PHILLIPS COUNTY HOSPITAL
& FAMILY HEALTH CLINIC

POLICY AND PROCEDURE

Facility Department: Business Office		**Interdepartmental:**
Title:	Financial Assistance Policy (FAP)	
Author:	Ward C. VanWichen, CEO	
Approved:		
Revision Information: (if applicable)		

PURPOSE: Phillips County Hospital is a not-for-profit, tax-exempt entity with a charitable mission of providing emergency and medically necessary health care services to residents of Phillips County Hospital's service area regardless of their financial status and ability to pay. The purpose of this Financial Assistance Policy is to ensure that processes and procedures exist for identifying and assisting hospital patients whose care may be provided without charge or at a discount commensurate with their financial resources and ability to pay.

I. Overview: The Hospital will provide financial assistance to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example, Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information demonstrating financial need, or other facts and circumstances readily demonstrate financial need; and (iv) the Hospital makes an administrative determination that financial assistance is appropriate based on the patient's ability to pay (as established by family income or based on criteria demonstrating presumptive eligibility) and the size of the patient's medical bills.

II. Definitions:

Plain Language Summary means a written statement that notifies an individual that PCH offers financial assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP.

Application Period means the period during which PCH must accept and process an application for financial assistance under the FAP. The application period begins on the date the care is provided and ends on the 240th day after PCH provides the first post discharge billing statement.

Billing Deadline means the date after which PCH or collection agency may initiate an ECA against a responsible individual who has failed to submit an application for financial assistance under the FAP. The billing deadline must be specified in a written notice to the responsible individual provided at least 30 days prior to such deadline, but no earlier than 120 days after the first post discharge statement.

Completion Deadline means the date after which PCH or collection agency may initiate or resume an ECA against an individual who has submitted an incomplete FAP if that individual has not provided the missing information and/or documentation necessary to complete the application or denied

application. The completion deadline must be specified in a written notice and must be no earlier than the later of 30 days after PCH provides the individual with this notice or the last day of the application period.

Extraordinary Collection Action (ECA) means any action against an individual responsible for a bill related to obtaining payment of a self-pay account that requires a legal or judicial process or reporting adverse information about the responsible individual to consumer credit reporting agencies/credit bureaus. ECAs do not include transferring of a self-pay account to another party for purposes of collection without the use of any ECAs.

FAP Eligible Individual(s) means a responsible individual eligible for financial assistance under the FAP without regard to whether the individual has applied for assistance.

Financial Assistance Policy FAP means PCH's Financial Assistance Program for uninsured/under insured patients which include eligibility criteria, the basis for calculating charges, the method for applying the policy and the measures to publicize the policy.

Responsible Individual(s) means the patient and any other individual having financial responsibility for a self-pay account. There may be more than on responsible individual.

Self-Pay Account means that portion of a patient account that is the individual responsibility of the patient or other responsible individual, net of the application of payments made by any available healthcare insurance or other third-party payer, and net of any reduction or write off made with respect to such patient account after application of an assistance program.

III. Nondiscrimination:

A. The Hospital will render health care services, inpatient and outpatient, to all residents who are in need of emergency or medically necessary care, regardless of the ability of the patient to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this policy.

B. The Hospital will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

IV. Eligibility for Financial Assistance:

A. Financial assistance will be given for emergency or medically necessary services to patients who are Financially Eligible or Medically Indigent (in both cases, based on information provided via the Financial Assistance Application attached as **Addendum 2**), or to patients who have been determined to be Presumptively Eligible.

B. Where possible, prior to the admission or rendering of service, a Financial Service Representative will conduct an interview with the patient, the guarantor, and/or his other legal representative. If an interview is not possible prior to the admission or rendering of service, the interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission,

the evaluation of payment alternatives may not take place until the required medical care has been provided.

C. At the time of the initial patient interview, the Financial Service Representative will gather routine demographic information and information regarding all existing third-party coverage The Financial Service Representative will be available to assist the patient with enrolling in any governmental payment programs that may be available. In cases where third-party coverage (including private insurance or payment by governmental program) is nonexistent or likely to be inadequate, the Financial Service Representative will inform the patient of the availability of financial assistance. However, in cases where third-party coverage is denied because the patient failed to comply with the insurer's stated pre-certification requirements and or coordination of benefit requirements, the patient will be ineligible for financial assistance pursuant to this policy.

