HAMH Financial Assistance Policy

Hayward Area Memorial Hospital	
Policy Title:	Financial Assistance Policy
Policy #	8675310
Effective Date:	10/1/16
Revision Date:	2/26/19
Review Responsibility and Final Authority to Determine Reasonable Effort has been made:	Sheila Itzen

Hayward Area Memorial Hospital and Waters Edge (HAMH) is committed to providing emergency and medically necessary health care services to patients without regard to their ability to pay. HAMH recognizes that, due to economic and personal financial hardship, financial assistance may be necessary to allow the patients we serve to get the care they need. No patient will be denied financial assistance on the basis of race, creed, nationality, origin, citizenship, or immigration status. Financial assistance will be provided to the patient and his or her guarantor (typically, the patient's parent or legal guardian) who, after investigation of circumstances surrounding ability to pay, is determined to be unable to pay all or a portion of billed charges. This includes patients who are insured, but determined to be unable to pay all or a portion of their co-payments, co-insurance, and deductibles.

Financial assistance will take the form of discounted or free care

Community based physicians not employed by the HAMH (Appendix A) may bill separately for services and will not be included in this policy. Refer to Appendix B for a list of providers included in this policy.

Financial assistance will be given only after applicable insurance coverage and government assistance programs have first been explored (and applied, to the extent available). Noncompliance with insurance policy guidelines (*i.e.*, appeals, referrals, and non-authorized services) or failure to pursue available government assistance programs may prevent participation in the Financial Assistance Program, as determined by HAMH in its discretion.

Notwithstanding any other provision of this policy, HAMH will provide, without discrimination, care for Emergency Medical Conditions (within the meaning of Section 1867 of the Social Security Act (42 USC 1395dd)) to all individuals seeking such care, regardless of their ability to pay or their eligibility for financial assistance under this policy.

This policy addresses only the most common situations that may arise, and it is not intended to be all-inclusive. This Policy is intended to describe HAMH general financial assistance guidelines.

Procedure

A. ***Notification of Program*** -- Guarantors will be notified of the availability of the HAMH Financial Assistance Program upon request; guarantors will be offered a plain language summary of this policy prior to the patient's discharge (plain language summaries will be available in the emergency department, admissions area and other appropriate areas of the hospital). HAMH will provide the plain language summary at the front desk or waiting area. In addition, as provided in HAMH's Policy on Billing and Collection for Self-Pay Amounts, in all billing statements (at least 3)

over a period of not less than 120 days commencing on the date of the first bill issued to the guarantor for such services, HAMH will inform the guarantor of the availability of financial assistance. During the same 120-day period, all written and oral communications with HAMH financial representatives regarding amounts due for the care provided will include information regarding the availability of financial assistance pursuant to this policy.

B. ***Determination of Household Income*** -- Financial assistance will be determined by measuring the income of the household of the designated guarantor and the household of any other adult responsible for the patient ("Household") against the current poverty guidelines established by the US Department of Health and Human Services (US DHHS).

C. ***Scope of Income to be Considered*** -- All income in the Household will be considered, including gross wages, government payments including but not limited to tax refunds and *Social Security payments*, pensions, alimony, child support, unemployment compensation, and any payments that are considered *taxable* income by the US Internal Revenue Service.

D. ***Discount Percentage*** -- The measure for financial assistance will be a sliding scale based on the US DHHS Federal Poverty Guidelines (FPG), as follows (see Appendix C for FPG table):

Household Income Level	*Maximum Discount Percentage (Includes Uninsured Discount)*
At or below 100% FPG	100%
At or below 200% FPG	50%

E. ***Calculation of Charges and Amount Due*** -- Following a determination of financial-assistance eligibility, the eligible individual will not be charged more for emergency or medically necessary care than the amounts generally billed (AGB) to individuals with insurance covering such care.

At HAMH the AGB is determined through the "Look-back method" which is calculated as follows:

- For 2019, HAMH is using the "look-back method" to calculate the AGB. This method based AGB on fully allowed payments amounts for hospital claims with a primary payer of either Medicare fee for service or a commercial payer during the period 1/1/18-12/31/18. HAMH divides the sum of total payments allowed by those payers (including coinsurance, copayments, and deductibles) by the sum of total hospital charges for those claims to identify the "AGB percentage".
- HAMH will not charge patients eligible for financial assistance more than below-noted AGB percentage for emergency or medically necessary services in 2019-2020.
    - AGB for the period 3/1/2019-2/29/2020 (unless earlier updated) will be 53 percent of total hospital charges.
- HAMH will re-calculate its AGB at least annually.

F. ***Qualification Based on Size of Bill*** -- Financial assistance may also be provided for guarantors who are unable to pay some or all of the patient's hospital bills because the bills are so extensive that payment threatens the Household's financial stability, even though the Household's income

otherwise exceeds 200% of FPG. Such financial assistance will be determined based on an individual assessment of the Household's financial resources (income and assets) and the size of the patient's hospital bill.

