Pulaski Memorial Hospital

BOARD POLICY

Subject: **PMH Financial Assistance Policy**	Policy #: **106.02**
Applicable to: **All Departments**	Effective: **09/01/2017**
Supersedes: **106.02 Issued 1/29/2013; revised 3/10/17**	**Page 1 of 4**
Approval Signature:	Review: **Annual**

Coordinating Dept. Initials	Author	CFO	Financial Counselor	Administration		
	Melanie Stoll					

Financial Assistance/Charity Policy Guidelines

POLICY

Pulaski Memorial Hospital is committed to providing access to quality Healthcare to all patients including patients in a difficult financial circumstance. This includes those with a need to receive emergency medical care and medically necessary hospital services. Extraordinary Collections efforts that may take place in the event of non-payment are described in Pulaski Memorial's Billing and Collection Policy. You may obtain a free copy of this on our website at www.pmhnet.com or call 574-946-2106, Monday through Friday 8:00 am to 4:30 pm. Upon adoption of this Policy by the Pulaski Memorial Hospital Board of Directors, this is the official Financial Assistance Policy which follows the guidelines set forth in the Internal Revenue Code Section 501(r).

This policy is based on the premise that Pulaski Memorial Hospital will not deny hospital service to any patient.

PURPOSE
This policy is intended to establish a fair and consistent method for all patients insured, under-insured and uninsured to apply for financial assistance for emergency services and other medically necessary hospital care. Financial assistance involves free or discounted care based on household income and assets that are required to be disclosed on the Financial Assistance Application.

IMPLEMENTATION

PMH will provide emergency services to all patients without regard to race, religion, gender, sexual preference, ethnicity and linguistics, source of payment, age, or handicap. PMH will follow the same criteria as established under the EMTALA Law and Regulations.

DEFINITIONS:

Amounts Generally Billed: AGB means the usual and Customary Charges for Covered Services provided to individuals eligible under the Financial Assistance Program, multiplied by the Hospital-Specific AGB Percentage applicable to the service.

Assets: Liquid Assets that can be converted to cash to meet financial obligations.

Billing and Collection Policy: means the Hospital Policy entitled "Billing and Collection Policy".

Emergency Services: means a medical condition with acute symptoms that if are not taken care of immediately are likely to place patient's health in serious jeopardy.

Extraordinary Collection Efforts: Actions taken against an individual to obtain payment of a bill that requires a collections agency or legal process and/or reporting to a consumer credit reporting agency.

FAP Eligible: means eligible for assistance under the Financial Assistance Policy.

Federal Poverty Guidelines: measures income levels annually. These levels are used to determine eligibility for Financial Assistance.

Limitations of Charges: this is limiting the charges for emergency care and other medically necessary care provided to individuals eligible for Financial Assistance to more than the amounts generally billed to individuals who have insurance covering them for the same care. The hospital may not engage in ECA's before reasonable efforts are made to determine whether the individual is eligible for financial assistance.

Medically Necessary: means inpatient or outpatient services required to identify or treat an illness or injury.

Plain Language Summary: is a written statement that notifies that the Hospital offers financial assistance under a FAP and that the information is provided clearly and concise.

PROCEDURES

The policy will be administered according to the following guidelines:

1. Financial assistance will be available to all patients regardless of race, religion, gender, sexual preference, ethnicity, and linguistics, source of payment, age or handicap.

2. Financial assistance will be provided for all hospital services deemed medical necessity (this does not necessarily include elective procedures).

3. Medicaid recipients who receive Medically Necessary Care not covered by Medicaid will have 100% of the Patient Responsibility for such Medically Necessary Care Automatically written off. This includes Out of State Medicaid recipients. An application will not be required in these circumstances.

4. The amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance will not be more than the amounts generally billed (AGB) to individuals who have insurance covering them. The AGB is determined by the prospective method and will be evaluated annually.

    A. In determining the AGB the hospital will use their typical billing and coding procedures to determine how much Medicare would pay for the services rendered. This amount, plus the amount the beneficiary would be personally responsible for paying (coinsurance, copayments, deductibles) for services, equals the hospital's AGB.

5. The hospital reserves the right to investigate and inquire as to the available assets, income and other factors that will assist the hospital in making a determination about the individual's ability to pay.

