PHILIP HEALTH SERVICES

Originating Department: **Patient Financial Services**	
Affected Departments/Employees: Patient Financial Services	

Financial Assistance

Purpose:

In accordance with our Mission, Vision, and Values Statement, Philip Health Services, Inc. believes it is imperative to provide our patients with not only the best medical care and accessibility that we can provide, but to also extend our commitment to our patients throughout the entire billing process and in compliance with 501(r)(4A). It is the goal of Philip Health Services, Inc. to provide quality care regardless of a patient's ability to pay for services. We understand that healthcare costs are usually unexpected and can also be very overwhelming; however, our ability to provide uncompensated care is limited.

Policy:

As a courtesy and convenience to our patients, our Financial Services Department offers financial assistance to qualified patients who are exempt from insurance in accordance with the ACA (Affordable Care Act) or are underinsured and do not have adequate resources to pay for medically necessary services that have been provided. See Appendix A for services that are eligible for coverage under the Financial Assistance Program (FAP). Financial assistance applications are processed in accordance with the policy. Any accounts that occurred more than 180 days previously will not be considered for financial assistance. No patient/resident that meets these requirements shall be denied uncompensated health care based upon race, creed, color, sex, national origin, sexual orientation, disability, age, or source of income.

Our program is a payer of last resort and if the patient qualifies for another program, including, but not limited to: government sponsored insurance, Affordable Care Act insurance plans, and has chosen not to utilize the program(s); they are not eligible for our financial assistance program. The Affordable Care Act (ACA) states that everyone must have insurance, but Philip Health Services, Inc. does consider hardship and debt ratio for those who are uninsured (Medically Indigent) and do not qualify for subsidized insurance plans (i.e. Medicaid). If the financial counselor believes that another program could be utilized and was denied, a denial will be requested before consideration can be given. If the denial cannot be obtained, our financial counselors will then work with the patient to arrange payment terms, based on the unique circumstances and in accordance with Philip Health Services, Inc.'s payment policy.

Philip Health Services, Inc.'s financial assistance program is administered in conjunction with the Federal Poverty Guidelines that are used nationwide and that pertain to medical services provided at Philip Health Services, Inc. only. These guidelines incorporate rationale for age, number and ages of dependents and provide definitions of family and gross income. The United States Department of Health and Human Services sets the Federal Poverty Guidelines (FPG) and applies annual revisions to account for increases in the Consumer Price Index.

The guarantor's household gross income is compared to the Federal Poverty Guidelines (FPG). If the household gross income is less than or equal to 100% of the FPG, 100% of the patient's eligible balance will be forgiven. If the household gross income is more than 100% but equal or less than 200% of the FPG a sliding scale will be applied to determine the amount forgiven.

Definitions

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have been or will be provided by a provider and are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

> Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources – determined on a before tax basis.
>
> If a person lives with a family, includes income of all family members. (Non-relatives, such as housemates, do not count.)

Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deduction from revenue are applied.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act (43 U.S.C. 139dd).

Medically Necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Poverty Guidelines: The poverty guidelines are simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of Census to prepare its statistical estimates of the number of persons and families in poverty. The poverty guidelines are used primarily for statistical purposes. However, the Department of Health and Human Services uses the thresholds for administrative assistance or services under a particular federal program. Other programs, such as our Financial Assistance Program, use the guidelines for the purpose of giving priority to lower income persons or families in the provision of assistance or services. Our poverty guidelines are based on last (calendar) year's increase in prices as measured by the Consumer Price Index. The poverty guidelines are published in the Federal Register and are revised yearly.

Amounts Generally Billed (AGB): No person eligible for financial assistance under the FAP will be charged more for medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care. Philip Health Services, Inc. determines AGB based on all claims paid in full to Philip Health Services, Inc. by Medicare, Medicaid and/or private health insurers over a 12-month period, divided by the associated gross charges for those claims. To obtain a copy of the AGB%, free of charge, please contact a financial assistance representative.

PROCEDURE:

Eligibility Requirements

1. Shall be consistently and equitably administered in accordance with established eligibility requirements
2. All patients with a self-pay balance may be eligible for financial assistance which can include free or discounted care as indicated in Attachment B. However, financial assistance generally excludes care found not to be medically necessary, or disallowed by government or third party payers including procedures considered elective, experimental or cosmetic in nature.
3. The full application process must be completed, preferably by the patient/responsible party. Falsification of the application information, failure to fully disclose all assets and/or income, or refusal to cooperate will result in denial of Financial Assistance benefits.
4. All third party resources and non-hospital financial aid programs including public assistance available through the state Medicaid program must be exhausted before

financial assistance can be considered. If an individual has applied for and has not yet received a determination, the eligibility for financial assistance will be postponed until the Medicaid Eligibility determination has been made.

