Financial Assistance Plan – Policy and Procedure

Distribution: All Employees
Original Date: 09/03/2020
Revised Date/s:

SCOPE: Policy applies to Wills Memorial Hospital (WMH).

POLICY: WMH FAP addresses the financial assistance available to patients and how patients may go about applying for such assistance. WMH financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. FAP applies to, all emergency and medically necessary care provided by the hospital.

Section 501(r)(4) of the Internal Revenue Code (IRC) requires tax-exempt hospital organizations to establish a written FAP. As a condition of participation in the Medicaid disproportionate share program, and to serve the healthcare needs of our community, WMH will provide indigent care to patients without financial means to pay for hospital services. All policies shall be implemented in accordance with all EMTALA and Indigent Care Trust Fund (ICTF) rules and regulations, as well as, any other federal or state law, rule or regulation as it related to the delivery of healthcare services, as they currently exist and any future changes or amendments to these rules and regulations.

Policy is Located:

1) On the WMH website;
2) Plain language summary hardcopies (in English and Spanish) are available upon request in the WMH Emergency Room, Registration, and Business Office;
3) A summary is publically displayed within each WMH facility (in English and Spanish).

DEFINITIONS:

Applicant: is the patient, the guarantor of a patient's financial account, or a designated patient's representative (i.e., legal guardian).

Assets: include, but are not limited to: bank accounts and certificate of deposits; investments including 401k and 403b accounts; real property; and business equipment and other such items.

Financial Assistance Program (FAP): program that provides financial assistance to individuals who have emergent and/or medically necessary healthcare needs and are uninsured and under-insured, ineligible for a government program, unable to pay for healthcare based on their individual financial situation, and who meet the requirements stated in this Policy.

Federal Poverty Guidelines (EPG): Poverty guidelines used to determine eligibility for poverty programs. These guidelines are issued by the federal government at the beginning of each calendar year and can be found on the U.S. Department of Health and Human Services website at www.hha.gov.

Gross Charges, or the Charge master Rate: Section 61(a) of the **Internal Revenue Code** defines **gross income** as **income** from whatever source derived, including (but not limited to) "compensation for services, including fees, commissions, fringe benefits, and similar items."

Household: the number of people claimed on income tax filing, or individuals the Applicant is legally responsible for, and any individual whose income is included in the applicant's gross income.

Medical Necessity: Any treatment/procedure reasonably determined to prevent, correct, diagnose, cure, alleviate, or avoid the worsening of conditions that endanger life, cause pain or suffering, result in illness or debilitation, threaten to cause or provoke a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment.

Elective Admissions/Procedures: will be denied if not covered by a third party source or if the patient, or responsible party, is unable to make satisfactory payment arrangements. All elective admissions/procedures will be categorized as "Full Pay". An elective admission/procedure is one that would not be covered by Georgia Medicaid if the patient was a Georgia Medicaid beneficiary; this includes services that Georgia Medicaid requires pre-certification, as well. For a matter of record: Persons with third party insurance who elect not to bill insurance for a hospital service, will be considered self-pay for that service; however, patient will not be eligible for ICTF because they have a health insurance plan.

WMH will determine if a service is eligible financial assistance.

Resident: an individual to be recognized as a resident of Georgia if he/she or his/her legal guardian is able to provide proof of Georgia residency documents as requested.

Family Unit: consists of individuals living alone; and spouses, parents and their children under the age of twenty-one (21) living in the same household.

PURPOSE:

To define Indigent Care as distinguished from bad debts and to establish procedures to ensure consistent identification and recording at WMH. Also, to adjust self-pay balances for discounts, as needed.

To provide standards and consistent eligibility criteria for staff use in determining the financial status of patients so that acute classification and distinction can be determined between uncollectible amounts arising from a patient's inability to pay and those arising from a patient's unwillingness to pay.

To identify those needing financial assistance at the start of the collection cycle and decrease the time it takes to resolve an account.

