Financial Assistance Policy Manual

Policy Title: Charity Care	**Policy Number:** FIN02209
Department: Finance	**Effective Date:** 04-01-1999
Dates Reviewed: 6-18-2015	**Dates Revised:** 6/18/2015

CHARITY CARE POLICY:

Buchanan County Health Center's mission exists to provide and promote quality humanitarian healthcare services to individuals in need. As part of that commitment, Buchanan County Health Center appropriately serves patients in difficult financial circumstances and offers financial assistance to those who have an established need to receive medically necessary medical services.

Charity care is defined as healthcare services provided at no charge or at a reduced charge to patients who do not have nor cannot obtain adequate financial resources or other means to pay for their care. This is in contrast to bad debt, which is defined as patient and/or guarantor who, having the financial resources to pay for health care services, has demonstrated by their actions an unwillingness to resolve a bill. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account race, creed, gender, national origin, disability, age, social immigrant status, or sexual orientation.

PURPOSE:

Buchanan County Health Center (BCHC) is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for government sponsored program or otherwise unable to pay. BCHC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

The purpose of this policy is to provide guidelines (1) to ensure and protect for the orderly, reasonable and prompt collection of patient charges from patients who have the ability to pay; (2) to determine patients financial resources and ensure patients understand their financial obligations; and (3) to identify and determine eligibility for financial assistance for patients who do not have the ability to pay.

SCOPE:

This policy applies to all individuals who receive health services from or at BCHC, and from that, incur a financial obligation to BCHC.

The information contained and referenced in this Policy applies solely to healthcare services provided at and billed by BCHC.

#2090085

POLICY:

It is the policy of BCHC to:

1. Provide medically necessary healthcare services to all individuals without regard to any existing ability to pay.

2. Pursue payment for all services rendered to patients with the ability to pay through all reasonable means.

3. Provide financial discounts to qualifying persons for medically necessary healthcare services.

4. Comply with all applicable state and federal laws and regulations in performing its billing and collections functions.

DEFINITIONS:

1. **Annual Household Income** means the cumulative total of the gross income(s) for all members of the patient's household as shown on the IRS Form 1040 for all household members.

2. **Federal Poverty Income Guidelines (FPIG)** mean the federal income poverty guidelines updated and published annually by the United States Department of Health and Human Services.

3. **Government Health Care Program** means any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or in part by the U.S. Government or any state health care program. It includes Medicare, Medicaid, TriCare, VA, and state Medicaid programs. It does not include the Federal Employees Health Benefits Program.

4. **Guarantor** means the person(s) that are financially/legally responsible for the patient.

5. **Out of Pocket Expense(s)** means any payment for services, including but not limited to any deductible, copayment, coinsurance or other payment, that is the financial responsibility of the Guarantor under the terms of any applicable Government Health Care Program or any other third party healthcare benefits policy or plan.

6. **Uninsured** means any patient ineligible for benefits under a health insurance policy or health benefits plan, Government Health Care Program, workers' compensation or third-party liability (e.g., automobile accidents or personal injuries) insurance, or that is not a beneficiary of a health spending account, such as a health savings account, health reimbursement arrangement or health flexible spending account. A patient who has a health insurance policy or health benefits plan or Government Health Care Program

which requires such patient to make payment of Out of Pocket Expenses, or fails, in whole or part, to cover certain medical services or procedures, may be underinsured but is not uninsured.

7. **Underinsured** means any patient insured by a health insurance policy or health benefits plan, Government Health Care Program or that is a beneficiary of a health spending account (the amount that the patient/Guarantor has on deposit with the HSA being considered insurance), but who are not eligible, in whole or in part, for benefits on the health care services provided.

PROCEDURE:

For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by Buchanan County Health Center without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and,
4. Medically necessary services evaluated on a case-by-case basis at Buchanan County Health Center's discretion.

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social immigrant status, sexual orientation, or creed. Buchanan County Health Center shall determine whether or not patients are eligible to receive charity for deductibles, co-insurance, or co-payment responsibilities.

1. **Payment**. Patients or their responsible parties are expected to pay their full liability for services rendered, including any applicable discounts, within thirty (30) days of receipt of their first bill.

    A. **Forms of Payment**.

        i. BCHC will accept payment in cash, Visa or Mastercard debit card, check, money order, or credit card.

        ii. Completed BCHC Financial Assistance Program Application.

        iii. BCHC Instalment Payment Plan.

