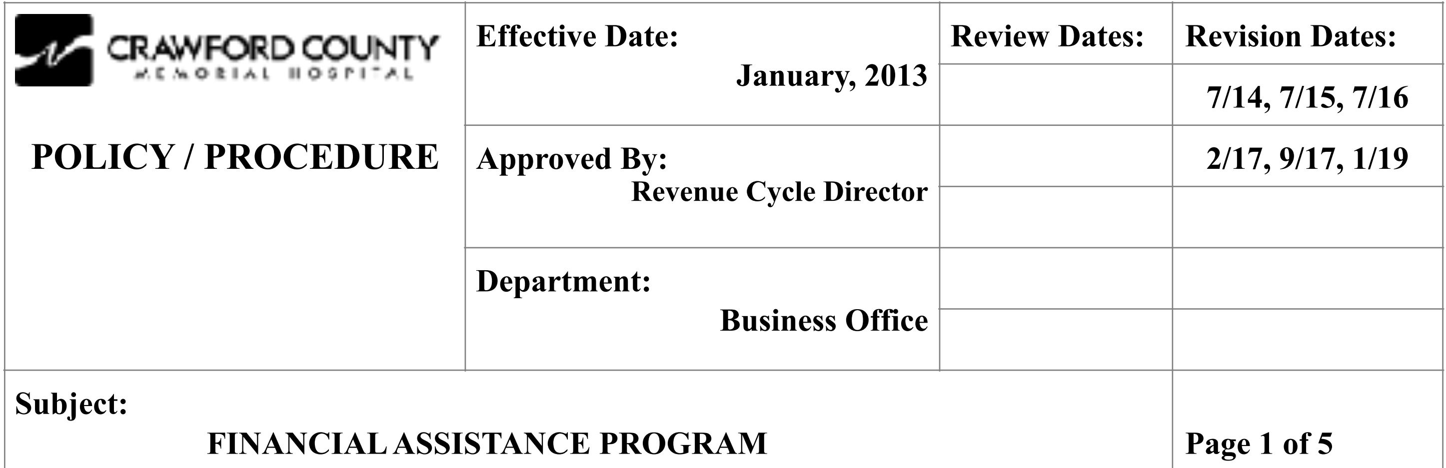
Policy / Procedure # 101.18



CRAWFORD COUNTY MEMORIAL HOSPITAL — POLICY / PROCEDURE	Effective Date: January, 2013	Review Dates:	Revision Dates:
			7/14, 7/15, 7/16
	Approved By: Revenue Cycle Director		2/17, 9/17, 1/19
	Department: Business Office		
Subject: FINANCIAL ASSISTANCE PROGRAM			Page 1 of 5

PURPOSE

Crawford County Memorial Hospital is dedicated to improving the lives of the patients and their families through the delivery of compassionate and effective healthcare.

Crawford County Memorial Hospital, as a public county hospital, is dedicated to providing to qualified patients an avenue to apply for and receive free or discounted care based upon demonstrated financial need.

ELIGIBILITY CRITERIA

Definitions

The following definitions apply to Financially Indigent eligibility criteria:

> "Uninsured": A patient who (i) has no health insurance or coverage under governmental health care programs, and (ii) is not eligible for any other third party payment such as worker's compensation or claims against others involving accidents.
>
> "Underinsured": A patient who (i) has limited health insurance coverage that does not provide coverage for hospital services or other medically necessary services provided by the Hospital, or (ii) has exceeded the maximum liability under his/her insurance coverage.
>
> "Household Income": The total income of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.
>
> "Net Worth": Net asset value (assets – liabilities (excluding Hospital liabilities) of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy but does not include a patients primary residence, qualified retirement accounts, nor one vehicle.
>
> "Financially Indigent": A patient having a Household Income less than or equal to 200% of the Federal Poverty Level and having a Net Worth less than or equal to such level that is set by this Program.

Eligibility

To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or greater than 225% of Federal Poverty Level; provided, however, that patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of $8,000 do not qualify as Financially Indigent.

Furthermore, patients who may be eligible for Medicaid or other government assistant (e.g. Hawk-i) and fail to apply for such governmental assistance are not considered eligible for financial assistance under this policy.

