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SCOPE

This Policy applies to Wise Health System, Wise Health Clinics, and all Controlled Affiliates of Wise Health System ("WHS") and provides direction and processes for WHS to identify patients who are eligible to receive financial assistance in connection with healthcare items or services provided by WHS.

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context. Additional defined terms may be found in the WHS Policy and Procedures Definitions document.

Application - the Application for Assistance that will be completed by the Eligibility Vendor and/or Financial Counselor that is used to gather information necessary to determine the patient or guarantor's eligibility for Financial Assistance

CONTROLLED AFFILIATES –any entity in which WHS is the owner or manages or controls the day-to-day operations of the entity

FPL –Federal Poverty Guidelines

Federal Health Care Program - any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including but not limited to: Medicare, Medicaid, TriCare/VA/CHAMPUS, SCHIP, Indian Health Services, Health Services for Peace Corp Volunteers, Federal Employees Health Benefit Plan, Railroad Retirement Benefits, Black Lung Program Services provided to Federal Prisoners, Pre-existing Condition Plans (PCIPS) and Section 1011 Requests

Financial Assistance –the discount provided to eligible patients that are determined to be financially or medically indigent

Financially Indigent - an Individual's annual gross household income falls under or within guidelines established by WHS and WHC, based on 300% or below of the federal poverty guidelines ("FPL") (Patients who fall under this category are accepted for care without a financial obligation or at a discounted rate)

Health Insurance Policy- any Federal Health Care Program, personal or group health policy or plan, whether fully insured or self-funded, which has as its primary purpose the reimbursement, in whole or in part, of medical services provided to a covered patient.

Medically Indigent –a patient who is eligible for partial Financial Assistance. This includes Individual(s) whose Health Insurance Policy, if any, does not provide complete coverage for all medical expenses and the medical expenses, in relationship to income would make them indigent if forced to pay the outstanding balance.

Reasonable Collection Efforts- the effort to collect Federal health care program deductible and coinsurance amounts be similar to the effort WHS puts forth to collect comparable amounts from non-Federal health care program patients. Specifically, the collection effort must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. Additionally, the collection effort

should include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

Required Documentation –health insurance or third party coverage, employment status, income via copies of last three paychecks or most recent year's income tax return, family size, proof of identity, proof of being a resident within the WHS and WHC service areas and proof of being denied for other financial assistance

Uninsured Patient - a patient of a WHS facility or entity who has no Health Insurance Policy in force at any time during which the patient receive treatment at the WHS facility or entity.

Uninsured Patient Discount – A 40% reduction of billed, non-covered, exhausted benefits or experimental charges.

Billed Charges – the actual charges of the WHS or WHC prior to the applications of any discounts for the healthcare items and services provided to a patient.

Non-Covered – healthcare items and services excluded from payment by a third party payer, because it is not a covered benefit.

Exhausted Benefits – the policy limits for reimbursement have been reached, resulting in no additional payments for that benefit period.

Experimental – product has FDA approval for medical use, but the product has medical benefits for use beyond what is in the payer guidelines and is deemed experimental in that situation or non-covered.

WHC –Wise Health Clinics

WHS –Wise Health System and Controlled Affiliates

POLICY

WHS is a not-for-profit institution. As part of its mission, WHS will provide Financial Assistance to certain patients who are determined to be Uninsured Patients or other eligible patients that have insufficient financial means to pay for their healthcare as defined in this policy. No patient is denied financial assistance due to gender, race, age, religion, disability, national origin, or sexual orientation; applications are processed on a consistent and nondiscriminatory basis.

