DECATUR COUNTY HOSPITAL

Policy: Financial Assistance/Collection Policy | **Business Office/Finance**
Effective Date: 5/95 | **Approved by PAC: 9/15/2016**
Reviewed: 8/16 | **Revised: 8/16**
Review Cycle: Annual | **CoP Tag:**

I. PURPOSE

Hospital is committed to ensuring financial counseling resources and payment options are available to assist patients in prompt resolution to their financial obligations for their healthcare services. Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Hospital will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for government assistance or their ability to pay.

Accordingly, this written policy in regards to Financial Assistance and Payment Program Policy:

- Includes eligibility criteria for financial assistance – free and discounted care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the Hospital
- Describes guidelines the hospital will use to protect for the orderly, reasonable and prompt collection of amounts due from patients who have the ability to pay and actions hospital may take in the event of nonpayment

II. SCOPE

This policy applies to all individuals who seek and receive services from our Hospital and that incur a financial obligation to Hospital. The information contained and referenced in this Policy applies solely to healthcare services provided at and billed by Hospital.

III. POLICY

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Hospital's procedures for obtaining financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

EMTALA. Any patient seeking care for an Emergency Medical Condition at Hospital shall be treated without discrimination and without regard to a patient's ability to pay for care. Hospital shall operate in accordance with all federal and state requirements for the provision of emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

In order to manage its resources responsibly and to allow Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient financial assistance, payment programs and collection functions.

IV. DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Amounts Generally Billed (AGB): The amount Hospital usually charges for a particular service determined by a look back method: prior 12 months of past claims allowed by Medicare together with all private health insurers to determine discount to be applied to gross charges. Hospital determines the amounts generally billed by multiplying the gross charges for such services by an AGB percentage that is identified on Schedule A, which is based on all claims allowed by Medicare together with all private health insurers over a specified 12-month period, divided by the associated gross charges for the claims.

Annual Household Income (Family Income) is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members over the age of 18 (Non-relatives, such as housemates, do not count).

Designated Service Area means the Hospital service area including all of Decatur County and portions of outlying county areas of Clarke, Ringgold, Wayne as well as Harrison and Mercer County Missouri.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Extraordinary Collection Action: Collection activities requiring legal or judicial process. Extraordinary Collection Actions may include: certain liens, foreclosures, attachments or seizing bank accounts, civil actions, writs of attachment, wage garnishment, reports to credit agencies, certain sales of debt to third party, delaying or denying care because of non-payment of prior bills, and other legal actions.

Family Size: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Federal Poverty Levels (FPL) means the federal income poverty guidelines updated and published annually by the United States Department of Health and Human Services.

Financial Assistance (Charity Care): Financial assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria; also known as charity care.

Financial Assistance Program Committee means the Hospital committee assigned to review all applications for the financial assistance program. This committee will meet routinely and may consist of the following positions: Chief Finance Officer (CFO), Revenue Cycle Manager, Financial Counsellor, Care Coordinator/Utilization Review and one Patient Access Representative. The Chief Executive Officer (CEO) may be consulted for applications with complex circumstances.

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.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

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

Medically Necessary: As defined by Medicare include services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Non-Emergent Medical Services means services for treatment of (1) a non-emergency medical condition at the hospital or (2) a medical condition outside the emergency department

Patient Financial Responsibility (PFR) means any payment for services, including but not limited to any deductible, co-payment, 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.

Routine Out of Pocket Expense(s) means any payment for services, including but not limited to any deductible, co-payment, 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.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. Patients exempt from federal mandates due to religious affiliation will be classified as uninsured for this policy.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

V. PROCEDURES

1. **Patient Responsibilities, Payment Expectations, Options and Discounts**. Unless Hospital Financial Assistance Program or other arrangements with Hospital direct otherwise, Patients or their

guarantor are expected to pay their full liability for services rendered or make account resolution arrangements with Hospital within thirty (30) days of receipt of their first bill, in accordance with the procedures below.

A. Payment at the Time of Service.

i. Insurance Eligibility and Education on Patient Financial Responsibility (PFR). Hospital will make reasonable efforts to identify the patient's third party coverage, the patient's estimated financial responsibility for the anticipated services provided and offer counselling resources to give them the tools to make an informed decision on their healthcare services.

ii. Routine Out of Pocket Expenses. Such expenses will be requested at the time of service. Payment of the amount estimated for the services provided will be due from the patient at time of service. If the patient cannot make the payment in full the patient access representative will follow the partial payment guidelines on Schedule A. The patient will be requested to make a minimum deposit as outlined in Schedule A and if uninsured or underinsured be asked to meet with a DCH financial representative. Out of Pocket Expense payments related to emergency care will be requested of the patient post-medical screening exam assessment and after they are medically stable and at time of discharge. (See *Policy Emergency Dept - Medical Screening Exam*).

iii. Medicaid ER Visits. Hospital will use commercially reasonable efforts to collect the copayment from all Iowa Medicaid members and Iowa Health and Wellness Plan members for emergency room (ER) treatment when the services include treatment of medical condition(s) that are NOT on the list of diagnosis codes considered emergent by the Iowa Medicaid Enterprise, and posted on the IME website (http://www.ime.state.ia.us), and the member is not admitted to the hospital. This will not occur until the patient has been screened and at the time of discharge.