Patient Responsibilities
The patient has a number of responsibilities to meet in order to qualify for Financial Assistance including:

1. Obtaining insurance coverage if affordable coverage is available to them.
2. Applying for any government sponsored insurance programs that they may qualify for.
3. Submitting all requested documentation concerning income, assets and residency that is needed to verify their qualifications for any financial assistance in a timely manner.
4. Keeping income, asset, demographic and insurance information updated to CCMH.
5. Paying all balances in accordance within the agreed time frames.
6. If a patient does not pay or is not making payments on an account with a charity care discount, he/she may be denied future assistance.

Categories of Care Eligible for Financial Assistance
Provided that the patient qualifies as Financially Indigent the following classes of care are eligible for financial assistance under the policy:

Emergency Medical Care
1. ER/Emergency Medical Services.
2. Emergency Ambulance Services provided by CCMH.

Medically Necessary Care
1. Doctor ordered routine nursing care and those ancillary services.
2. Out-Patient IV / Chemotherapy Services.
3. Physical, Occupational, Pulmonary, and Speech Services.
4. Cardiac Rehab Phase II Services.
5. MRI, CT, Ultrasound, etc. Services.
6. CCMH Physician Clinic Services.
7. Observation, Acute, or Skilled Services.

Categories of Care Not Eligible for Financial Assistance
Generally, any class of care which is not listed as eligible for assistance is not eligible for financial assistance, which includes, but is not limited to:
1. Physician fees including radiologists, pathologists, or any independent contractor not employed by CCMH.
2. Cosmetic or not medically necessary surgical services
3. Phase III cardiac rehab services.
4. Sleep studies
5. Fertility testing

Covered Providers:
Care provided by Crawford County Memorial Hospital and CCMH employed physicians and practitioners is covered by this policy. Care provided by independent community physicians and other independent service providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance.

Patients may obtain a current list of providers who are and are not subject to this policy at no charge by visiting a Financial Counselor or by calling 712-265-2500 or visiting the facility website at www.ccmhia.com.

Payment Requirements and Payment Plans
Discounts approved under this policy will be applied when a patient is deemed qualified. Payment plans will be offered in accordance with existing guidelines under CCMH's Payment, Credit & Collections Policy.

LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED

Patients who are deemed to be eligible for financial assistance will not be charged more than Amounts Generally Billed by the Crawford County Memorial Hospital. Discounts granted to eligible patients under this policy will be taken from gross charges.

Calculation of Amounts Generally Billed

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Crawford County Memorial Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is CCMH's gross charges multiplied by the AGB Percentage. Patients may obtain CCMH's most current AGB Percentage and a description of the calculation in writing, free of charge, by visiting a Financial Counselor or by calling 712-265-2500. CCMH calculates its AGB Percentage on an annual basis. For purposes of this policy each new AGB Percentage will be implemented within 120 days of the 12 months period used by CCMH to calculate the AGB Percentage.

Amount of Financial Assistance/Discount

Patients who qualify for financial assistance as Financially Indigent are eligible for financial assistance based upon the following sliding fee scale for 2020:

Family Size	1	2	3	4	5	6	7	8	Add'l
Income	12,760	17,240	21,720	26,200	30,680	35,160	39,640	44,120	4,480

Poverty Guideline	% Written Off
0 – 125%	100%
126 – 160%	75%
161 – 190%	50%
190 – 224%	25%
225 – OVER	0%

Such scale will be updated on an annual basis by referencing the U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs as reported by the U.S. Department of Health and Human Services.

If financial assistance provided to the patient results in a charge greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

Medical Settlement:

In the event that there is a liability claim paid or a medical settlement made to the patient for medical/surgical bills that the patient applied to have treated as Financial Assistance, the Hospital reserves the right to void the application for Financial Assistance, approved or not, seek restitution from the patient, and pursue whatever legal recourse is necessary to secure payment.

APPLICATION PROCESS & DETERMINATION

Patients who believe they may qualify for financial assistance under this policy are required to submit an application on the Hospital's financial assistance application form during the Application Period.

For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 120th day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date the Hospital provides the patient the requisite final notice to commence extraordinary collection actions ("ECAs").

Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial assistance application free of charge (i) by mail by calling 712-265-2500 (ii) by download from the facility website at www.ccmhia.com , or (iii) in person at (a) the emergency room, (b) admission areas, or (c) patient financial services at the main hospital entrance.

Emergency Medical Care
Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under this financial assistance policy. CCMH will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical treatment conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with CCMH policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

No Application Submitted
If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and
2. Provides at least thirty (30) days' notice to the patient that:
    - Notifies the patient of the availability of financial assistance;
    - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and
    - 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 patient;
3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and
4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

Incomplete Applications
If a patient submits an incomplete financial assistance application during the Application Period, "reasonable efforts" will have been satisfied if the Hospital:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information of the Hospital department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 30 days to provide the required information; and
2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, the Hospital must suspend ECAs and make a determination on the application.

Completed Applications
If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if the Hospital does the following:

1. Suspends all ECAs taken against the individual, if any;
2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and

3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If the Hospital has requested that the patient apply for Medicaid, the Hospital will suspend any ECAs it has taken against the patient until the patient's Medicaid application has been processed or the patient's financial assistance application is denied due to the failure to timely apply for Medicaid coverage.

If a patient is eligible for financial assistance other than free care, the Hospital will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the ABG for the care provided;
2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to the Hospital (unless such amount is less than $5); and
3. Take reasonable measures to reverse any ECAs taken against the patient.

COLLECTION ACTIONS

For further information on the actions the Hospital may take in the event of non-payment, please see the Hospital's Payment, Credit & Collections Policy (CCMH Policy #101.16). Patients may obtain the Payment, Credit & Collections Policy free of charge (i) by contacting patient financial services at 712-265-2500, (ii) by request in person at patient financial services, the emergency room front desk or the admissions desk.

ADDITIONAL INFORMATION

Confidentiality and Record Keeping
All information obtained from patients, guarantors and family members shall be treated as confidential. CCMH will retain a central repository by each patient/guarantor containing financial assistance applications. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

Due Process
If the applicant is not satisfied with the decision rendered, he/she may request a meeting with the Patient Financial Services Director to ascertain the rationale used in making the decision.

If the applicant is not satisfied with the explanation given by the Patient Financial Services Director, he/she may request a meeting with the CFO or CEO of the Hospital.

Notification to the Public
Notifications of Financial Assistance opportunities will be posted in the Admitting areas, Emergency Room and other Outpatient areas of the Hospital. It will also be included in the information packets given to patients who are admitted to the medical/surgical area.

Annual Review
The income guidelines and criteria for approval will be reviewed on an annual basis to assure that the Financial Assistance Program of Crawford County Memorial Hospital is current in meeting the needs of the medically indigent.

CRAWFORD COUNTY MEMORIAL HOSPITAL

TO APPLY FOR FINANCIAL ASSISTANCE

- Complete the financial assistance application enclosed
- Provide the Hospital with a letter from the Department of Human Services indicating if you do or do not qualify for the assistance from them.
- Proof of your income in the form of: copies of your latest State and Federal Income tax return, copies of your most recent bank statement and copies of your most recent pay stub.
- Other documentation as requested.

Application must be completed and returned along with all required documentation to Crawford County Memorial Hospital by: ____

If you have any questions, please call (712) 265-2500.

APPLICACION PARA ASISTENCIA FINANCIERA

- Complete la aplicación de asistencia financiera.
- Provea a Crawford County Memorial Hospital una carta del Departmento de Servicios Humanos indicando si usted si califico o no califico para la asistencia departe del Departamento de Servicios Humanos.
- Prueba d ingresos en la siguiente forma: copias de los más reciente impuestos Estatales y Federales, copias del más reciente estado de cuenta bancario y un talon de pago.

Por favor complete y regrese la aplicación y la documentación requerida por Crawford County Memorial Hospital para la Siguiente fecha: ____

Si usted tiene preguntas, por favor llame (712) 265-2500.

