Policy/Procedure Title	Financial Assistance			Policy #	
Manual Location(s)	Business Office Manual	Effective		Page	1 of 3
Department Generating Policy	Business Office				
Affected Departments	All Departments				
Prepared By	Terri Martinez	Date/Title	7/12/2017, Chief Financial Officer		
Medical Staff Committee	Richard Foutch, MD	Date/Title	7/26/2017, Chief of Staff		
Governing Board	Judith Cooper	Date/Title	7/26/2017, Governing Board President		

POLICY:

The hospital is committed to treating all patients equitably, with dignity, respect and compassion. The hospital shall pursue its collection policy fairly and consistently in compliance with the Federal Fair Debt Collection Practice and state collection laws. All patients will be treated with dignity and respect in regard to collection activities. The hospital will make reasonable efforts to identify patients who may be eligible for financial assistance. This policy shall apply to the hospital's collection process and to outside agencies performing collection activities on behalf of the hospital.

PROCEDURE:

1. Financial Counseling and/or Payment Plans. The hospital will review a patient's financial record prior to initiation of collection activities to determine whether a payment plan has already been arranged with the patient pursuant to financial counseling at admission or discharge. If the patient is uninsured and such an offer has not been made, the hospital shall present to the patient the option of financial counseling and work with patient to determine whether the patient is eligible for financial assistance under the Financial Assistance Policy or establish a reasonable payment plan pursuant to the Discount and Payment Plan Policy.
2. Staff Education. The hospital's billing and collection staff will be trained to administer this policy and provide assistance to the patient. Medicare and non-Medicare patients will be treated in a similar manner.
3. Timeliness. A bill shall be issued in a timely manner after discharge or death to the party responsible for the patient's financial obligations.
4. Future Services. A patient shall not be denied future emergency services at the hospital based on outstanding account balances.
5. Documentation of Collection Effort. The hospital shall document all collection efforts in the patient's financial record including:
   a. Subsequent billing records;
   b. Collection letters;
   c. Correspondence communicating the availability of financial counseling to patients unable to meet their debt obligation;
   d. Correspondence evidencing subsequent attempts at collection;
   e. Logs or documentation on individual patient accounts of all telephone calls to patients; and

f. Logs or documentation on individual patient accounts of all personal contacts with patients.

6. Extraordinary Collection Actions. As used herein, "Extraordinary Collection Actions" has the meaning given such term in Section 501(r) of the Internal Revenue Code, including (i) deferring, denying, or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care, (ii) actions that require legal or judicial process, and (iii) reporting an individual to consumer credit reporting agencies or credit bureaus. Placing a patient's account with a collection agency is not an Extraordinary Collection Action.
   a. The hospital will notify individuals that financial assistance is available to eligible individuals at least 30 days prior to pursuing Extraordinary Collection Actions to obtain payment by (i) providing written notice to the individual indicating that financial assistance is available to eligible individuals, indicating that the hospital intends to initiate or have a third party initiate actions to obtain payment, and providing a deadline after which Extraordinary Collection Actions may be pursued and which is no later than 30 days after the date of the written notice, (ii) providing the individual a plain language summary of the Financial Assistance Policy with the written notice, and (iii) making reasonable efforts to orally notify the individual about the hospital's Financial Assistance Policy.
   b. Extraordinary Collection Actions will not commence for a period of 120 days after the date of the first post-discharge billing statement for the applicable care.
   c. The financial assistance application period begins on the date medical care is provided and ends 240 days after the first post-discharge billing statement or 30 days after the hospital or authorized third party provides written notice of intent to initiate Extraordinary Collection Actions, whichever is later. The hospital will widely publicize the availability of financial assistance and make reasonable efforts to identify individuals who may be eligible. If a patient submits a complete financial assistance application during the application period, the hospital will suspend Extraordinary Collection Actions and make an eligibility determination before resuming Extraordinary Collection Actions.
   d. Prior to engaging in Extraordinary Collection Actions, the hospital's Chief Financial Officer will identify whether reasonable efforts were made to determine whether an individual is eligible for financial assistance.
7. Referral to Collection Agency.
   a. The referral of an account to a collection agency shall be limited to situations where the patient has ignored the hospital's offer of financial counseling or has violated the payment plan established to address the individual needs of the patient. The Chief Financial Officer or designee must approve the referral of any account to a collection agency.
   b. Prior to the engagement of any collection agency, the hospital shall ensure that a written agreement is in place. Such agreement shall require the agency to abide by the hospital's collection policy. Any agency with which the hospital has an agreement must be appropriately bonded and insured. All agencies will meet all HIPAA requirements for handling protected health information.