Note the ER copayment does not apply if the visit to the ER is for an emergent condition and/or results in a hospital admission. A list of the diagnosis codes considered emergent is posted on the IME website (http://www.ime.state.ia.us).

The exclusions applicable to all Medicaid copayments may apply. The most common exclusion examples are: members under age 21; members who are pregnant; members presenting with an emergent condition; or members receiving family planning services.

B. Forms of Payment.

i. Hospital will accept payment in cash, Visa, Discover or MasterCard debit or credit card, check, money order, and ACH account auto-deduction.
ii. Hospital Financial Assistance Program Application
iii. Hospital Installment Payment Plan plus a minimum payment from Schedule A.

C. Insurance Coverage. Hospital will extend credit on insurance benefits in effect (i.e., commercial insurance or governmental health care program benefits) assigned to Hospital, minus applicable Routine 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.

D. Uninsured Patients Presenting for Non-Emergent Medical Services. A patient who presents for a Non-Emergent Medical Service and meets the definition of an uninsured patient will be requested to meet with a DCH financial counsellor to determine how the services will be financially covered **PRIOR** to receipt of the services. If services have already been rendered the patient will be requested to make the minimum deposit per Schedule A and meet with a HOSPITAL financial representative promptly. This policy will act as a reference for all the options available to the patient.

E. Employees. Employee patient accounts will be handled in accordance with this Policy and in a manner consistent with that of any other Hospital patient. All employee payment arrangements must follow minimum payment requirements and timeframes as outlined in this Policy. Employees may cash in PTO as payment for their hospital bills by contacting the Revenue Cycle Manager or CFO.

F. Discounts (Uninsured and Prompt Pay). Uninsured patients will receive a discount on all services equal to the average discount awarded to other payors (see Schedule A for current applicable discount rate). For all patients if the balance due, as estimated by the patient access representative, is **paid in full at or before time of service** an additional prompt pay discount will be awarded. See Schedule A. Non-Covered services as determined by a patient's insurance plan would qualify for the uninsured discount and prompt pay discount. The patient may qualify for financial assistance under the Hospital's Financial Assistance Program (see Section V.2 below). Government plan enrolled (i.e. Medicare) patients must meet the criteria as outlined in the "Discounts for Government Health Care Program Patients" section of this policy to be eligible for any discounts.

G. HOSPITAL Instalment Payment Plans. For Patients who cannot reasonably make payment in full within 30 days of the statement date, DCH will accommodate the following payment arrangements.

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

Account Balance	Maximum Time	Minimum Monthly Payment
Up to $100.00	30 days	Payment in Full
$100.01 to $500.00	5 months	$50
$500.01 to $750.00	10 months	$75
$750.01 to $1,000.00	10 months	$100
$1,000.01 to $1,500.00	12 months	$125
$1,500.01 to $2,100.00	12 months	$175
Over $2,100.00	18 months	$200

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

i. There is no interest charged on installment plans.
ii. Any requests for alternative payment terms outside these parameters must be referred to the CFO/CEO or Financial Assistance Program Committee for review and approval.

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

i. The Revenue Cycle Manager may offer and/or approve settlement terms including discounts up to 20% of the account balance where the repayment period is 12 months or less.
ii. All requests for settlement of account(s) with balances exceeding $2,500 or for a discount greater than 20% of the aggregate outstanding account balance or with a repayment period beyond 12 months must be directed to the CFO or CEO for review and approval.
iii. All requests for legal settlements must be directed to the CFO or CEO for review and approval.

I. 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 DCH approved date.

2. Hospital Financial Assistance Program. Hospital will provide financial assistance discounts for eligible services to qualifying patients and Guarantors.

A. Locations and Providers Covered by this Policy. This policy applies to certain healthcare services (defined below) provided at DCH. Individuals who receive healthcare services at these locations may be seen by Hospital providers as well as private physician group or other third-party providers. This policy only applies to Hospital, its providers, and other providers for whom Hospital submits bills for their services. This policy does not apply to other providers who independently submit bills for their services. The list of eligible and ineligible providers can be found on the Hospital website at www.decaturcountyhospital.org. The providers will be presented by the associated group vs. by individual name unless a group is not applicable. The list will be updated at a minimum on a quarterly basis.