To explain how patients may apply for financial assistance.

To offer a sliding scale discount based on income levels.

To offer a prompt-pay discount to patients with self-pay balances, which in turn may positively affect cash flow.

To streamline and clearly identify the process for patients and WMH Staff.

To gather and record data that confirms a patient's inability to pay.

To meet requirements of the: Internal Revenue Code Section 501(r) and the Affordable Care Act for 501(c)(3) hospital.

PROCEDURE:

Indigent care will be provided to all patients who present for care at WMH without regard to race, creed, color, or national origin, and who are classified as financially indigent or medically indigent according to the hospital's eligibility system.

Eligibility for Indigent Care:

A. Financially/Medically Indigent:
   1. A **financially indigent** patient is an individual who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on WMH's eligibility criteria set forth in this process. A **medically indigent** patient is a person with medical insurance who may also qualify for balances after insurance payment to be discounted, provided the patient meets the income requirements.
   2. To be deemed eligible for indigent care, a person's total household income shall be at or below 200% of the current U.S. Federal Poverty Guidelines and not qualify for Medicaid assistance. WMH may consider other financials assets and liabilities for the person when determining eligibility.
   3. WMH Staff will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for indigent care as a financially indigent patient. The poverty income guidelines are published in the Federal Register at the beginning of each calendar year and for the purposes of this process will become effective the first day of the month following the month of publication.
   4. WMH, in no occasion, will establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or lower than 200% of the current federal poverty income guidelines. WMH may adjust the eligibility criteria occasionally based on the financial resources for WMH and as necessary to meet the indigent care needs of the community.
   5. To be eligible for indigent care you must be a resident of the State of Georgia or qualify for Medicaid in another state.

B. Charity Care Discount:
   1. To be eligible for the Charity Care Discount, an individual's total household income shall be greater than 200% of the current federal poverty guidelines. See specific discount levels below:

- 75% Discount of self-pay balances for a patient at 201% up to 250% of the FPL
- 50% Discount of self-pay balances for a patient at 251% up to 300% of the FPL
- 25% Discount of self-pay balances for a patient at or above the 301% of the FPL

WMH may consider other financial assets and liabilities for the individual when determining eligibility.

2. Patients eligible for charity care will have their medical bill discounted at 75%, 50%, or 25% off the charges based on their household income above the Federal poverty guidelines. The remaining balance will be due and payable by the patient, and normal collection efforts will continue.

C. Identification of Indigent and Charity Cases:

1. Signs stating *"Do You Need Help With Your Hospital Bill?"*, in English and Spanish, are posted in the WMH Emergency Room, Clinics, Registration, and Business Office areas.
2. All self-pay **Inpatients** will be screened for potential governmental programs. All self-pay **Outpatients** will be screened by the WMH Financial Counselor.
    - The Financial Counselor will determine the patient's qualification for indigent or charity care, from information gathered from the application and supporting documentation. The Financial Counselor will complete and approve the application prior to any write-off. The Financial Counselor will also screen all self-pay patients for Presumptive Medicaid Eligibility.
    - The applicant is responsible for providing the Financial Counselor with the following information:

Verification of your household include:

- ✓ Last three months of check stubs, or verification of wages on a company letterhead.
- ✓ Last three months of bank statements.
- ✓ Copies of Social Security checks or a letter from the Social Security Office showing amount, or documentation of amount, received from any other pension source.
- ✓ Last year's federal or state tax returns.

Additional Information:

- ✓ Valid driver's license or state issued identification card with photo
- ✓ Food Stamp letter, if applicable
- ✓ Any records demonstrating all child support due and received, if applicable
- ✓ Income of all household family unit members responsible for the patient's medical bills. The family unit consists of individuals living alone; and spouses, parents, and children under age 21 living in the household.

Proof that you are a Georgia resident (present one of the following):

- ✓ Utility bill
- ✓ Telephone bill
- ✓ Rent/mortgage receipt

- ✓ If you live with someone, please provide a letter from that person stating your residency and the amount of rent you pay.