B. **Insurance Coverage**. BCHC will extend credit on insurance benefits in effect (i.e., commercial insurance or governmental health care program benefits) assigned to BCHC, minus applicable Out of Pocket Expenses, and will bill any payor(s) for the same at the time of service if the patient presents adequate information to determine coverage and proper filing of the claim. Reimbursement is expected from such third party and/or government payor(s) within 60 days of billing at which point the remaining balance becomes Guarantor responsibility, except where prohibited by law or contract.

C. **Employees**. Employee patient accounts will be handled in accordance with this Policy and in a manner consistent with that of any other BCHC patient. All employee payment arrangements must follow minimum payment requirements and timeframes as outlined in this Policy. BCHC also offers their employees the convenience of payroll deduction.

D. **Prompt Payment Discounts**. Prompt payment discounts are available only for current accounts (all patient service charges generated after the policy effective date) and will not apply to any payments made pursuant to an approved BCHC Installment Payment Plan.

2. **Basis for Calculating the Amounts.** The amount that a patient is expected to pay and the amount of financial assistance offered depends on the patient's insurance coverage and income and assets as set forth in the eligibility section of this Policy. The Federal Income Poverty Guidelines will be used in determining the amount of the write off and the amount charged to patients, if any, after an adjustment.

   Amounts charged for emergency and medically necessary medical services to patients eligible for Financial Assistance will not be more than the amount generally billed to individuals with insurance covering such care. All eligible patients that meet the financial assistance criteria would receive the average of our three lowest negotiated commercial insurance provider rates and then would receive the appropriate financial assistance discount based upon federal poverty levels. BCHC will provide an itemized statement to the patient showing the charges and the discount amount applied to the patient's account. The discount will be applied once the patient has submitted a complete application for financial assistance.

3. **BCHC Installment Payment Plans**. For Patients who do not otherwise qualify for the BCHC Financial Assistance Program and cannot reasonably make payment in full within 30 days of the statement date, BCHC will accommodate the following payment arrangements.

   A. Short-Term Installment Plans. BCHC will accept the following Short-Term Installment Plans:

      i. The Patient/Guarantor must meet the minimum monthly payment and minimum balance requirements set forth in the table below.

Short Term Installment Plans
Minimum Monthly Payment & Minimum Guarantor Balance Table

Minimum Balance*	**Payment in Full within days**	**Minimum Monthly Payment**
$0 - $250	90	$25
$251 - $500	180	$50
$501 - $750	270	$75
$751 - $1,000	365	$100
$1,001>	365	10% of outstanding balance

* The minimum balance means the aggregate outstanding balance for all BCHC accounts for such Guarantor.

ii. There is no interest charged on short-term installment plans.

iii. All short-term installment plans must be paid off in 12 months.

B. Long-Term Installment Plans. For Patients/Guarantors who cannot reasonably make payment in full within 12 months of the first billing date, BCHC may accept the following Long-Term Payment Plans:

i. The Patient/Guarantor minimum balance for all outstanding BCHC accounts must exceed $1,001.

ii. The minimum monthly payment must exceed $25, but in any case will not exceed 10% of the patient's gross monthly income.

iii. There is no interest charged on long-term installment plans.

iv. All long-term installment plans must be paid off in 36 months.

C. Alternative Installment Plans. Requests for alternative installment payment terms must be referred to the Chief Financial Officer (CFO) for review and approval.

4. **Settlements**. BCHC may employ discretionary discounting of account balance to obtain payment of outstanding balances on aged accounts and bad debt accounts.

A. All requests for settlement of account(s) must be directed to the CFO for review and approval.

B. All requests for legal settlements must be directed to the CFO for review and approval.

5. **Missed Payments**. There is no interest penalty for a missed payment. However, failure to make agreed upon payments under an installment plan or settlement may result in the cancellation of the payment arrangement, demand issued for payment in full and referral to a third party collection agency for additional collection activities. Payment arrangements may be reinstated at the discretion of the CFO, and in all cases where a patient/Guarantor pays all plan arrears by a BCHC approved date.

6. **BCHC Financial Assistance Program**. BCHC will provide financial assistance for eligible services to certain qualifying patients and Guarantors based on the following guidelines:

   A. Eligible Services. All medical services provided and billed by BCHC constitute an eligible service.

   B. Prompt Payment Discounts. Upon request, BCHC may grant up to a 15% prompt payment discount, which represents the cost to BCHC for collection of outstanding accounts, to eligible Guarantors/patients on Eligible Services if outstanding balance of the patient/Guarantor account is paid in full within 30 days of the first statement date. Prompt payment discounts may not be combined with Charity Care discounts. Any prompt payment discount will be disclosed to the patient's third party payer. BCHC will bear the cost of all prompt pay discounts.