B. Services Eligible Under This Policy. For purposes of this policy, "financial assistance" refers to healthcare services provided by Hospital without charge or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance:

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, as determined by Hospital's discretion which may include consultation with patient’s medical provider(s).

C. Eligibility Requirements for Financial Assistance. Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit 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 financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. Financial assistance discounts are secondary to all other financial resources available to a patient/Guarantor including balances in personal asset accounts, eligible asset values, and HSA and Flex Plan accounts. Patients must expend these accounts prior to being eligible for Hospital financial assistance plan. To be eligible to participate in the Financial Assistance Program and receive discounts, patients/Guarantors must meet the following criteria:

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

Residency. Patients/Guarantors must reside in the Designated Service Area. All DCH Financial Assistance Program enrollees residing outside the Designated Service Area will be reviewed on a case-by-case basis by the CFO/CEO OR the Financial Assistance Program Committee. Items considered for approval will be location of family care provider and availability of access to healthcare services.

Utilization of Available Insurance Options. Hospital requires that patients **MUST** utilize other options that they have for insurance coverage, as long as such insurance is available at a reasonable cost as defined by the Affordable Care Act. If other financial resources including HSA and Flex benefit accounts, personal assets or third party liability funds are available these must be exhausted before they are eligible for Hospital Financial Assistance Program. Hospital will initially assist or direct the patient to agency representatives who can assist in applying for Medicaid, Iowa Health and Wellness Plans or coverage on the Marketplace. The patient must cooperate by providing 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 Hospital.

D. Method by Which Patients May Apply for Financial Assistance – Application.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

- Include an application process, in which the patient or the Guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
- If necessary, the patient or the Guarantor shall be provided with contact information for assistance with the financial assistance application process;
- Include the use of external publically available data sources that provide information on a patient's or a Guarantor's ability to pay such as credit scoring and other propensity to pay tools;
- Include reasonable efforts by Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
- Take into account the patient's available assets, and all other financial resources available to the patient;
- Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history

- Include a review of the completed application by an internal Financial Assistance Program Committee; and
- Include an approval until the next June 30; updated financial information will be required for all FA patients annually by June 30 thereafter.

2. An individual may obtain applications for financial assistance at Decatur County Hospital, at the Business Office or online at www.decaturcountyhospital.org. The Business Office (641-446-2238) will serve as a resource to individuals for assistance with this application process.

3. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

Hospital's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly and Hospital shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

4. Determination of eligibility for discounts will be made within a reasonable period of time after a completed application has been received along with ALL supporting documentation.

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

6. Recipients will remain eligible for financial assistance discounts for up to one year, unless patient's/Guarantor's financial status changes within the year. It is the patient's responsibility to monitor their eligibility period and reapply at least 60 days prior to expiration to ensure eligibility does not lapse.

7. Hospital reserves the right to review utilization of Hospital services by Financial Assistance recipients on a quarterly basis. Recipients that are determined to be utilizing Hospital services inappropriately may be required to receive additional service utilization counseling.

E. Alternative Application Approval Options. Any patient/Guarantor who refuses to complete the application will be considered as having the ability to pay his/her account and subject to the normal account flow process for collection.

Presumptive Eligibility. There are instances when a patient may appear eligible for financial assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance; Hospital may utilize information from a third party

consumer reporting agency to determine eligibility for presumptive eligibility for Financial Assistance and potential discount amounts.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless clinic;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address; and
8. Patient is deceased with no known estate.

Patients who receive presumptive financial assistance may apply for more generous assistance through the application process.

Retroactive Review. Hospital, or a contracted third party, may perform retroactive reviews of accounts (up to 365 days old) referred to outside collection agencies periodically, to determine if any accounts would have been more properly recorded as Financial Assistance discounts and, if so, Hospital will recall such accounts from the outside collection agency and reclassify them to the Hospital Financial Assistance Program, in accordance with generally accepted accounting principles.

F. Application of Financial Assistance Discounts. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by Hospital to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges and shall not be charged more than the AGB. The basis for the amounts Hospital will charge patients qualifying for financial assistance will be determined using the following guidelines:

1. Patients whose family income is at or below 200% of the FPL are eligible to receive free care;
2. Patients whose family income is above 200% but not more than 300% of the FPL are eligible to receive discounts per the table located in Schedule B attached to this policy.
3. Patients whose family income exceeds 300% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Hospital; however, the discounted rates shall not be greater than the AGB;
4. Upon determination of financial assistance eligibility, an individual will not be charged more than amounts generally billed for emergency or other medically necessary care; and
5. The amount charged for any medical care provided to financial assistance eligible individuals shall be less than the gross charges for that care.