5. Philip Health Services, Inc. reserves the right to review eligibility status at any time, and to modify or nullify prior benefit determination if financial circumstances have changed.
6. Outside factors may be used to determine presumptive eligibility when a patient has not applied, or if information submitted is incomplete. Outside factors used may include credit-score-like data (prior credit history with the hospital); demographic information obtained during admission, prior FAP applications, etc. If the patient is determined to qualify for charity care under presumptive requirements the patient receives a 100% discount. If an application is received, the hospital will make final determination based on the application.
7. Net worth will also be considered when determining eligibility. Regardless of income, your debt to Philip Health Services, Inc. must be more than 20% of your net worth (assets minus liabilities) to be eligible for financial assistance.

Method for Applying for Financial Assistance

The Financial Assistance Application (Attachment D) can be completed before or after services are provided. The application must be received within 180 days after discharge.

The forms may be completed by the applicant at home or onsite with the assistance of Patient Financial Services Personnel. All required supporting documentation must be included with the application.

The application can be obtained as described in the section below:

1. Telephone: (605) 859-2511
2. Address: Philip Health Services, Inc., P.O. Box 790, Philip, SD 57567
3. Website: www. philiphealthservices.com

A patient will not be deferred or denied medically necessary care based on the non-payment of previously provided care, if financial assistance has not yet been determined.

Extraordinary Collection Actions (ECA):

Philip Health Services, Inc. will not take any ECA actions without making a reasonable effort to determine at patient's financial assistance eligibility in accordance with limitations outlined in the policy.

Measures to widely publicize this policy within the community served by the facility

1. Financial Counselors will make paper copies of the financial assistance policy, application, (attachment D) and plain language summary (Attachment C).
    - The paper copies are available upon request and without charge.

- Documents are readily available during normal business hours either directly from the Financial Counselor or by mail.
- Each document is available in English and in the primary language of any populations with limited proficiency in English that constitutes more than either (a) 1,000 individuals or (b) 5% of the residents of the community services by the facility.

2. As part of the intake or discharge process, patients are offered a Patient Information packet that outlines payment plan options and Financial Assistance Policy Information including the Plain Language Summary (Attachment C).

3. Notify and inform members of the community served by the hospital facility about the Financial Assistance Policy with the information available on each billing statement.

4. Philip Health Services, Inc. financial assistance contact information is posted on the home page of the facility website at www.philiphealthservices.com . The financial assistance documents can be accessed, downloaded, viewed and printed from the website.

Administration/Guidelines of Financial Assistance Program:

1. Philip Health Services, Inc. Financial Assistance Program will be administered according to the following guidelines:
    a. The application information, along with all the required documentation will be reviewed by the Patient Financial Counselor.
    b. Patient Financial counselor will complete the Worksheet for Annual Income, Worksheet for Income and Asset Calculation, and Worksheet for Discount Calculation.
    c. After reviewing the application, the CEO or designee will determine if the patient/responsible party qualified for financial assistance based on the supporting documentation and the recommendation of the Patient Financial Counselor who verified the information contained in the application.
    d. The approval of the CEO is required for all amounts to be written off to the Financial Assistance Program.
    e. Patient Accounts Data Entry personnel will write off approved amounts from the patient's accounts(s) per established procedures.
    f. The patient/responsible party will be notified in writing within thirty (30) days from applying (when all documentation has been received) if they were approved for financial assistance.
    g. The application will be kept on file for seven (7) years.
    h. Providing the patient/responsible party's finances change significantly between tax seasons, current income for the household as defined in Attachment D will determine eligibility in lieu of the federal income tax requirements. An approved application will be a one-time grant.

i. If an applicant is habitually non-compliant with the program guidelines and assistance efforts made by the financial counselor and staff, the applicant will fall under a penalty status and will not be able to reapply for 6 months or may be required to submit a fully completed application with all required documents prior to non-emergent services(s). During this penalty status period patient balances will be eligible for collection and credit reporting after 30 days from the date of service.

Appeal Process:

1. The patient/responsible party has the right to appeal the financial assistance decision.
2. The appeal must be received with in thirty (30) days of the determination.
3. The appeal must include documented proof justifying why the patient/responsible party is unable to pay.
4. The appeal is forwarded to the Director of Patient Accounts and is reviewed with the CEO.
5. The patient/responsible party will be notified within sixty (60) days from submission of the appeal if they are approved.