D. Patients seeking financial assistance will be asked to complete the Financial Assistance Application attached as **Addendum 2** to this policy. Copies of the application form are available from any Business Office personnel and at http://www.pchospital.us. Applications may be completed directly by the patient, by the patient's guarantor and/or other legal representative, or by PCH Business Office Personnel based on information derived from any of the foregoing through an interview either in person or by telephone, or reliable information provided in writing. If assistance is needed with gathering necessary information or materials requested as part of the financial assistance qualifying process, patients are encouraged to contact the Hospital's CFO or any Business Office personnel at *406-654-1100*. These folks may also assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.

E. Patients completing the Financial Assistance Application must return the signed form and required supporting materials through any of the following measures:

- Hand-delivering to Phillips County Hospital CFO and/or any Business Office Personnel
- Mailing to Phillips County Hospital, Attn: Steph Denham, CFO; PO Box 640, Malta, MT 59538

Financial Assistance Applications will be considered if received at any time during the 240-day period following the first post-discharge billing statement issued by the Hospital to the patient for such care.

F. Eligibility for financial assistance is based upon family income and size, and based on (i) the patient's provision of complete and accurate information on the Financial Assistance Application set forth as **Addendum 2**, (ii) the patient's timely cooperation throughout the financial assistance application process. In connection with determining a patient's eligibility for financial assistance, the Hospital will not request information other than as described on **Addendum 2**, although patients may voluntarily provide additional information that they believe to be pertinent to eligibility. If the Hospital contacts the patient to request missing information, the patient will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being suspended from further processing; the patient may re-activate the Application by providing the requested information at any time during the 240-day period following the first post-discharge statement issued by the Hospital to the patient for such care. If a patient provides information that is inaccurate or misleading, he or she may be deemed ineligible for financial assistance and, accordingly, may be expected to pay his or her bill in full.

G. Once a completed Financial Assistance Application is received, the PCH CFO will review for approval. Patients who are determined to be Presumptively Eligible will be processed for financial assistance without need for completion of the Financial Assistance Application or other additional information from the patient.

H. Patients who are uninsured and who do not qualify for financial assistance may contact the Hospital to discuss payment options, including the availability of a payment plan. PCH Business Office personnel will inform such patients of any other discounts that may be available under other PCH policies.

V. Determination and Notification Regarding Financial Assistance:

A. A determination of qualification for financial assistance will cover services provided by PCH (providers include Dr. Medina, MD; Theresa Ohl, FNP; Elke Houser, FNP; Danyeil Thomas, FNP) on an inpatient or outpatient basis (in both cases, based on information provided via the FAP attached as addendum 2) or to patients who have been determined to be Presumptively Eligible. The amount of financial assistance available to the patient will be determined by utilizing the Financial Assistance Guideline (Addendum 4). The Guidelines reflect family income levels tied to the most recent Federal Poverty Guidelines and establishing corresponding discount percentage. The Guidelines will be adjusted to reflect the annual update to the Federal Poverty Guidelines.

B. The applicable discount percentage from **Addendum 3** will be applied to the gross charges otherwise billable to the patient. Such discounts have been established in a manner intended to comply with applicable Federal law, which prohibits the Hospital from billing a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients with third-party coverage, calculated in this case using the look-back method set forth in applicable Treasury Regulations, considering amounts allowed by Medicare and commercial payors during a prior 12-month measurement period.

C. Within 15 business days after submission of a completed Financial Assistance Application, the Hospital will determine whether the patient qualifies for financial assistance based on Financial Assistance Guidelines and will notify the patient in writing of such determination and the amount of the discount to be provided. Unless otherwise determined by the PCH CFO, the Hospital need not notify patients determined to qualify for financial assistance based on Presumptive Eligibility. In the event that the Hospital determines a patient *not* to qualify for financial assistance, the Hospital will notify the patient in writing of such determination, including the basis for the denial; the notice will state that the patient may reapply if the patient's financial circumstances have changed so as to make the patient Financially Eligible in connection with future services.

