

Financial Assistance for Patients – Hospital

POLICY

Royal Oaks Hospital will provide charity care or financial assistance to eligible patients based on 300% of the current Federal Poverty Guidelines as published by U.S. Department of Health and Human Services. Any patient may apply for financial assistance for medically necessary services and all applications will be considered without regard to race, ethnicity, income, gender, religious preference, disability, or any other category. Charity care and/or discounts from hospital charges will be calculated using the following standards:

- **Family Income below 200% of Poverty Guideline = 100% Charity**
- **Family Income between 200-250% of Poverty Guideline = 75% Charity**
- **Family Income between 251-300% of Poverty Guideline = 50% Charity**
- **Any amount of hospital charges due from a patient that exceeds 35% of their family annual income will be considered charity.**

Patients who may be eligible to receive Charity care, or a discount on hospital charges must complete a Financial Assistance Eligibility Application (Exhibit A) and must present required documentation to substantiate their family income during the past six months. It is not required that a patient do this prior to receiving services at Royal Oaks Hospital.

The hospital will limit amounts charged for medically necessary care to an individual who is eligible for financial assistance pursuant to the hospital's Financial Assistance Policy to not more than amounts generally billed (AGB).

The hospital's AGB will be calculated by the "look-back method", which entails calculating the ratio of the amounts allowed by third-party payers (Medicare, Medicaid, and commercial insurances) vs. these billing's corresponding charges, over a specified period of time. The Hospital's AGB calculation will be updated yearly within 120 days after its fiscal year-end, and will use the prior fiscal year's charges as the basis of the calculation. The hospital will maintain an attachment outside this policy that updates the AGB calculation (see Exhibit H).

AUTHORITY/REFERENCE

Health and Human Services guidelines

PROCEDURE

- A. The hospital will post signs in its front lobby and in its admissions office that notify patients and/or their guardians that financial assistance for free or reduced hospital services is available for those who qualify. At the time of admission for hospital care, the Hospital Admissions Staff will advise each patient of the financial assistance policy and will be responsible for providing a Financial Assistance

Eligibility Application to those patients and/or guardians who request it. The application period begins on the date of discharge and will extend 365 days from said date. The patient will have the right to request this application at any time within the above mentioned period, and the provision of services is not contingent on them completing this application. Completed applications will only be considered after all third-party coverage has been exhausted. If a patient does not have Medicaid, but would qualify, he/she must cooperate with the Medicaid application process. Only if the Medicaid application is denied or the patient is deemed ineligible may the Financial Assistance Eligibility Application be considered. Only patient balances will be considered for charity or discount assistance. The patient's balance is considered that amount for which there is no third-party coverage or other funding available.

1. If the hospital has previously denied an application for charity and/or discount from charges, and the patient and/or guardian's income changes significantly while an outstanding balance for hospital charges exist, they will be entitled to complete another Financial Assistance Eligibility Application and submit new supporting documentation for re-evaluation. Any payments previously made to date will be counted toward the amount due, and the hospital will not refund any of those payments to the patient.
2. The hospital will not grant charity care and/or a discount for hospital services when such action would be deemed a violation of federal or state law.

B. Eligibility Definitions

The following definitions are pertinent to eligibility

1. **Indigent**

A person who is a member of a family unit (if applicable) whose income falls within the applicable percentage of the current federal income poverty guidelines; **and** a person who is not eligible to receive benefits from other third-party payment sources, including private insurance, or a patient who is eligible to receive such third party payment benefits to the extent that such benefits do not provide adequate compensation for the cost of services rendered.

2. **Charity Care**

Hospital services that are provided to an Indigent patient and the hospital has pre-determined that patient has no ability or resources to pay for the care and no other third-party payer options exist. Services that are provided as Charity care are "written-off" from the hospital's financials and accounts receivables without billing or expecting payment from any source.

3. **Service area for Royal Oaks Hospital (primary & secondary)**

Primary service area includes the following Missouri Counties: *Henry, Johnson, Lafayette, Saline, Howard, Boone, Cooper, Pettis, Moniteau, Cole, Morgan, Miller, Camden, Hickory, Benton, Polk, St. Clair, Cedar, Vernon, Bates and Cass*. The secondary service area includes all other Missouri counties.

4. **Eligible Providers**

All providers employed of and billed by the Hospital and/or Compass Health, participate in the Financial Assistance Program. See Exhibit G for further information.

5. **Contractual adjustments**

The difference between actual hospital charges and any contractual agreement with third party payers.

6. **Bad debt**

Outstanding patient balance that is not eligible for a discount, or third party for which the hospital expected payment and for which all possibilities of payment has been exhausted.

7. Indigent care bad debt

Unpaid balance of patient's responsibility that remains unpaid after good faith effort to collect.

C. Eligibility Guidelines

1. Eligibility is based on residency, income and family size.

a. Residency

The applicant must be a permanent resident of Royal Oak Hospital's primary or secondary service area to be eligible for discounted services.

- i. If a person is an immigrant, to prove residency an applicant must have an "Alien Resident Card" or a "United States Citizen Identification Card".

b. Income Determination

Eligible residents will be asked to disclose and document all sources of income received by the family unit. This includes an unmarried couple applying for assistance. If a patient and/or guardian is unable to provide documentation, staff will gather what information they can and present to the Hospital President, CEO or CFO. This individual will have the authority to draw appropriate conclusions based on what the patient provides, and the staff present and/or documents on the discount application and will accept it as the truth.