The degree of Financial Assistance offered to any patient will be based on WHS's eligibility criteria which are indexed to the Federal Poverty Guidelines. Certain Individuals who are not Uninsured Patients may not be eligible for financial assistance due to regulatory or other legal requirements that limit reductions or waivers of copayments, deductibles, or other patient responsibility payments. For those patients that are eligible, the Financial Assistance that is offered may be for all or a portion of the patient's account balance. Eligibility for partial Financial Assistance ("Medically Indigent") or full charity ("Financially Indigent") is based on total patient responsibility as a percentage of gross annual income and is subject to change by WHS. Financial Assistance may be considered only for services received within twelve months from the date of Application. The effective date of assistance may include more than the twelve (12) month period if approved in writing by at least two of the following Administrative team members Vice President of Revenue Cycle, Chief Financial Officer CFO, or Chief Executive Officer (CEO). Financial Assistance covers coinsurance and/or deductible amounts, and for non-covered services as defined within these guidelines. In general, any urgent or medically necessary services may be considered for financial assistance. No financial assistance may be provided in connection with Elective or non-medically necessary services provided to a patient. WHS shall continue to provide emergent care for all individuals, without consideration of their ability to pay.

Consideration for financial assistance requires patient cooperation with staff to explore alternative means of assistance, including Medicare, Medicaid, Crime Victims, and Indigent care. At times, staff can determine eligibility from information provided by outside sources without an official application in instances where financial verification has occurred in the last twelve months. Patients will be required to provide necessary information and documentation

when applying for hospital financial assistance or possible public payment options. Patients who are uncooperative and do not provide the required documentation may be deemed ineligible for Financial Assistance.

PROCEDURE

1. **Availability and Notification**

   1.1. Applications for Financial Assistance are available to anyone who requests an application. The hospital will post notices as required by law regarding the availability of the financial assistance program.
   1.2. WHS or WHC Billing statements may include a notice that informs and notifies recipients about the availability of financial assistance under the Policy including a phone number for inquiries about financial assistance and the website where additional information can be obtained.
   1.3. WHS or WHC staff may discuss the Policy when appropriate in person or during billing and customer service contacts with a patient.
   1.4. Paper copies of the Policy and Assistance Application are made available to all patients upon request.

   1.5. The hospital's annual community benefits report is available upon request and posted in a public location within the facility or

2. **Method for Applying or Obtaining Financial Assistance**

   2.1 Applying for financial assistance can be initiated by a patient requesting assistance in person or over the phone by calling WHS Customer Service at 940-539-3644.

   2.2 Patients of certain approved community and charitable organizations and programs with the same or more restrictive eligibility requirements as this policy qualify for assistance under this policy without providing additional information. For organizations or programs not approved under this policy, another assistance application may be used as long as substantially the same items on the application are satisfied or documentation as to why they were not satisfied is included.

   2.3 WHS may use publicly available information for the basis of determining financial assistance when a patient does not provide an assistance application or supporting documentation.

3. **Application for Assistance Process**

   3.1. If it is determined that an admission or outpatient procedure will be unfunded or underfunded, the Eligibility Vendor and/or Financial Counselor representative ("Representative") may interview and screen for eligibility on behalf of the patient, guarantor or anyone deemed legally responsible for the payment of service rendered.

   3.2. During the interview, the Representative will gather information about the Patient or guarantor's circumstances and ability to pay. The Representative may assist the patient or patient's family in completing an Application for Financial Assistance, if requested and advise the patient of all the required documentation ("Required Documentation") requested of the patient or guarantor to assist in the determination of eligibility for Financial Assistance.

   3.3. Required Documentation may include, but is not be limited to, health insurance or third party coverage, employment status, income via copies of last three paychecks/paystubs or most recent year's income tax return, family size, proof of identity, proof of being a resident within the WHS and WHC service areas and proof of being denied for other financial assistance. The same financial guidelines will apply to all persons in determining full or partial financial assistance; guidelines are applied on a consistent and nondiscriminatory basis.

4. **Insurance Coverage or Beneficiaries of Federal Programs**

4.1. Eligibility for a financial assistance is granted after available insurance resources have been utilized. All patients will be screened for sources of coverage / funding:

a. Medicare, Medicaid, Crime Victims, commercial, or any other third party coverage;
b. Eligibility for public assistance programs;
c. Third party coverage from an employer or family member's employer;
d. If a tax-supported hospital is not available in their county of residence OR the services are not available at the tax-supported hospital within their county of residence.

