Billing and Collection Policy

Hayward Area Memorial Hospital	
Policy Title:	Collection Policy
Policy #	8675309
Effective Date:	4/1/2016
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I. **PURPOSE:**

This policy applies to Hayward Area Memorial Hospital and Waters Edge and its employed medical partners (collectively "HAMH") , together with Financial Assistance Policy (FAP), is intended to meet the requirements of applicable federal, state, and local laws, including, without limitation, section 501(r) of the Internal Revenue Code of 1986, as amended, and the regulations there under. This policy establishes the actions that may be taken in the event of nonpayment for medical care provided by HAMH, including but not limited to extraordinary collection actions. The guiding principles behind this policy are to treat all patients and Individual(s)'s Responsible equally with dignity and respect and to ensure appropriate billing and collection procedures are uniformly followed and to ensure that reasonable efforts are made to determine whether the Individual(s) Responsible for payment of all or a portion of a patient account is eligible for assistance under the Financial Assistance Policy.

II. **DEFINITION:**

Plain Language Summary means a written statement that notifies an Individual(s) that HAMH offers financial assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP.

Application Period means the period during which HAMH must accept and process an application for financial assistance under the FAP. The Application Period begins on the date the care is provided and ends on the 240th day after the HAMH provides the first post discharge billing statement.

Billing Deadline means the date after which HAMH or collection agency may initiate an ECA against a Responsible Individual(s) who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual(s) provided at least 30 days prior to such deadline, but no earlier than 120 days after the first post discharge statement.

Completion Deadline means the date after which HAMH or collection agency may initiate or resume an ECA against an Individual(s) who has submitted an incomplete FAP if that Individual(s) has not provided the missing information and/or documentation necessary to complete the application or denied application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after HAMH provides the Individual(s) with this notice; or (2) the last day of the Application Period.

Extraordinary Collection Action (ECA) means any action against an Individual(s) responsible for a bill related to obtaining payment of a Self-Pay Account that requires a legal or judicial process or reporting adverse information about the Responsible Individual(s) to consumer credit reporting agencies/credit bureaus. ECAs do not include transferring of a Self-Pay Account to another party for purposes of collection without the use of any ECAs.

FAP-Eligible Individual(s) means a Responsible Individual(s) eligible for financial assistance under the FAP without regard to whether the Individual(s) has applied for assistance.

Financial Assistance Policy (FAP) means HAMH's Financial Assistance Program for Uninsured Patients Policy, which includes eligibility criteria, the basis for calculating charges, the method for applying the policy, and the measures to publicize the policy, and sets forth the financial assistance program.

PFS means Patient Financial Services, the operating unit of HAMH responsible for billing and collecting Self-Pay Accounts.

Responsible Individual(s) means the patient and any other Individual(s) having financial responsibility for a Self-Pay Account. There may be more than one Responsible Individual(s).

Self-Pay Account means that portion of a patient account that is the Individual(s) responsibility of the patient or other Responsible Individual(s), net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of an Assistance Program, as applicable.

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III. POLICY

A. Subject to compliance with the provisions of this policy, HAMH may take any and all legal actions, including Extraordinary Collection Actions, to obtain payment for medical services provided.

B. All patients will be offered a Plain Language Summary (Appendix A) and an application form (Appendix B) for financial assistance under the FAP as part of the discharge or intake process from a hospital.

C. At least three separate statements for collection of Self-Pay Accounts shall be mailed or emailed to the last known address of each Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All Single Patient Account statements of Self-Pay Accounts will include but not limited to:

1. An accurate summary of the hospital services covered by the statement;
2. The charges for such services;
3. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and
4. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of Financial Assistance under the hospital FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

D. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A Plain Language Summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

E. Responsible Individual(s) propensity to pay will be scored based on that assessment of the Responsible Individual(s) likelihood to pay and dollar amount of the Self-Pay account.

F. HAMH offers payment plans that bear no interest. Generally, balance require a minimum payment of $25.00 per month and must be paid in full within 24 months.

G. Prior to initiation of any ECAs, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.

H. ECAs may be commenced as follows:

1. If any Responsible Individual(s) fail to apply for financial assistance under the FAP by 120 days after the first post discharge statement, and the Responsible Parties have received a statement with a Billing Deadline described in Section III.E above, then HAMH or collection agency may initiate ECAs.