G. Communication of the Financial Assistance Program to Patients and Within the Community. Notification about Hospital's Financial Assistance and Payment programs shall be made publicly available as follows:

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

2. Placing a note on the healthcare bill and statements regarding how to request information about the Hospital Financial Assistance and Payment Programs.
3. Designating departments or individuals who can explain the Hospital Financial Assistance and payment programs.
4. Staff that interacts with patients will be instructed to direct questions regarding any Hospital Financial Assistance or payment program to the proper representative.

Such notices and summary information shall be provided in plain language, and in the primary languages spoken by the population serviced by Hospital. Referral of patients for financial assistance may be made by any member of the Hospital staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

H. Relationship to Collection Policies. Hospital management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from Hospital, and a patient's good faith effort to comply with his or her payment agreements with Hospital. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, Hospital may offer payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. Hospital will not impose extraordinary collections actions, including wage garnishments; liens on primary residences; foreclosures; attachments or seizing bank accounts; civil actions; writs of attachment; reports to credit agencies; or other legal actions, for any patient without first making reasonable efforts to determine whether that patient is eligible for financial assistance under this financial assistance policy.

1. **Reasonable efforts shall include:** Notifying the patient or their Guarantor of financial assistance policies from the date of care to 120 days after the Hospital provides the patient or their Guarantor with the first post-discharge billing statement for the care. Notifications by Hospital shall include:

    a. A plain language summary of the financial assistance policy;
    b. A notice included with all billing statements that informs patients or their Guarantor of the availability of financial assistance under this policy and includes contact information of the hospital facility office or department that can provide information about the financial assistance and the website site address where copies of forms and other information about this policy can be obtained;
    c. Reasonable efforts to inform the patient or their Guarantor of financial assistance policy in all oral communications regarding the bill; and
    d. Providing at least one written notice that indicates that financial assistance is available, identifies the extraordinary collection actions that Hospital may take if the individual does not submit a financial assistance application or pay the amount due by a date no earlier than the last day of the 120 day period, and states a deadline after which the extraordinary collection actions may be initiated (which is no earlier than 30 days after the date of such notice).
2. In the event Hospital receives an incomplete financial assistance application within 240 days after Hospital provides the patient or their Guarantor with the first post-discharge billing statement for care, Hospital shall:

a. Suspend all extraordinary collection actions against the patient until Hospital determines whether individual is eligible for financial assistance or after the patient had failed to respond to requests for additional information within a reasonable period of time;
b. Provide written notice to the patient or patient's guarantor of the information necessary to complete the financial assistance application; and
c. Provide written notice of extraordinary collection actions DCH may take if information is not submitted or amounts are not paid within 240 days of the issuance of the first billing statement for the care.

3. In the event DCH receives a complete financial assistance application within the 240 days after Hospital provides the patient or their Guarantor with the first post-discharge billing statement for care, Hospital shall:
a. Suspend all extraordinary collection actions against the patient until DCH determines whether individual is eligible for financial assistance;
b. Provides written notice of the determination whether individual is eligible for financial assistance;
c. If the patient is eligible for financial assistance, Hospital shall correct the amount charged to the individual in accordance with this Policy;
d. Takes all reasonable measures to reverse any extraordinary collection action.

4. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the hospital;
5. Documentation that Hospital has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the hospital's application requirements;
6. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

3. **Confidentiality and Record Keeping**. All information obtained from patients, Guarantors and family members shall be treated as confidential. DCH will retain a central repository by each patient/Guarantor containing any financial information obtained for program qualification. Written denials of Financial Assistance discounts, including denial reasons, shall be retained in a confidential central file.

4. **Discounts for Government Health Care Program Patients.** In limited instances and only where permitted by federal and state law, DCH 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 (the full financial assistance application or a presumptive eligibility tool may be utilized);
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 relating to 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.

5. **Collection Process**. The Business Office of DCH 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.

6. **Regulatory Requirements.** In implementing this Policy, Hospital management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

VI. RESPONSIBILITIES:

Questions regarding this Policy should be directed to the Chief Financial Officer or the Revenue Cycle Manager. The Hospital Board of Trustees will have oversight of this policy through annual approval.

FORMS:

Schedule A – Financial Payment Schedule and Guidelines

Schedule B – Federal Poverty Level (FPL) Guidelines Table

Schedule C – Financial Assistance Application & Plain Language Summary

Schedule D - Financial Assistance Application Review Checklist

Schedule E - Annual Income Calculator

REFERENCES:

Section 1867 of the Social Security Act (42 U.S.C. 1395dd).

EMTALA Policy Medical Screening Exam (MSE)