4.2 *Financial Assistance to Federal Program Patients.* WHS and WHC may not routinely waive or reduce copayments, coinsurance, or deductibles for Federal Health Care Program patients. However, WHS and WHC may offer Financial Assistance such as a waiver or reduction of copayments, coinsurance, or deductibles for Federal Health Care Program patients in accordance with the provisions set forth this Section must meet the following criteria:

a. WHS/WHC must not later claim the amount reduced or waived as a bad debt for payment purposes under any Federal Health Care Program or otherwise shift the burden of the reduction or waiver onto any Federal Health Care Program, State health care program, other payers, or individuals.

b. WHS/WHC must not offer to reduce or waive the coinsurance or deductible amounts without regard to the reason for admission, the length of stay of the beneficiary, or the diagnostic related group for which a claim for reimbursement is filed.

c. The offer to reduce or waive the coinsurance or deductible amounts must not be made as part of a price reduction agreement between WHS or WHC and a third-party payer (including a health plan).

d. The Financial Assistance or Waiver may not be offered as part of any advertisement or solicitation.

e. The Financial Assistance such as a reduction or waiver of the coinsurance amounts is only given after determining in good faith that the patient or responsible individual is in financial need or after reasonable collection efforts have failed. Reasonable collection efforts ("Reasonable Collection Efforts") requires that the effort to collect Federal Health Care Program deductible and coinsurance amounts be similar to the effort that WHS/WHC puts forth to collect comparable amounts from non-Federal health care program patients. Specifically, the collection effort must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. Additionally, the collection effort should include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

f. Under no circumstance will a waiver of deductible, coinsurance, patient portion be offered for the purpose of generating revenue payable by a Federal health care program.

5. Income

5.1. Income includes total cash receipts from all sources before taxes. If married, income from both spouses is included. Verification of income for dependents is not required. The following are considered as income:

a. Wages and salaries before deductions
b. Self-employment income
c. Social security benefits
d. Pensions and retirement benefits
e. Unemployment compensation
f. Strike benefits from union funds
g. Workers' compensation
h. Veterans' payments
i. Public assistance payments

j. Training stipends
k. Alimony
l. Child support
m. Military family allotments
n. Income from dividends, interest, rents, royalties
o. Income from estates and trusts
p. Regular insurance or annuity payments
q. Support from an absent family member or someone not living in the household
r. Lottery winnings

5.2. The following are not considered income:

a. Capital gains
b. Any assets drawn down as withdrawals from a bank
c. Sale of property, house, or car
d. Food or rent in lieu of wages
e. Non-cash benefits
f. Gifts
g. Student loans and grants
h. Tax refunds

5.3. The following may be used to prove income:

a. A tax return for the prior calendar year;
b. W-2 Form, or other IRS income forms;
c. Telephone verification from employer of employment and income is acceptable;
d. Most recent payroll check stubs: at least one, if it reflects a straight 40/80-hour period for a full-time employee; or a minimum of two if a part-time employee;
e. Other current income from retirement or disability benefits, Social Security, Veteran's Benefits or any other source of income not directly related to employment must be verified with check stubs or other documentation;
f. In the absence of any of the above, a signed affidavit from the patient attesting to income amounts.

5.4. Unemployment may be documented by presentation of:

a. Texas Employment Commission documents;
b. Letters from state and local agencies on their letterhead;
c. A statement from a physician, physician assistant, or a nurse practitioner, attesting to a physical condition precluding a patient from working. It must include "From and To" dates.
d. Confirmation of being a recipient of school reduced lunch program, Food Stamps (LoneStar Card), WIC or WARM of Wise County, any other private, local, state, or federal charity
e. In the absence of any of the above, a signed affidavit from the patient attesting to unemployment status.

6. Family Size

6.1. A family is a group of two or more persons related by birth, marriage, or adoption, which live together. All such related persons are considered as members of one family.