G. ***Application Process*** -- Applicants for the Financial Assistance Program must complete the "Financial Assistance Application" (Appendix D). Supporting documentation such as tax returns and check stubs as outlined in the Financial Assistance Application are required. Financial assistance applications are available by contacting the Patient Financial Service Department at HAMH via telephone at (715) 934-4267, in person (Monday through Friday, or by appointment) at the registration desk. The application is also available for download from HAMH website: http://haywardmemorialhospital.com/financial-assistance-policy/ Representatives are available to assist families with the application process. Completed applications should be returned in person at the registration desk or by mail to the HAMH Patient Financial Services, 11040 N State Road 77, Hayward, WI 54843. If an incomplete application is submitted, a letter will be generated to the guarantor asking for additional information to be provided within 30 days.

H. ***Approval/Denial of Financial Assistance*** - A letter either approving or denying a request for financial assistance will be sent to the applicant within 30 days of the receipt of a completed application. A completed application includes all required supporting documentation. Denials may be appealed through the Patient Financial Services Department. All appeals should be requested in writing, and include supporting documents that demonstrate the inability to pay that were not available or included at the time of initial consideration. Decisions regarding Financial Assistance are documented in the billing system.

I. ***Time Period for Submission of Applications*** -- HAMH will accept and consider financial assistance applications submitted at any time up until the date that is 240 days after the date of the first billing statement issued by HAMH to the guarantor for the services at issue. Applications made during this timeframe will be considered even if the account has already been placed with a collection agency; if such an application is received for financial assistance, collection efforts will be terminated or modified as appropriate based on the financial assistance determination.

J. ***Duration of Eligibility Determination*** -- A determination of qualification for financial assistance will apply with respect to all medically necessary services rendered, and charges incurred, during a period commencing *with the date of* the original services for which financial assistance was *sought* and continuing for 180 days after financial assistance qualification was determined. Additional services rendered and charges incurred after such date will require the completion of a new application as described in (G) above.

K. ***Effect of Non-Payment*** -- Balances remaining after application of the financial assistance discount are subject to timely payment consistent with standard HAMH billing and collection practices. In the event of non-payment, HAMH may take any and all collection actions described in HAMH's policy on Billing and Collection for Self-Pay Amounts; a free copy of that separate policy can be obtained by contacting the Patient Financial Service Department, or our website as described in (G) above.

L. ***Presumptive Financial Assistance Eligibility*** -- Patients who are unable to complete an application form may be eligible for Financial Assistance if other evidence is available which may indicate financial hardship. This information may be obtained from a patient interview, credit bureau, or other available records. Consideration may be given on an individual basis. Examples of patient circumstances that would indicate financial hardship and presumptively qualify for finance assistance are as follows:

1. Deceased with no estate – based on the conclusion that the decedent has no assets, and therefore no ability to pay.
2. Accounts uncollectible due to discharge of account by bankruptcy.
3. Patients who are homeless at the time of registration or admission.
4. If it has been determined that a patient has been approved for Medical Assistance, but not backdated to cover delinquent accounts with Hospital will be written off for Financial Assistance.
5. Any account returned by the collection agency that has been determined to be uncollectible may be considered for Financial Assistance.
6. Qualified individuals under another organization's similar Financial Assistance application process.
7. If verified with out of state Medicaid, and hospital is not contracted with said state and they deny for no contract.
8. Patients listed for collections will be scored through a credit bureau. This score will cause a "soft hit" on your credit file and will not affect your credit score. All accounts that score below 499 and have no payments applied to the account will be qualified for Financial Assistance.
9. Patients with Medicaid coverage from other states that the hospital is not contracted with. Medicaid coverage will be verified and then billed first; presumptive eligibility will occur at time of denial.

M. ***Publication of Financial Assistance Policy*** -- This policy, the Financial Assistance Application, and a plain-language summary will be made available for download from HAMH website: http://haywardmemorialhospital.com/financial-assistance-policy/. Paper copies will be made available upon request and without charge at the registration desk. Signs notifying hospital visitors about the policy will be posted. The hospital will develop a plan to inform and notify residents of the community served about the policy in a manner reasonably calculated to reach those most likely to require financial assistance.

N. ***Uninsured Discount*** – Uninsured patients - excluding those receiving cosmetic procedures will be given an uninsured discount of 5%. The discount is comparable to the discount provided to most insurance companies.

Approved by: _____

Brad Zeller, Vice President
Hayward Area Memorial Hospital and Waters Edge

Appendix A: Non Covered Providers
(Click link above for list)

Appendix B: Covered Providers
(Click link above for list)

Appendix C: Federal Poverty Guidelines FFY 2019

Unit Size	100% Discount (100% of FPL)	50% Discount (200% of FPL)
1	$12,490	$24,980
2	$16,910	$33,820
3	$21,330	$42,660
4	$25,750	$51,500
5	$30,170	$60,340
6	$34,590	$69,180
7	$39,010	$78,020
8	$43,430	$86,860
9	$47,850	$95,700
10	$52,270	$104,540

Appendix D: 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 715-934-4267.

* 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