c. Collection efforts must allow the patient appropriate time to dispute his or her obligation. A collection agency shall cease collection efforts while a patient's balance is in dispute. All disputed accounts shall undergo an appropriate investigation. Under no circumstances will a collection agency make a report to a consumer credit reporting agency or credit bureau unless (i) all of the requirements for taking Extraordinary Collection Actions have been met with respect to the affected individual, and (ii) if applicable, it is disclosed that the patient has disputed the obligation to the hospital.
d. The agreement with the agency shall provide that the hospital will have the right to withdraw any account from the agency at any time and for any reason.

8. Legal Action.
   a. The hospital recognizes its right to initiate legal action where there is evidence that the patient or responsible third party has income or assets to meet his or her obligation.
   b. If the hospital chooses to engage a law firm, the hospital shall enter into a written engagement agreement prior to referring any matter to the firm for collection. All firms will meet all HIPAA requirements for handling protected health information.
   c. A lawsuit may be filed against a responsible party only in those situations where there is evidence that the responsible party has or will likely have in the future income or assets to meet his or her debt obligation.
   d. Prior to the filing of any lawsuit, the law firm shall send written notice to the responsible party of its intent to institute legal action to collect the account.
   e. The hospital's Chief Financial Officer shall have final authority to approve any settlement of a lawsuit.

ATTACHMENT (S)

- Application for Financial Assistance
- Financial Assistance Approval Worksheet
- Charity Application Instructions

REFERENCE (S)

None

Original Effective Date:					
Reviewed and/or Revised Dates					
	1st	**2nd**	**3rd**	**4th**	**5th**
Review Date:					
Revised Date:					
Supersedes:					
By:					

Union County General Hospital

APPLICATION FOR FINANCIAL ASSISTANCE

To apply for financial assistance, on the bill from ___________________, complete this application, sign your name, and return the application to the Financial Department within 30 days of your visit. Call the Financial Department If you need help at (___) __________, _________________.

PERSONAL INFORMATION

Name: (Please Print)	Name and Social Security Number of Patient (if different from person completing application):
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?

HOUSEHOLD MEMBERS AND MONTHLY INCOME

Name of Household members	Relationship to Household Member	Age and Date of Birth	Gross MONTHLY Income	MONTHLY Welfare/Child Support	MONTHLY Payments, Pensions, Retirement, Social Security	Any Other Monthly Income

INCOME VERIFICATION

Please provide any of the following types of documentation to verify your income.

(This information will be used solely for the purpose of assessing eligibility for medical assistance.)

IRS Form W-2, Wage and Earnings Statement Paycheck Remittance	Bank Statement/Records
Individual Tax Return	Government Program
Social Security, Work Comp or Unemployment Comp letter	Telephone verification by employer
Physician Disability Statement	Patient deceased
	Other

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

____

Other Resources: Please provide the total amount of other resources available to you, including such things as savings accounts, checking accounts, stocks, bonds, etc.: $ _______________

____

____

MONTHLY EXPENSES

Rent/Mortgage payment		Car/Truck Payment	
Electric and/or Gas Payment		Child Care Expenses	
Telephone Cell Phone		Loans	
Cable/Satellite		Other: Water/Auto Insurance	

SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of CHARITY CARE for services rendered at UNION COUNTY GENERAL HOSPITAL; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to immediate denial.

X ______________________________ X ______________________________

SIGNATURE OF ADULT HOUSEHOLD MEMBER SOCIAL SECURITY NUMBER

DO NOT WRITE BELOW THIS LINE — FOR HOSPITAL USE ONLY
(Monthly income conversion: weekly x 4.33, Every 2 weeks x 2.15, Twice a Month x 2)
(Yearly income conversion: monthly x 12)

Total Household Size: Monthly Income: Yearly Income:	
Food Stamps: Y / N	
Eligibility Determination: Approved ❑ Denied ❑ Pending ❑	
Reason for Denial: Income too much ❑ Incomplete Information❑ Other ❑	
Account This Application Applies To:	Patient:
Signature of Determining Official:	Date:
	Other:
Reason applicant did not complete application (if applicable):	
Reason verbal attestation of income necessary (if applicable)	