6.2. Family members are defined as follows:

a. The patient and, if married, a spouse;
b. Any natural, or adopted minor of the patient or spouse who has not had the disabilities of minority removed by a court and who is not, nor has ever been married;

c. Any minor for whom the patient or spouse has been given the legal responsibility by a court;
d. Any person designated as "dependent" on the patient's latest tax return;
e. Any student over 18 years old dependent on the patient's family income for over 50 percent support;
f. Any other person dependent on the patient's family income for over 50 percent support;
g. The clinically documented unborn child of a pregnant women within the patient's family;
h. Any minor child of a minor who is solely, or partially supported by the minor who is a member of the patient's family.

6.3. Marriage includes a common-law defined as a couple:

a. Having made a declaration of their marriage under Section 1.92 of the Family Code on a form prescribed by the Bureau of Vital Statistics; or
b. Having agreed to be married, and after the agreement, living together as husband and wife, and representing to others that they were married
c. Lacking any documentation proving otherwise.

6.4. Dependency is resolved by one of the following documents that contain the adult or spouse's name:

a. Court-ordered guardianship/conservatorship;
b. Current tax return;
c. Birth certificate;
d. Baptismal record;
e. Social security award letter;
f. U.S. Immigration documentation.
g. In the absence of any of the above, a signed affidavit from the patient attesting to the dependency of minor child, or other family member.

6.5. Generally, the patient's declaration of family size is accepted if it is consistent with the other documentation provided, except in those instances where the number of dependents and/or age of dependents does not appear reasonable in terms of the adult's or spouse's age.

6.6. A minor is defined as not having reached his/her eighteenth (18th) birthday and neither is, nor has been married. If the marital status of the minor cannot be determined, or there is no documentation indicating the patient is an emancipated minor, the parents or legal guardian shall be designated as the responsible party. The parent's or guardian's income and residence should be used to determine eligibility for reduced fees.

7. Other Applicant Categories

7.1. **Homeless Person** - A homeless person is defined as an individual who has no home or haven and depends on charity or public assistance. Such persons will generally be considered eligible, without presenting financial documentation. Proof of using shelter benefits may be required..

7.2. **Deceased Patients** - A patient who has expired may still be considered for financial assistance. The deceased patient's account may be reviewed for probate or other responsible parties (*e.g.* a guarantor). If the deceased patient has no estate and no other guarantor appears on the account, then the patient's income is deemed as zero for the purposes of the Application, an application and supporting documentation is not required if death can be determined.

7.3. **Federal health Care Program Patients** - If a patient qualifies for Medicaid, s/he may be considered eligible for an allowance to cover remaining balances after Medicaid has paid provided all the requirements of section 3.2 above are met. If the Texas Medicaid patient has met their 30-day Inpatient reserve days, any denied services related to that stay is written off to Charity if the requirements of 3.2 above are met. While it is our policy to attempt to collect Out of State Medicaid, if it is impossible after Reasonable Collection Efforts, the services rendered are Charity.

7.4. **County Indigent Care Patients** – If a patient meets the County Indigent guidelines and s/he has met their per year maximum benefits, s/he will automatically be considered eligible for Charity Care. Proof of Indigent Care eligibility may be required.

7.5. **Special programs as defined by WHS or WHC Administration** – If patient has accounts related to one of these programs a completed application on file is not required, subject to section 3.2

Community Programs – patient balances resulting from these programs or individually may be considered as charity adjustment without an application for assistance on file:
Sports Medicine Program
Medical Nutritional Counseling
First Responders
WARM recipient

Patient balances resulting from the Community DSRIP programs such as diabetic education, mental health dual diagnosis, CHF360, are considered as a charity adjustment without an application for assistance on file.

6.6 **Probability to Pay rating** – Attempts to collect on patient portions for patients who do not qualify or choose not to apply for financial assistance. Once the collection process is complete, the business office will determine that patient's probability to pay. If the rating is poor or moderate, the account is determined to meet charity requirements and collection attempts cease. These accounts are adjusted as charity without a completed application on file.

8. Determination and calculation of Eligibility

8.1. If a patient does not have Medicaid, but would qualify, s/he must cooperate with the application process. Only if the application is denied will the patient be considered for reduced fees.