6. The policy is posted on the Hospital's website and is available at various locations throughout the hospital including all registration areas and the ER. The hospital billing statements also include notice of financial assistance and there is signage throughout the hospital giving notice of financial assistance.

7. The plain language summary is available at each registration desk and the ER.

8. All insurance sources (health insurance, liability insurance, auto insurance, workers comp, etc.) will be billed before receiving financial Assistance.

9. The most recent federal poverty guidelines are used to determine the individual's financial obligation.

10. This policy only applies to those patients who have exhausted all other sources of payment or assistance.

    A. Per the Patient Protection and Affordable Care Act (Public Law 111 – 148, signed on March 23, 2010 / HR 3590 / Sec 1501: effective January 1, 2014, self-pay patients must demonstrate and provide documentation that they have applied for health insurance through one of the Marketplace Exchanges, the Healthy Indiana Plan (HIP) insurance, Medicaid, or other State programs. Sec 2702 of the PPACA provides for Guaranteed Availability of Coverage. If you have been denied, you must provide documentation that denial was for reasons other than failure to complete and follow-through of the application process.

    B. The Financial Counselor may assist patients in applying for HIP, government-funded programs (such as Medicaid, all Medicaid Advantage Plans, the State Children's Health Insurance Program (SCHIP), or crime victim funds), setting up an extended payment plan or applying for PMH charity assistance.

How to Apply for Financial Assistance:

Patients may apply for financial assistance by completing the FAP application prior to, at the time of service or after services are rendered. Applications may be picked up from the Financial Counselor, be obtained from the hospital website, by calling Financial Services at (574) 946-2106, or by requesting my mail at:

Pulaski Memorial Hospital
616 E 13th St
PO Box 279
Winamac, IN 46996

Notification Requirements

The availability of the FAP will be widely publicized within the communities serviced by the Hospital. All admitting areas shall have signage prominently displayed that advises patients of the existence of financial aid. Plain Language summaries will be available at each Admission desk. The availability of financial aid will also be displayed on the billing statements. The hospital will provide at least one written notification informing the patient of any ECA's the hospital may take if the FAP is not received or payment has not been received.

Eligibility Criteria and Determination

In determining the adequacy of income, the most current federal poverty income guidelines for the low end and ~~200%~~ 300% of the guidelines for the high end will be used as a scale based on the gross income of the patient and the patient's household, the patient's household size, and other medical/financial obligations. In addition, determination will include the availability of all other assets (i.e. savings accounts, CD's, etc.).

1. Eligible applicants may receive a total or partial write-off as determined by Schedule A of the Federal Poverty Guidelines.

2. Application is to be submitted in writing on the approved Financial Assistance application and must be completed, signed and returned to the Financial Counselor along with the applicable documentation requested.

3. Eligibility for financial assistance may be based on, but not restricted to, the following criteria:

   Family Size and Household Income, as determined by the most current HHS Federal Poverty Guidelines and Schedule A

4. Once the applicant is determined to be eligible for financial assistance and the level of assistance is determined; the information will be forwarded to the Board of Trustees for approval. Upon receipt of the Board of Trustees' decision, a Patient Accounts Representative will notify the applicant in writing of the final determination.

5. Partial assistance:

   A. Approved amount will be written off.

   B. Patient/Guarantor is responsible for paying any balance that remains.

      1. A percentage reduction of the minimum monthly payment amount will be given as allowed by Schedule A of the current Federal Poverty Guidelines. This reduction is applicable to payments arranged through established patient finance payment programs offered through the hospital.

      2. If the applicant does not comply with the established criteria for fulfilling their financial obligation on the remaining balance, the account will be referred to an external collections agency or attorney for continued collection efforts.

6. If patient's income or other criteria exceed this policy guideline for qualification for charity under the Schedule A Federal Poverty Guidelines, the Financial Counselor will notify the applicant in writing and provide options for payment arrangements through financial payment programs.

7. Appeals of the determination must be made by the Patient/Guarantor/Authorized Representative in person before the Board of Trustees at the regular monthly meeting immediately following the receipt of notification. Written notice of the intent to appeal must be included in the Board packet for that meeting. The Financial Counselor can assist in this process.

REFERENCES

Patient Protection and Affordable Care Act, Section 9007

Internal Revenue Code, Section 501 (r)

Appendix A

Plain Language Summary

Hospital List of Physicians covered under this Financial Assistance Policy