100 Medical Parkway
Denison, IA 51442
(712) 265.2500
(888) 747.0852 *toll free*

(712) 265.2533 *fax*

CRAWFORD COUNTY MEMORIAL HOSPITAL

Exhibit B

Date Received___________

FINANCIAL ASSISTANCE APPLICATION

▫ Application is in Advance of Services ▫ Application is After Services Provided

As provided in the Crawford County Memorial Hospital Charity Care Policy, I hereby request consideration of my eligibility to receive reduced care at Crawford County Memorial Hospital/CCMH Medical Clinic.

FILLING OUT THIS APPLICATION IS NOT A GUARANTEE OF ACCEPTANCE

Responsible Party / Applicant Information

Full Name Home Phone

Street Address Cell Phone

Mailing (If Different) Work Phone

City State Zip Code

Date of Birth SS#

Resident of Crawford County ___Yes ___No

Are you: ❑ Pregnant ❑ Blind ❑ Disabled ❑ Active Duty Service (Military)

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Unmarried (Single or Widowed)

Employment ❑ Not Employed Since ___________ ❑ Retired Since _____________
❑ Disability since __________ ❑ Laid off since _______________

Employer Hourly wage/salary $

Employer Phone

City State

How Long Employed? How Often Paid?

Spouse / Significant Other Information

Full Name Cell Phone

Date of Birth SS#

Is spouse/significant other: ❑ Pregnant ❑ Blind ❑ Disabled ❑ Active Duty Service (Military)

Employment ❑ Not Employed Since ___________ ❑ Retired Since _____________
❑ Disability since __________ ❑ Laid off since _______________

Employer Hourly wage/salary $

Employer Phone

City State

How Long Employed?	How Often Paid?

Additional Household Members and Dependents

Total Family Size (include yourself and spouse/significant other): _________

- List All Other Legal Dependants Living in Household

Name	Relationship	Date of Birth	Social Security #	Health Insurance Coverage?
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No
				□ Yes □ No

If more family members than can be listed above, please attach an additional sheet of paper with the above information.

Please check any of the following that you have applied for and received in the past or are currently receiving:
❑Medicaid ❑HAWK-I (for children) ❑Iowa Care ❑Welfare/AFDC ❑WIC❑Food Stamps ❑ Fuel Assistance ❑ SSI

Have you ever been granted financial assistance at a hospital? ❑Yes ❑No

Sources of Income

- List all household sources of income BEFORE taxes and deductions. Please use another piece of paper if needed.

Source of Income or Money	Who Receives It	Amount Received Per Month
Money from Job (s) Before Taxes (Gross Income) Include odd jobs and tips		
Unemployment, Worker's Compensation, Disability		
Social Security or Supplemental Security Income (SSI)		
Pensions, Retirement, or Veteran's Benefits		
Child Support or Alimony		
Regular Support from Family or Friends to assist with expenses		
Other:		

Cash Resources

Cash on Hand $	1)
Checking Account (s) $	2)
Savings Account (s) $	
Savings Bonds/Stocks $	Employer Medical Flex Spending $
Certificates of Deposit $	Life Insurance Cash Value $

- List all other cash resources for all members of the household.
Name and City of Financial Institution/Bank

*Do not list funds specifically held in trust for retirement, burial, or college education

Liabilities

- Indicate your monthly expense for the following or total owed if requested.

	Monthly Expense	Total Owed		Monthly Expense	Total Owed
Mortgage/Rent	$	$	Other Bank Loans	$	$
Car Payment	$	$	Medical Debt	$	$
Insurance-All Types	$	N/A	Prescriptions	$	N/A
Credit Cards	$	$	Other:	$	$

Additional Information

- Please send copies of all of the items below
    1. Copy of your most recent federal tax return and State Taxes.
    2. Copy of last two pay stubs from all employers for all household members for this year
    3. Copy of most recent bank Statement(s)
    4. Copy of DHS approval or Denial Letter

All the information provided above is true and correct to the best of my knowledge. I understand that providing any false or misleading information may result in denial of this application and the recovery of any financial assistance that is provided to me. I further understand that intentionally providing any false information may result in civil legal action being brought against me. I also understand that should any of the information provided change in the application approval timeframe, I must notify CCMH. If I do not provide this detail, my current and future applications may be denied.

Signature of Applicant ____Date ______________

Best time of day to reach ____________________________at Number ______________________

Revised 09/24/18