D. Except as provided below, all determinations of qualification for financial assistance will be effective for a period commencing 8 months prior to the date of the completed Financial Assistance Application and continuing until the date that is 6 months following the date of the completed Financial Assistance Application. Accordingly, if a patient has qualified for financial assistance within the last 6 months and the patient's financial circumstances, family size, and insurance coverage have not changed, the patient will be deemed to have qualified for financial assistance with respect to additional emergency or medically necessary care, without having to submit a new Financial Assistance Application. However, if a patient has qualified for financial assistance but then experiences a material change in his or her financial circumstances and/or insurance status that may impact his or her continued qualification for financial assistance, the patient

will be expected to communicate that change to the Hospital within 30 days or, in any event, prior to obtaining further healthcare services. Alternatively, the Hospital may request an update of the information provided on the Financial Assistance Application and, based on such updated information, may re-evaluate the patient's continued qualification.

VI. Impact on Billing and Collection Process:

A. Patients qualifying for discounted, but not free, care will be notified in writing regarding any remaining balance due. Any such remaining balances will be treated in accordance with Patient Accounts policies regarding self-pay balances.

B. In the event that a patient qualifies for financial assistance but fails to timely pay the remaining balance due (including, if applicable, per the terms of the agreed-upon payment plan), the Hospital may take any of the actions set forth in the PCH Payment, Billing and Collection Policy, a copy of which is available at http://www.pchospital.us.

VII. Recordkeeping, and Reporting:

A. Completed Financial Assistance Applications (along with required supporting information) to be maintained in the Business Office records. Such records will also reflect information as to whether such Applications were approved or denied.

B. Financial assistance provided by the Hospital pursuant to this Policy will be calculated and reported annually as required under applicable law. Except as otherwise specifically permitted based on context, the Hospital will report its financial assistance provided to qualifying patients under this policy using the cost of services provided (not the charges for the associated services), with cost determined by applying the total cost-to-charge ratio derived from the Hospital's Medicare cost report.

VIII. Confidentiality:

The Hospital recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient's Financial Assistance Application may be released except where authorized by the patient or otherwise required by law.

XII. Other Related Policies:

A. Payments, Billing and Collection Policy

EXHIBIT 1

Financial Assistance Guidelines

2019 Federal Poverty Guidelines (FPG)

Family or Household Size	100% FPG	150% FPG	200% FPG	250% FPG	300% FPG	400% FPG
	Free Care	***70% Discount***	***60% Discount***	***50% Discount***	***40% Discount***	***30% Discount***
1	$12,490	$18,735	$24,980	$31,225	$37,470	$49,960
2	16,910	25,365	33,820	42,275	50,730	67,640
3	21,330	31,995	42,660	53,325	63,990	85,320
4	25,750	38,625	51,500	64,375	77,250	103,000
5	30,170	45,255	60,340	75,425	90,510	120,680
6	34,590	51,885	69,180	86,475	103,770	138,360
7	39,010	58,515	78,020	97,525	117,030	156,040
8*	43,430	65,145	86,860	108,575	130,290	173,720

* Add $4,420 for each additional person above 8 household occupants

The foregoing discount percentage has been established in a manner intended to comply with applicable Federal law, which provides that the Hospital may not bill a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients who have insurance covering such care. The Hospital has calculated its AGB using the look-back method set forth in applicable Treasury Regulations, considering amounts paid by Medicare and commercial payors.

There is a minimum $10 fee on any clinic visit that is approved for this financial assistance.

The Hospital will recalculate its AGB periodically (and at least annually) and, based thereon, may adjust the discount percentages set forth above. Any such adjustments will be effectuated through a revision to this **Addendum 3**.

Signed:_____

This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact Steph Denham, CFO or any Business Office personnel at *406-654-1100.*

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.

- ☞ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.
- ☞ NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided

FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address Since _____ Phone # (_____) _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Social Security # _____ Date of Birth _____

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position _____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This Semester _____

Employment information of Spouse (if applicable):

Spouse's Employer _____ Unemployed ? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This semester _____

IV. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Phillips County Hospital, and I authorize Phillips County Hospital to contact third parties to verify the accuracy of the information I have provided. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request_____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering to Steph Denham, CFO or to one of the PCH Business Office personnel at either:
  - 311 South 8th Ave East, Malta, MT 59538
- Mailing to Phillips County Hospital, ATTN - Steph Denham, CFO, Box 640, Malta, MT 59538

**** To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application *****

Applicants will be notified within 15 business days after submission of a complete application with all required supporting documentation