8.2. Individual(s) who qualify for Medicaid but have service dates within the same calendar year prior to the effective date will qualify automatically for financial assistance for dates not covered by Medicaid.

8.3. Only patient balances are considered for charity write-off. The patient's balance is considered that amount for which there is no other funding available.

8.4. *Financially Indigent* – Individual(s) whose annual gross household income falls under or within guidelines established by Wise Health System and Wise Health Clinics, based on 300% or below of the federal poverty guidelines (Patients who fall under this category are accepted for care without a financial obligation or at a discounted rate).

8.5. *Medically Indigent* – Individual(s) whose insurance coverage, if any, does not provide complete coverage for all medical expenses and the medical expenses, in relationship to income would make them indigent if forced to pay the outstanding balance.

a. The patient is expected to pay the balance, after any partial financial assistance is adjusted, in monthly installments over a reasonable period.
b. If the patient does not qualify under the hospital's financial assistance guidelines, then the patient is expected to make reasonable payment arrangements, and the usual collection procedures will apply.
c. If the patient's income changes significantly; supporting documentation may be submitted for re-evaluation of financial assistance. Any payments made to date will are applied toward the amount due, and will not be refunded.
d. If a patient has not qualified for financial assistance based on the hospital's standard guidelines, and the patient presents extraordinary circumstances, such cases ae submitted to the VP of Revenue Cycle, CFO, or CEO for consideration.

8. Approval and Notification

8.1 All of the required documentation (exceptions noted considered) for Financial Assistance determination will be reviewed and approved by the Business Office and/or eligibility vendor.

a. Completed Applications for financial assistance and supporting documentation based on qualifying category are forwarded to the specified Business Office representative or eligibility vendor.
b. Once approved or denied, the Financial Counselor sends a Financial Assistance Outcome Notification letter to the patient along with instructions for obtaining an identification card. If the patient has a balance due, the letter should outline the monthly payments that will be required to meet the financial obligation. Notification will include a statement indicating that if the patient receives funding related to the services (e,g, liability settlement) they must remit payment to the hospital.
c. The Financial Counselor will document the patient account(s) as to the outcome of the financial assistance application, any balance due and the payment arrangement to fulfill the outstanding balance. Documentation level of financial assistance approved and any financial arrangements with the patient or guarantor are required on the initial account. Subsequent accounts are noted simply with the appropriate carrier code.

9.1. If an applicant wishes to appeal a denial or the level of the reduced fee allowance approved, s/he may do so by writing to the VP of Revenue Cycle. The appeal request will be reviewed by the VP of Revenue Cycle and VP of Corporate Compliance or VP of Legal Services.

10. System Designations

10.1. Appropriate financial classifications are assigned to qualified accounts to identify the level of patient responsibility. Upon approval, patients will receive an identification card which may include a picture and expected co-pays by service type

***11*. Changes to the Policy or Eligibility Criteria**

11.1. The eligibility criteria is reviewed annually by the Vice President of Revenue Cycle or designee, and updated to reflect published changes in the federal poverty guidelines. Revisions may be made at any time to the criteria or the policy based on changes in the hospital's financial ability to provide charity care, or changes in the state or federal regulations.

ATTACHMENTS

HHS Federal Poverty Guidelines (A1)
Financial Assistance Copay Schedule (A2)

RELATED DOCUMENTS

None.

REFERENCES

1128(b)(7) of the Social Security Act (the "Act")

1128A(a)(7) of the Act

42 CFR § 1001.952(k)

OIG Advisory Opinion 08-03 (Jan. 30, 2008)

Federal Poverty Guidelines published by the US Department of Health and Human Services periodically

2004.02.19: Text of Letter From Tommy G. Thompson Secretary of Health and Human Services To Richard J. Davidson, President, American Hospital Associations

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf

The information contained in this document should not be considered standards of professional practice or rules of conduct or for the benefit of any third party. This document is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider or, if applicable, the "Approver" deems appropriate under the circumstances.