- WMH will not approve incomplete applications. The Financial Counselor is responsible to notify the patient via certified mail with the "incomplete" status.

Factors to be considered for Indigent and Charity Care Determination

A. The following factors are to be considered in determining the eligibility of the patient for Indigent and Charity care:
   1. Gross income
   2. Family size
   3. Employment status and future earning capacity
   4. Other financial resources
   5. Other financial obligations
   6. Amount and frequency of hospital and other medical bills

   See current Federal Poverty Guidelines available at dch.georgia.gov/federal-poverty-guidelines-0, to include the definition of "Family Unit".

B. All prospective Indigent or Charity accounts must remain in a self-pay financial class, and regular collection efforts will continue until the application and supporting documentation is received by WMH. These accounts are not to be left on the active Accounts Receivables indefinitely, but adjusted off to bad debt, and if information is not received in a timely fashion, referred to a collection agency.

Documentation of Eligibility Determination

A. Once the eligibility determination is made, the results are to be documented in the comments section of the patient's account and the financial class changed to reflect the appropriate status. The Financial Counselor will complete an Indigent/Charity Care application and submit it to the Patient Financial Services (PFS) Director for approval, and then adjustments will be posted by the Accounting Department. The completed and approved Financial Application (FA) will be scanned into the patient's registration folder for all qualifying accounts. The Patient Financial Counselor will maintain all indigent care applications and supporting documents for a period of 7 years. The approved Indigent and Charity Application will be in effect for a period of six (6) months unless there are reported changes in the applicant's financial status; the applicant is responsible for notifying WMH of any changes.

B. Notification of Payment Classification – Patients will be notified upon approval for indigent services via the U.S. Postal Service mail through Certified Mail. Adjustment will be reflected on the patient's hospital bill. Patients may receive one (1) to two (2) statements, any additional statements will be available upon request only.

Reporting of Indigent/Charity Care

A. Information regarding the amount of indigent care provided by WMH in its fiscal year shall be aggregated and included in the hospital's Georgia Department of Community Health (DCH) Annual Report. It is the responsibility of the Financial Counselor and the Business Office Manager to provide this aggregated information to the CEO for inclusion on the DCH report.

B. WMH reserves the right to set limits on a patient has received Indigent Status and taken advantage of the WMH Indigent Policy, the patient cannot refuse consent for use of Health Information. Account/s will be reactivated with full collection efforts being made if patient refuses consent or withdraws consent. In addition, patient may be barred from future participation in indigent program.

Billing and Collection

WMH may take, or authorize a third-party collection agency or law firm to take, certain actions related to obtaining payment of a bill for medical care, including the following extraordinary collection actions.

A. If clinically appropriate, WMH may defer or reschedule non-emergent services until payment is received or payment arrangements made.
B. WMH may report unpaid debts to external collection agencies, credit reporting agencies, and/or credit bureaus.
C. Legal or judicial actions, including, but not limited to:
   1. Commencing a civil action or lawsuit against the patient or responsible individual;
   2. Garnishing individual's wages;
   3. Attaching or seizing an individual's bank account, or other personal property, or other judgment enforcement action permissible under state law after securing a judgement.

Neither WMH nor a collection agency or law firm will commence Extraordinary Collection Actions prior to 30 days from the date of the enclosed billing statement or 120 days after the date of the first post-discharge billing statement for the applicable medical care received, whichever date occurs later, and only after making reasonable efforts to determine whether an individual is eligible for assistance under the financial assistance policy.