   C. Charity Care Discounts. Charity Care discounts will be available to eligible patients/Guarantors for outstanding Eligible Services to the extent described below.

Table 2(C)(i) - Percentage Discount For Charity

Based on Family Size/Income

Family Size	Household Income	3 times Poverty Limits
1	$ 11,770	$ 35,310
2	$ 15,930	$ 47,790
3	$ 20,090	$ 60,270
4	$ 24,250	$ 72,750
5	$ 28,410	$ 85,230
6	$ 32,570	$ 97,710
7	$ 36,730	$ 110,190

8	**$ 40,890**	**$ 122,670**
Add	**$ 4,160**	**$ 12,480**

2015- U.S. Dept. Health & Human Svcs

http://aspe.hhs.gov/poverty/15poverty.cfm

Table 2(C)(i) - Percentage Discount For Charity

Based on Family Size/Income

Charity Rate: FPIG Amount	**Charity Limits ***
0—100%	**100%**
101—140%	**90%**
141—160%	**80%**
161—180%	**75%**
181—200%	**65%**
201—240%	**50%**
241—260%	**40%**
261—280%	**30%**
281—300%	**20%**

*= Guideline only-discretion of CFO who can alter.

1. Charity Care discounts may not be combined with prompt pay discounts.
2. All Charity Care adjustments must be approved by the CFO.

D. **Eligibility Requirements.** Financial Assistance discounts are secondary to all other financial resources available to a patient/Guarantor. To be eligible to participate in the BCHC Financial Assistance Program and receive prompt pay or charity care discounts, patients/Guarantors must meet the following criteria:

i. Financial Resources.

1. Patient must be Uninsured or Underinsured;

2. Guarantor's Annual Household Income cannot exceed 300% of the FPIG, based on Guarantor Family Size.

3. In addition to income, BCHC will consider the extent to which the Guarantor has other available resources, including assets other than income (including but not limited to cash, savings and checking accounts, certificates of deposit, stocks and bonds, individual retirement accounts, trust funds, real estate and motor vehicles), and the likelihood of future earnings (net of living expenses) that could be used to meet the financial obligation for the health care services provided. BCHC will also take into account any liabilities that are the responsibility of the Guarantor.

ii. Other Considerations. At the discretion of the CFO and in all cases subject to review of the individual circumstances, the following patients/Guarantors may be eligible participate in the BCHC Financial Assistance Program:

1. Patients/Guarantors enrolled in a Government Health Care Program in which BCHC is not enrolled as a provider or is ineligible to enroll as a provider and therefore cannot obtain payment.

2. Patients who are deceased and have no estate.

3. Patients who are bankrupt.

4. A patient requiring emergency care that does not qualify for the BCHC Financial Assistance Program, but whose patient responsibility incurred for medical care at BCHC, even after payment by third-party payers, significantly exceeds the patient's ability to pay.

5. A patient unable to pay due to a catastrophic financial situation.

E. **Determination of Eligibility for Charity Care Discounts**.

i. Application. BCHC shall use an application process for determining eligibility for Charity Care. Any patient/Guarantor who refuses to complete the application will be considered as having the ability to pay his account and subject to the normal account flow process for collection.

ii. Presumptive Eligibility. If BCHC becomes aware of factors which might qualify the patient for Charity Care discounts (for example, the applicant is eligible for another government program with the same or more restrictive income requirements such as food stamps, low income housing assistance etc.), it shall advise the patient of this potential and grant appropriate Charity Care discounts on a "presumptive basis".

iii. Retroactive Review. BCHC, or a contracted third party, may perform retroactive reviews of accounts referred to outside collection agencies periodically, to determine if any accounts would have been more properly recorded as Charity Care discounts and, if so, BCHC will recall such accounts from the outside collection agency and reclassify them to the BCHC Financial Assistance Program, in accordance with generally accepted accounting principles.

iv. Final Determination. Determination of eligibility for Charity Care discounts will be made within a reasonable period of time after a completed application has been received along with ALL supporting documentation. BCHC may utilize information from a third party consumer reporting agency to determine eligibility for presumptive Financial Assistance. Pending final determination, BCHC will not initiate collection efforts or request deposits, provided that the Guarantor is cooperative with BCHC's efforts to reach a final determination status.

v. Supporting Documentation. Supporting documentation must include documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the Guarantor, other available resources, liabilities, verification family size and proof of residency. Should documentation not be supplied or should the application remain incomplete, financial assistance will NOT be granted. BCHC reserves the right to request additional supporting documentation deemed necessary and/or waive any documentation requirement in determining eligibility for the Financial Assistance Program.

vi. Eligibility Period. Recipients will remain eligible for Charity Care discounts for up to one year, unless patient's/Guarantor's financial status changes within the year.

vii. Utilization Review. BCHC reserves the right to review utilization of BCHC services by Charity Care recipients on a quarterly basis.