2. If any Responsible Individual(s) submits an incomplete application for financial assistance under the FAP prior to the Application Deadline, then ECAs may not be initiated until after each of the following steps has been completed:

a. PFS provides the Responsible Individual(s) with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the Plain Language Summary.

b. PFS provides the Responsible Individual(s) with at least 30 days' prior written notice of the ECAs that HAMH or collection agency may initiate against the Responsible Individual(s) if the FAP application is not completed or payment is not made; provided, however, that the Completion Deadline for payment may not be set prior to 120 days after the first post discharge statement.

c. If the Responsible Individual(s) who has submitted the incomplete application completes the application for financial assistance, and PFS determines definitively that the Responsible Individual(s) is ineligible for any financial assistance under the FAP, HAMH will inform the Responsible Individual(s) in writing the denial and include a 30 days' prior written notice of the ECAs that HAMH or collection agency may initiate against the Responsible Individual(s); provided, however, that the Billing Deadline may not be set prior to 120 days after the first post discharge statement.

d. If the Responsible Individual(s) who has submitted the incomplete application fails to complete the application by the Completion Deadline set in the notice provided pursuant to Section III.G.3.b above, then ECAs may be initiated.

e. If an application, complete or incomplete, for financial assistance under the FAP is submitted by a Responsible Individual(s), at any time prior to the Application Deadline, HAMH will suspend ECAs while such financial assistance application is pending.

I. After the commencement of ECAs is permitted under Section III.G above, collection agencies shall be authorized to report unpaid accounts to credit agencies, and to file judicial or legal action, garnishment, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior approval of PFS shall be required before initial lawsuits may be initiated. HAMH and external collection agencies may also take any and all legal other actions including but not limited to telephone calls, emails, texts, mailing notices, and skip tracing to obtain payment for medical services provided.

IV. POLICY AVAILABILITY

Contact our Business Office at 715-934-4267 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, FAP application form, or Collection Policy to be mailed to you, or if you need a copy of the FAP, FAP application form, or Collection Policy translated to Spanish. Full disclosure of the FAP, FAP application form, or Collection Policy may be found at www.haywardmemorialhospital.com/financial-services/ . A paper copy of our FAP, FAP application form, or Collection Policy can be obtained at our facility located at 11040N State Rd. 77, Hayward, WI 54843 at the registration desk.

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Appendix A: FAP Plain Language Summary

The Financial Assistance Policy at Hayward Area Memorial Hospital outlines the general guidelines for providing assistance to patients and families. It addresses the most common situations that may happen. It is not intended to be all inclusive.

Some highlights of the policy include:

- No patient will be denied financial assistance because of his or her:
    - Race
    - Creed
    - Nationality
    - Origin
    - Citizenship
    - Immigration status
- Financial assistance will be provided to any families who are determined to be unable to pay all or part of billed charges. This includes co-payments, co-insurance and deductibles.
- Financial assistance will be given after insurance coverage, government assistance programs and other benefits available to the patient have been explored and used.
- Non-compliance with insurance policy guidelines (for example, appeals, referrals, non-authorized services) or failure to pursue available government assistance programs before requesting assistance may prevent participation in the Financial Assistance Program.
- Hayward Area Memorial Hospital will provide care for emergency medical conditions to anyone.
- All income in the patient's household will be considered when determining ability to pay. This includes gross wages, government payments, pensions, child support, unemployment compensation, car accident or personal injury payments, and any other payments that are considered income by the U.S. Internal Revenue Service.
- A letter will be sent to let the patient know if the application is approved. If financial assistance is denied, an appeal can be filed with the Patient Financial Services Department.

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Appendix B: Financial Assistance Request Form

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY STATE ZIP		PRIMARY CARE PHYSICIAN
DATE OF BIRTH / TELEPHONE - HOME	TELEPHONE - WORK		TELEPHONE - CELL

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP	Please check this box if you are applying to pre-qualify ☐
STREET ADDRESS	CITY STATE ZIP	SOCIAL SECURITY NUMBER
DATE OF BIRTH / TELEPHONE - HOME	TELEPHONE - WORK	TELEPHONE - CELL

III. Household Information – Please indicate ALL people living in your household, including applicant (use additional paper, if necessary)

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	EMPLOYER NAME	YEAR TO DATE INCOME	INSURED? IF YES, LIST INSURANCE (I.e. Blue Cross, Medica, etc.)
1.					Yes ☐ No ☐
2.					Yes ☐ No ☐
3.					Yes ☐ No ☐
4.					Yes ☐ No ☐

IV. EMPLOYER		SALARY WEEKLY $
V. SPOUSE'S EMPLOYER		SALARY WEEKLY $
VI. OTHER INCOME		AMOUNT $

VII. Expenses and Assets

Rent/mortgage payment $	Checking account balance $	Health Insurance Premium $
Mortgage loan balance $	Savings account balance $	Other Assets $
Real market value of home $	Stocks, bonds, CDs, etc. $	Monthly Food Costs $
Real estate other than primary $	Recreational vehicles $	Child Support received/paid $

Please feel free to attach additional information regarding your current situation.

VIII. Required Documentation – Information that must be sent with this application

Please check that you have included the following:

☐ * Copy of previous year's tax returns	☐ Copy of latest bank statements	☐ Income verification showing earnings or pay stubs for all income year-to-date

We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. If you have questions regarding this form, please call 715-934-4321.

* Please note: If your parent or someone else provides your basic living support, you must include their tax and income information.

IX. Authorization

I hereby certify the information contacted in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Hayward Area Memorial Hospital to verify any or all information given.

_____ _____

RESPONSIBLE PERSON'S SIGNATURE DATE