FINANCIAL ASSISTANCE APPROVAL WORKSHEET

Office use only

Name: ______________________________

Date of Birth: ______________________________

Gross Annual Household Income: $ ______________________________

Number in Household: ______________________________

Patient Account Number(s): ______________________________

Social Security Number ______________________________

Charges: $ ______________________________

Amount Due: ______________________________

Circle type of documentation or income verification provided:

- IRS Form W-2, Wage and Earnings Statement Paycheck Remittance
- Individual Tax Return
- Social Security, Work Comp or Unemployment Comp letter
- Government Program
- Telephone verification by employer
- Bank Statement/Records
- Physician Disability Statement
- Written Attestation (Patient signed Assistance Application verifying Total Yearly Income)
- Verbal Attestation (Patient verbally verified Total Yearly Income)
- Patient deceased

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Guidelines — Schedule A)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third party payors equal to or greater than 10% of Total Yearly Income?

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

3. Is Total Gross Annual Household Income equal to or less than 500% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B.)

YES Total Yearly Income is less than_______% of the Federal Poverty Guidelines. Approved for ____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B

NO Continue to Step 4.

4. Is balance due after payment by all third party payors equal to or greater than 50% of Total Yearly Income?

YES Balance due is _______% of the total yearly income. Eligible for ______% discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule C.

NO Patient does not qualify for Financial Assistance.

I. ($ ______________) X (______ %) = $ ________________ 2. ($ ______________) - ($ ________) = $ ______________

Balance Due *% Discount* *Discount Amount* *Balance Due* *Discount Amt.* *Remaining Bal. Due*

____

Employee Signature

If Discount = $1 - $2,000: Approval by: ____________ or above
If Discount = $2,001 - $5,000: Approval by: ____________ or above
If Discount = Above $5,000: Director of Patient Financial Services

Date: ____

Union County General Hospital

CHARITY APPLICATION INSTRUCTIONS

PERSONAL INFORMATION:

- Print your full legal name.
- Write your home and work telephone number and give a daytime telephone where you can be reached most often.
- Write your current address and which country you presently live in.
- If you are completing this application for someone other than yourself, write the full legal name and social security number of the patient for whom this application is being completed.

HOUSEHOLD MEMBERS AND MONTHLY INCOME:

- Print the names of everyone in your household along with their ages, whether they have income or not.
- Include yourself, other related and unrelated people in your household. (use another piece of paper if you need more space.)
- Write the amount of income each household member received last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, child support, social security and other income.
- If any amount last month was more or less than usual, write that person's usual monthly income.

PROOF OF INCOME, RESIDENCY, AND IDENTIFICATION:

- ALL APPLICANTS SHOULD ATTEMPT TO PROVIDE PROOF OF ANY OF THE FOLLOWING TO VERIFY INCOME:
    - IRS Form W-2
    - Wage and Earnings Statement Paycheck Remittance
    - Bank Statement/Records
    - Individual Tax Return
    - Social Security, Workers Compensation or Unemployment Compensation letter
    - Proof of eligibility for Government Program
    - Physician disability statement listing term of disability and documentation or proof of three or more months with no income for period of disability
    - Telephone verification by employer of patient's income

- Other

- You may also verify your income by: (a) having your employer provide written verification; (2) having your employer speak with a Hospital representative.

➢ **If you are unable to provide one of the sources of income documentation listed above, please provide an explanation of income verification for the patient file.**

MONTHLY EXPENSES:

➢ Write the usual amount of household expenses.

SIGNATURE AND SOCIAL SECURITY NUMBERS:

➢ All applications should have the signature of an adult household member (unless medical problems or situations, i.e. isolation, I.C.U., etc. are certain.). If it is not possible or feasible to obtain a signature, please explain to hospital staff why signature is unavailable.

➢ The application must have the social security number of the adult who signs.

➢ If the adult does not have a social security number, write "NONE" to show that the adult does not have a social security number.

➢ Additional information may be required to determine your eligibility, depending upon the program for which you are applying.

ELIGIBILITY DETERMINATION:

➢ Eligibility will be determined based on 200% Poverty Income Guidelines.

➢ Approved applications cover charges at Union County General Hospital only.