- i. **No income** - When a patient claims no income, they must complete a signed affidavit, witnessed by a hospital representative attesting to the income amounts. This can be done using the Income Address Certification form.
- ii. **Income sources** will include last four paycheck stubs, previous year W-2 earnings statements from all adults living in the home. It will also include settlement payments, social security payments, pension and retirement payments, workers compensation payments, unemployment compensation, veterans' payments, child support payments, alimony payments, public assistance payments, lottery/gambling winnings and any other reportable income from other sources.

iii. Income calculations

- a. 3 months of income provided
 - Multiply total income by 4 to calculate annual income
- OR**
- b. 12 months of income provided
 - Total income listed will be annual income
- c. Self Employed and all expenses for 3 full months provided
 - Total all income from the 3 months
 - Subtract all expenses from the income
 - Multiply by 4 to arrive at annual income
- d. Last check stub showing *Year to Date* income
 - Divide YTD by number of months to get a monthly average
 - Multiply monthly figure by 12 to calculate annual income

2. Family Unit

A family is two or more persons related by marriage, birth, or adoption who reside together; all such related persons are considered as members of one family. This includes an unmarried couple applying for assistance if they have mutual children together, a minor for whom the patient or spouse has been given the legal responsibility by a court, any person designated as "dependent" on the patient and/or guardian's latest tax return, any student in the family over the age of eighteen or any other family member dependent on the patient and/or guardian's

family income for over fifty percent support and any minor child of a minor who is solely or partially supported by the minor who is a member of the patient and/or guardian's family.

3. Net Worth Calculation

A patient's ability to pay may not be represented by an income test alone. The Financial Assistance Eligibility application includes questions that also evaluates the patient and/or guardian's overall net worth and potential for seeking available credit. Net worth is defined as the value of all possessions less any outstanding debts or obligations. This would include an evaluation of equity in real estate, equity in other assets, stocks, bonds, CDs, Trust funds and available credit lines at banks or credit cards. Should the patient and/or guardian have an overall net worth in excess of ten times that of the total hospital charges due, the Hospital President, CEO or CFO may deny the application even though the patient and/or guardian meets the income criteria.

4. Eligibility Period

Eligibility will be limited to a single episode of care and will be re-assessed with each admission.

D. Circumstances for Administrative Approval of Charity Care or discount from Hospital charges without completion of a Financial Assistance Eligibility Application from the Patient.

There may be certain circumstances or conditions where Charity Care or a discount from Hospital services is approved by the Hospital President, CEO or CFO without the necessity of the patient and/or guardian completing the Financial Assistance Eligibility Application. Examples of these circumstances are as follows:

1. Homeless Persons - A Homeless person is defined as an individual who has no home or haven and depends on charity or public assistance. Such individuals will generally be eligible, even if they are unable to provide all of the documentation required for completing an application.
2. Deceased Patients – A patient who has died may be considered for Administrative charity write-off if there is no estate. In such cases, the patient income should be deemed as zero.
3. Illegal Immigrants – Individuals who are unable to provide appropriate documentation to prove United States citizenship. Generally, these individuals have limited or no resources available to pay for health care.
4. Medicaid Patients - If a patient qualifies from Medicaid, he/she will be considered eligible for charity for any remaining balance after Medicaid has paid and/or exhausted benefit limits

E. Evaluation, Approval and Notification

1. Completed applications and supporting documentation submitted by the patient and/or guardian should be sent to the Billing Office.
2. The Billing Office staff will review the application and supporting documentation for its completeness. If the application is not complete, or the patient and/or guardian has failed to provide the supporting documentation required, the Director of Patient Accounts will mail a dated letter (example attached as Exhibit E) that clearly explains what is needed to complete the application. This letter will also provide the option of the patient and/or guardian to come to the hospital to receive assistance from the Business Office in completing the application. A copy of this letter will be maintained in the financial billing folder and/or will be scanned as an attachment to the electronic billing record.
3. Patients and/or Guardians will be given sixty (60) days from the date of the letter to comply to the requests and complete the application and/or provide the supporting documentation. During this period of time, the Billing Office will suspend billing for any of the balance due from

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the patient. Should the patient and/or Guardian fail to submit the completed application and/or supporting documentation within this sixty-day period, billing of the patient balance with resume.

4. If an application remains incomplete for a period of six months, it will be considered expired, and the patient and/or guardian must submit a new application and updated supporting documentation.
5. Once an application is fully completed by the patient and/or guardian, the Billing Office Staff will present it to the Hospital CEO and COO Billing Office Supervisor for approval. A monthly report of charity care is reviewed by the Hospital CEO and COO.
6. The Billing Office staff will send a letter to the patient and/or guardian notifying them of the decision. (Approval or denial) Examples of such letters are attached as Exhibits C & D). A copy of such letter will be kept in the Patient Financial Accounts folder and/or scanned as an attachment to the electronic billing record.
7. The Billing Office staff will post the approved charity amount or discount amount to the Hospital Accounts Receivable/Billing System.

F. Collection Efforts

1. Royal Oaks billing and collection functions are conducted by its parent company, Compass Health, Inc. Policies on collection efforts FAP patients are inclusive under Compass Health's Accounts Receivable policy. This policy is available upon request.

G. Updates to Policy

1. This policy should be updated on an annual basis to reflect changes in the following:
 - a. Published changes in the Federal Poverty Guidelines
 - b. Hospital's Financial ability to provide Charity care
 - c. Changes in State and Federal Regulations
2. It will be the responsibility of the Hospital CFO to review and implement changes to this policy on an annual basis and to ensure that Hospital personnel are adhering to the current policy.