Recipients that are determined to be utilizing BCHC services inappropriately may be required to receive additional service utilization counseling to remain in the Program.

viii. Appeals. Reconsideration of eligibility for financial assistance may be requested by providing additional verification of income or family size to the CFO within 30 calendar days of receipt of notification. The CFO will review all requests for reconsideration and will make the final determination. If the determination affirms the previous denial of financial assistance, written notification will be sent to the Guarantor.

ix. Non-Discrimination. Determination of eligibility for the BCHC Financial Assistance Program shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, sexual orientation, age, handicap status, or marital status.

F. **Patient Responsibilities**.

i. Payment Contribution. Financial assistance does not eliminate personal responsibility. Patients/Guarantors are expected to contribute to the cost of their care based on their individual ability to pay.

ii. Provide Information. Patients/Guarantors must provide BCHC with the necessary financial and personal documentation that is required in determining eligibility for applicable financial assistance programs and inform BCHC of any changes in the patient's/Guarantor's income, financial or insurance status.

iii. Utilization of Available Insurance Options. BCHC requires that patients utilize any options that they have for insurance from an employer, as long as such insurance is available at reasonable cost, or other source, such as Medicaid, Medicare, third party liability, etc., before they are eligible for BCHC Financial Assistance Program. BCHC will initially assist the patient in applying for agency assistance. The patient must cooperate with these agencies including provided necessary documentation and complying with requests for interviews. Failure to complete the application process with an agency will result in an automatic denial of Financial Assistance from BCHC.

G. **Communications to the Public**. Information about BCHC's financial assistance program shall be made publicly available as follows:

i. Placing signage, website information, or brochures in appropriate areas of BCHC (e.g., the Emergency Department and organized registration areas) stating that BCHC offers financial assistance and describing how to obtain more information about the BCHC Financial Assistance Program.

ii. Designating departments (Registration, Business Office, and Social Service) who can provide the patient with the necessary financial assistance application.

iii. Staff that interacts with patients will be instructed to direct questions regarding the BCHC Financial Assistance Program to the proper representative. (Social Service or Business Office)

iv. The Financial Assistance Policy will be placed on the website in a location visible and available to the public.

H. **Confidentiality; Record Keeping**. All information obtained from patients, Guarantors and family members shall be treated as confidential. BCHC will retain a central repository by each patient/Guarantor containing financial assistance applications. A listing of all charity care discounts shall be maintained by the Business Office, documenting patient names, patient account numbers, dates of service, brief descriptions of services provided, total charges, amounts written-off to charity, dates of write-offs and the names of the authorizing individuals. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file in the Business Office.

4. **Discounts for Government Health Care Program Patients.** In limited instances and only where permitted by federal and state law, BCHC may waive or discount Out of Pocket Expenses for patients participating in Government Health Care Programs, including financial assistance discounts, if all of the following requirements are met:

A. The waiver is not advertised or otherwise solicited;

B. The waiver is not routinely offered; and

C. The waiver is made:

i. after determining, in good faith, that the individual is in financial need;

ii. after reasonable efforts have failed to collect the co-payments or deductibles directly from the patient; or

iii. in settlement of a disputed claim resulting from the services provided to the beneficiary.

Other circumstances may warrant the non-routine waiver of Government Health Care Program co-insurance or deductibles. The CFO or their designee may approve specific waivers. Prompt pay discounts may be provided to Government Health Care Program patients to the extent all of the safeguards outlined in this Policy under Section 5 relating

to prompt pay discounts are followed and the discount is disclosed to the Government Health Care Program.

Appropriate written records documenting the reasons for each waiver or discount shall be maintained as cost report supporting documents.

1. **Collection Process**. The Business Office of BCHC or its designee will attempt to collect all debts by way of monthly statements, telephone contacts, and/or collection letters. Uncollected delinquent accounts may be referred to an external collection agency or attorney for continued collection.

