   a. Placing a lien on an individual's property;
   b. Foreclosing on an individual's real property;
   c. Attaching or seizing an individual's bank account or any other personal property;
   d. Commencing a civil action against an individual;
   e. Causing an individual's arrest;
   f. Causing an individual to be subject to a writ of body attachment; and
   g. Garnishing an individual's wages."

   Ottawa County Health Center may send accounts to one or more collection agencies, but such action is not considered an ECA. Collection agencies will be held, in a written agreement, to the terms and conditions of this policy and will not take ECAs without the prior authorization of Ottawa County Health Center.

2. Ottawa County Health Center will not take ECAs against an individual for at least 120 days from the date Ottawa County Health Center provides the individual with the first post-discharge bill for care; and
   a. Provides at least thirty (30) days' written notice to the individual that:
      i. Notifies the individual of the availability of financial assistance;
      ii. Identifies the specific ECA(s) Ottawa County Health Center intends to initiate against the individual, and
      iii. States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the individual;
   b. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and
   c. Makes a reasonable effort to orally notify the individual about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the individual describing how the individual may obtain assistance with the financial assistance application process.

3. Once an individual has submitted a complete application within the Application Period, while determining if the individual is eligible according to the policy Ottawa County Health Center will,
   a. Suspend any ECA against the individual, including that which was initiated by the collection agency;

   b. Not initiate any new ECAs; and
   c. Make and document a determination as to whether individual is eligible according to the policy.
4. If an individual submits an incomplete application at any time during the Application Period, Ottawa County Health Center will comply with F. 1,2 &3 as well as the following:
   a. Suspend any ECA against the individual, including that which was initiated by the collection agency;
   b. Provide written notice with a copy of the policy, to the individual describing the information necessary to complete the application.
   c. If Ottawa County Health Center does not receive the required information within the required time frame, collection actions may resume.



Appendix A

2018 Federal Poverty Levels (FPL)

Size of Family Unit	Percentage of FPL - 200%
1	24,120
2	32,480
3	40,840
4	49,200
5	57,560
6	65,920
7	74,280
8	82,640
For each additional person, add	4,180

APPENDIX B: PROVIDERS AND PRACTITIONERS COVERED BY OTTAWA COUNTY HEALTH CENTER FINANCIAL ASSISTANCE POLICY

FRANK REESE - CRNA

APPENDIX C: PROVIDERS AND GROUPS NOT COVERED BY XXXXXX FINANCIAL ASSISTANCE POLICY

The following providers and groups are NOT covered under OTTAWA COUNTY HEALTH CENTER, Financial Assistance Policy. Patients or guarantors must contact these providers directly to ask if they offer financial help and if you can make a payment plan with them.

Salina Regional Health Center, Inc – dba Comcare

Salina Regional Health Center, Inc.

United Radiology Group

Weber Palmer & Macy Chartered

Labcorp

City of Minneapolis Ambulance

Lifetouch

Tammy Walker Cancer Center

Orthopedic Clinic of Salina

Orthopedic Sports Health Clinic of Salina

Salina Sports Medicine and Orthopedic Clinic

Central Kansas ENT

Salina Surgical Arts Center

Mowery Clinic

PERSONAL FINANCIAL STATEMENT FOR FINANCIAL ASSISTANCE

Patient Name	Age	Phone Number	Marital Status S M W D	Social security Number

Date Pt. Received:	Acct. #/Balance: /$	; Acct. # / Balance: /$
Please Return by:	Acct. #/Balance: /$	; Acct. # / Balance: /$
Date Returned:	Acct. #/Balance: /$	; Acct. # / Balance: /$

Patient	Person Responsible for bill: *(if not patient)*	Relationship
Street:	Name:	
City, State, Zip	Street:	
	City, State, Zip	
Phone: ( ) Cell: ( )	Phone : ( ) Cell: ( )	

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, name of last employer:	If unemployed, name of last employer:
How long unemployed?	How long unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

NAME	AGE	RELATIONSHIP TO PATIENT

DO YOU HAVE HEALTH INSURANCE COVERAGE AVAILABLE? YES NO

IF YES, WHY NOT AVAILABLE FOR THIS DATE OF SERVICE?____________________

IF NO, PLEASE INDICATE THE REASON FOR LACK OF INSURANCE COVERAGE.

IS THE INSURANCE COST TO HIGH? YES NO

PRE-EXISTING CONDITION? YES NO

OTHER, PLEASE DESCRIBE: ____________________

HAVE YOU APPLIED FOR MEDICAID? YES NO

IF DENIED, DATE: ____________ REASON FOR DENIAL: ____________

IF DENIED, PLEASE ATTACH A COPY OF MEDICAID DENIAL LETTER.

You have to apply for Medicaid to be eligible for payment assistance!

MONTHLY INCOME: Attach Copies of Proof of Income *(i.e. tax return)*			
	Patient	Spouse	Other Members of Household *(18 or older)*
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List…			
MONTHLY INCOME SUBTOTAL:			
TOTAL INCOME: $	**MONTHLY: $**		**YEARLY: $**

EXPENSES	**MONTHLY**	**BALANCE DUE**	**HOUSEHOLD ASSETS**	**VALUE**
Mortgage or Rent Payment	$	$	Savings *(attach copy)*	$
Car Payment			Checking *(attach copy)*	
Utilities *(Gas, Electric, Water)*			Stocks and Bonds	
Cable			Mutual Funds, Money Market, etc	
Phone *(including cell)*			Cash Value of Life Insurance	
Food			Real Estate Value	
Child Care			Farming Real Estate Value	
Clothing			Vehicles Value *(not primary)*	
Insurance			Jewelry & Other Personal Property	
Gas/Transportation			Other Assets *(Describe)*	
Recreation				
Physicians				
Hospitals				
Other Medical				
Credit Cards				
Other Expenses *(Describe)*			**TOTAL HOUSEHOLD ASSETS:**	$
			HOUSEHOLD DEBTS	VALUE
			Home Loan	$
			Auto Loan	
			Credit Card Debt	
			Other: *Total Expenses from "Balance Due" column – (Mortgage + Car Loan = Credit Cards)*	
TOTAL EXPENSES:	**$**	**$**	**TOTAL HOUSEHOLD DEBTS:**	**$**

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I verify the information provided is correct and complete. I authorize verification of any information and understand that additional documentation may be requested. If any information if found to be false, financial arrangement or assistance may be voided.

Patient/Responsible Party Signature Date:

Application Determination: APPROVED / DENIED Date Determination Letter Mailed: ____________

Reason for Denial: ____

Hospital Representative Signature(s)______________________________________ Date:____________________