All financial assistance information may be obtained free of charge, upon request including the Financial Assistance Policy (see below) or at https://www.willsmemorialhospital.com/

Mailing	Hours of Operation
Wills Memorial Hospital Business Office 120 Gordon Street Washington, GA 30673 706-678-9333	8:00 a.m. – 4:30 p.m., Monday – Friday

For Emergent, Medically Necessary Services Including:
✓ Emergency Room ✓ Inpatient Care

Physicians Included in Financial Assistance Plan
✓ Lester Johnston, M.D. – Participating ✓ Kirk Dodson, MD - Not Participating ✓ Robert J. Williams, MD - Not Participating ✓ Wills Memorial Emergency Medical Services –Not Participating

Addendum 1 - WMH FAP Plain Language Letter

Addendum 2 – WMH FAP Plain Language Summary

Addendum 3 – WMH FAP "Do You Need Help With Your Hospital Bill"

Addendum 4 – WMH Financial Application Form

Hospital Authority of Wilkes County
Wills Memorial Hospital, 120 Gordon Street, Washington, GA 30673
706-678-2151 Fax 706-678-1546

Dear Patient:

This letter includes important information for you about how to get help with your hospital and medical bills. The Financial Assistance Plan includes assistance with hospital and medical bills for applicants who quality and includes applying for programs like indigent care, charity care or Medicaid.

If you would like to apply for financial assistance at the Hospital Authority of Wilkes County, please complete the attached application. In addition, we will need some supporting documentation to determine whether you qualify. The items below are the basic requirements; however, during the interview process it may be determined that additional information is required.

Verification of your household include:

- ✓ Last three months of check stubs, or verification of wages on a company letterhead.
- ✓ Last 3 months bank statements
- ✓ Copies of Social Security checks or a letter from the Social Security Office showing amount, or documentation of amount, received from any other pension source.
- ✓ Last year's federal or state tax returns.

Additional Information:

- ✓ Valid driver's license or state issued identification card with photo
- ✓ Food Stamp letter, if applicable
- ✓ Any records demonstrating all child support due and received, if applicable
- ✓ Income of all household family unit members responsible for the patient's medical bills. The family unit consists of individuals living alone; and spouses, parents, and children under age 21 living in the household.

Proof that you are a Georgia resident (present one of the following):

- ✓ Utility bill
- ✓ Telephone bill
- ✓ Rent/mortgage receipt
- ✓ If you live with someone, please provide a letter from that person stating your residency and the amount of rent you pay.

Financial Assistant Plan Application: Once you complete the application and have copies of all required supporting documentation, please mail the enclosed application with copies (do not mail original versions) of supporting documents to:

Wills Memorial Hospital
Attn: Financial Assistance Program
120 Gordon Street
Washington, GA 30673

Instead of mailing the application to us, you may also call our office at 706-678-9333 to schedule an appointment with a financial counselor to discuss your application. The applicant will be required to have completed your application and present supporting documents prior to meeting with a Financial Counselor. If applicant does not supply Wills Memorial Hospital with a completed application and all supporting documents, the application will not be processed. Please be aware that once WMH receives a complete application with all required supporting documentation, it will take up to five (5) business days to determine whether the applicant qualifies for financial assistance.

Thank you for trusting the Hospital Authority of Wilkes County with your health care needs.

Financial Counselor
706-678-9333
Fax 706-678-3986

Addendum 1 - WMH FAP Plain Language Letter

Financial Assistance Program
Plain Language Summary

Hospital Authority of Wilkes County offers discounted care under a Financial Assistance Program to qualified individuals for emergency and medically necessary services. The Hospital Authority does not discriminate in the provision of emergency or medically necessary care based on ability to pay or source of payment.

Emergency and or Medically Necessary care is not charged more than the Amount Generally Billed (AGB).

Eligibility Criteria Overview

- Family Annual Household Income less that is below 200% of the Federal Poverty Level (FPL),
- Not eligible for government assistance
- Financial need
- Provide necessary documentation and information about your household finances (see application form for details)

If you need formation about the financial assistance plan or an application form:

- Online - https://www.willsmemorialhospital.com/
- By Phone – Call us at 706-678-9333 to schedule a time to meet with a Financial Counselor at Wills Memorial Hospital.
- By Mail – Call us at 706-678-9333 to request a copy by mailed. Hardcopies available in English and Spanish.