RESPONSIBILITIES:

In implementing this Policy, BCHC's management shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy. Questions regarding this Policy should be directed to the Chief Financial Officer, or the H.I.S. Manager.

Buchanan County Health Center

Here for you. Trusted for life.

Finance
1600 First Street East
Independence, IA 50644
Office: (319) 332-0999
www.bchealth.info

Application for Financial Assistance

In recognition of Buchanan County Health Center's policy to provide quality health care to all persons regardless of their financial status, the financial assistance program provides assistance to those in need in a fair, non-discriminatory manner.

Financial Assistance Instructions:

1. A completed application must be returned to the hospital for consideration within 30 days of issue. Financial Assistance is only available for BCHC hospital services.
2. To be eligible for financial assistance, each applicant must meet minimum gross income requirements set by the Federal Government along with cash and asset requirements.
3. Buchanan County Health Center reserves the right to request verification of income. Refusal of an applicant to provide any requested information may result in denial of financial assistance.
4. Buchanan County Health Center will submit a response to the applicant within 14 working days of the receipt of a completed application and supporting information.
5. Only ONE financial assistance determination will be made per account.
6. Financial assistance applicants will be responsible for paying the balance remaining on an account after any assistance has been granted WITHIN 60 DAYS. Failure to pay the remaining balance may cancel any assistance granted on the account. Payment arrangements may be extended due to special situations.
7. Complete all the questions on the application for financial assistance.
8. Enter employment information for both husband and wife. If unemployed enter "unemployed" under employer, indicate date of unemployment under employment date and indicate current monthly gross income.
9. Other income sources should include income from self-employed business ownership, farm and any other income received.
10. Complete cash assets section for both husband and wife.
11. Both husband and wife must sign and date the application.
12. Please submit the following information along with your application. Financial assistance cannot be provided without the requested information:
    a. _____ Copy of your most recent paycheck stub/voucher
    b. _____ Verification of monthly income from Social Security if applicable
    c. _____ Verification of unemployment income if applicable
    d. _____ Copy of your _____ calendar year signed Federal Tax Return
    e. _____ Copy of last month's complete bank checking and savings statements

If you have any questions call the Health Center's business office at 319-332-0999.

Buchanan County
HEALTH CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

For Office Use Only *Date Issued:* _____ *Date Received:* _____

Patient Account Number(s): _____

Date of Service: _____ Name of Patient: _____

APPLICANT INFORMATION:

Applicant Name: _____ / _____ / _____
First *Middle* *Last*

Applicant Birthdate: _____ / _____ / _____ Applicant Social Security Number _____ - _____ - _____

Address: _____ _____ _____ _____
Number and Street *City* *State* *Zip*

Telephone Number: ( ) _____ Cell Phone Number: ( ) _____

Spouse Name: _____ / _____ / _____
First *Middle* *Last*

Spouse Birthdate: _____ / _____ / _____ Spouse Social Security Number _____ - _____ - _____

Residence: ☐ Own ☐ Rent ☐ Reside With Family Member ☐ Other: _____

Amount of Rent / Mortgage: $_____

Are you a United States Veteran? ☐ Yes ☐ No Are you required to file a tax return? ☐ Yes ☐ No

Is your spouse? ☐ Yes ☐ No Is your spouse? ☐ Yes ☐ No

DEPENDENT INFORMATION:

Number of Adults: _____ Number of Children: _____

Names and Ages of Children: _____

EMPLOYMENT INFORMATION:

First Name	Employer	Length of Employment	Full Time	Part Time	Pay Period: Weekly, Monthly Bi-Monthly, etc.	Hours Worked Per Pay Period	Hourly Pay

OTHER INCOME SOURCES:

Sources	Applicant	Spouse	Total Amount Received
Unemployment Benefits			
Disability Benefits			
Social Security Benefits			
Child Support			
Alimony			
Interest Income			
Pension Benefits			

ASSETS:

Financial Institution	Names on Account	Checking Account Number	Checking Account Balance	Savings Account Number	Savings Account Balance

OTHER ASSETS:

Assets	Applicant	Spouse	Cash Value
Stocks / Bonds / C.D.			
Life Insurance			
401k / Retirement Savings Plan			

Comments: _____

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services provided. I hereby grant permission to Buchanan County Health Center to investigate the information contained herein.

Applicant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Send completed application to: Business Office
Buchanan County Health Center
1600 First Street
Independence, Iowa 50644

For Office Use Only:
Approval Percentage: _____

Approved by: _____ Date: _____