Completed Financial Assistance Application and Supporting Documentation may be mailed to:

Wills Memorial Hospital
Attn: Financial Assistance Program
120 Gordon Street
Washington, GA 30673

If you have questions about your bill or need to schedule a payment plan, call WMH Patient Financial Services at 706-678-9333.

Addendum 2 – WMH FAP Plain Language Summary

DO YOU NEED HELP WITH YOUR HOSPITAL BILL?

WMH Financial Assistance Program Available

Online - https://www.willsmemorialhospital.com/

By Phone – Call us at 706-678-9333 to schedule a time to meet with a Financial Counselor at Wills Memorial Hospital.

By Mail – Call us at 706-678-9333 to request a copy be mailed. Hard copies available in English and Spanish.

¿NECESITA AYUDA CON SU CUENTA DE HOSPITAL?

Programa de asistencia financiera de WMH disponible

En línea: https://www.willsmemorialhospital.com/

Por teléfono: llámenos al 706-678-9333 para programar un horario para reunirse con un asesor financiero en el Hospital Wills Memorial.

Por correo: llámenos al 706-678-9333 para solicitar que le enviemos una copia. Copias impresas disponibles en inglés y español.

Addendum 3 – WMH FAP "Do You Need Help With Your Hospital Bill"

APPLICATION FOR FREE AND REDUCED-CHARGE SERVICES
UNDER THE INDIGENT CARE TRUST FUND (ICTF) PROGRAM
Wills Memorial Hospital

Patient's Full Name: _____ Patient's Date of Birth: _____

Date/s of Service: _____ Amount of Charges: $_____

Applicant's Full Name: _____ Relationship to Patient: _____

Applicant's Mailing Address: _____

Applicant's Telephone/s: (home)_____ (mobile)_____ (work)_____

Applicant's E-Mail Address: _____

List members of household, birthdate, relationship to patient, and income from each source: state whether income is per week, month, or year.

FULL NAME	BIRTHDATE	RELATIONSHIP	INCOME (WK/MO/YR)	INCOME (WK/MO/YR)	TOTAL INCOME

If income on any member if from self-employment, you may give information on costs so that we can determine actual income to be counted. Document details on back of this page.

(**Note to Applicant:** You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

Signature of Applicant: _____ Date: _____

For Hospital Staff Use:

(Average monthly income for last year or past three months, whichever is more favorable.)

NUMBER COUNTED IN HOUSEHOLD: _____ TOTAL COUNTABLE INCOME: _____

Determination: Eligible for free services_____ Conditional?_____ Pending: _____

Eligible for discount _____% Conditional?_____ Pending: _____

Ineligible: _____ Reason: _____

Date notice mailed: _____ Staff Signature: _____ Date: _____

Reconsideration: Result: _____ Date: _____

Page 1 Financial Assistance Worksheet

Patient Information:

Full Name:	
Social Security #:	
Date of Birth:	
Address:	
Phone Number:	Home: _____ Mobile: _____ Work: _____
Employer Name and Address:	
Employment Status:	*Check one:* Full-time___ Part-time___ Retire___ Not Applicable____
Spouse's Full Name:	
Spouse's Social Security #:	
Spouse's Date of Birth:	
Spouse's Employer Name and Address:	
Spouse's Employment Status:	*Check one:* Full-time___ Part-time___ Retire___ Not Applicable____

Monthly Expenses	***Amount***
Rent/Mortgage	
Auto	
Utilities	
Phone	
Other: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
TOTAL EXPENSES	

Description of Assets	***Amount***
Savings Account Amount and Location	
Checking Account Amount and Location	
Savings Bonds and Location	
CD Amount and Location	
Retirement Funds	
Life Insurance Face Value	
Rental Property	
Other Assets	
TOTAL ASSETS	

Patient/Guarantor Signature: _____ **Date:** _____

Addendum 4 – WMH Financial Application Form