

Financial Assistance Policy (FAP)

<i>Department:</i>	Business Office
<i>Category:</i>	Financial Assistance Policy
<i>Approval Responsibility:</i>	Board of Directors
<i>Review Responsibility:</i>	CFO, CEO

PURPOSE:

Wayne County Hospital, Inc., a tax-exempt organization, is committed to meet the needs of patients who seek emergency and medically necessary care within our scope of services, regardless of the financial ability to pay for services provided. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the related regulations. The purpose of this policy is to outline the circumstances under which Wayne County Hospital, Inc. will provide free or discounted care to patients who are unable to pay for services, and to address how Wayne County Hospital, Inc. will calculate the amounts charged to those patients. This policy has been adopted by the governing body in accordance with the regulations under Section 501(r).

DEFINITIONS:

- A. 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.
- B. Medically Necessary – Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity threaten to cause or aggravate a handicap, or cause physical deformity of malfunction, if there is no other equally effective, more conservative or less costly course of treatment available. Medically necessary does **NOT** include the following: elective cosmetic surgery; surgical weight loss procedures; experimental procedures, including non-FDA approved procedures and devices or implants; services for which prior authorization is denied by the Patient’s insurance carrier; fertility treatment; services or procedures for which there is a reasonable substitute or if the Patient’s insurance company will provide a service or procedure that is a covered service or procedure.

POLICY:

Overview. Wayne County Hospital, Inc. is dedicated to providing quality healthcare to all patients regardless of age, sex, sexual orientation, race, color, religion, disability, national origin and/or ability to pay. This policy establishes the Financial Assistance Program that is available to uninsured patients. All patients identified as uninsured will be screened for Financial Assistance Program eligibility.

Financial Ability. Financial assistance is available for medically necessary services at a discount rate of 100% of gross charges. The 100% discount will be extended to those self-pay patients(uninsured) whose family income is equal to or less than 150% of the Federal Poverty Level. Lesser discounts are not available for those that exceed 150% of the Federal Poverty Level.

Exclusions. This policy does not apply to charges for services from other providers whose services are coincident to those proved at WCH. For example, services provided by contracted ER physicians, contracted radiology services, pathology, etc. are not covered by this policy. For a list of providers who follow this Financial Assistance Policy, please see Exhibit A. Providers that do not follow this policy will be listed on Exhibit B. WCH will update these exhibits at least quarterly.

PROCEDURES:

A. Financial Assistance Policy Publication

1. WCH will publicize the availability of its Financial Assistance Policy within the communities it serves by taking the following action:
 - a. WCH will post this Policy and its Financial Assistance Application on its website.
 - b. Signs will be posted at registration areas describing the available assistance and directing eligible patients to the Financial Assistance Application.
 - c. Financial Counselor will be available during her regular work hours to address questions related to Financial Assistance. A paper copy of the application may also be mailed to a patient at their request free of charge.

B. Financial Assistance Application

1. Patients or their guarantors wishing to apply for Financial Assistance must submit a Financial Assistance Application with supporting documentation within one hundred twenty(120) days of receiving their first billing statement from WCH to avoid extraordinary collection actions.
2. Financial Assistance Applications may be obtained as follows:
 - a. Request and obtain them while being treated at the facility.
 - b. Download the policy and application from our website at www.waynehospital.org.
 - c. Request the policy and/or application to be mailed to you by calling 606-348-9343.
 - d. Visit our Patient Financial Counselor at 166 Hospital Street, Monticello, KY 42633.
 - e. Obtain the policy and application at each hospital registration desk.
 - f. Mail the completed application (with all required documentation/information specified to Patient Financial Counselor, Wayne County Hospital, Inc.,166 Hospital Street, Monticello, Ky 42633.
3. WCH keeps all applications and supporting documentation confidential.

C. Eligibility Criteria and Determination

1. Except as otherwise provided herein, an uninsured patient will ordinarily qualify for the Financial Assistance Program if he or she meets each of the following requirements:
 - a. Must be self-pay
 - b. Services cannot be related to an auto accident
 - c. Completes the Financial Assistance Application attached as Exhibit C of this Policy
 - d. Has an annual household income equal to or less than 150% of the Federal Poverty Level
 - e. Cannot exceed Countable Resources as stated in the FAP application
 - f. If there are minor children in the home, must be referred to the Medicaid office
 - g. If requested by WCH to apply for Medicaid or other state or federal programs, fully cooperates in the application and eligibility determination process;
 - h. Is denied Medicaid Coverage; and
 - i. Complies with the Patient Responsibilities listed in this policy
 - j. Must supply proof of income to determine eligibility. Proof of income examples:
 - a) Check stubs for the last 30 days
 - b) Social Security award letters or copy of bank deposit showing SS deposit

Wayne County Hospital

- c) Written verification of wages from employer for the last 30 days
 - d) Written verification from public assistance summarizing benefits
 - e) Workers Compensation checks/award letters
 - f) Unemployment checks/award letters
 - g) W-2's
 - h) If self employed a financial statement of gross income less business expenses
 - i) Copy of 1040 federal income tax return
2. When a determination of eligibility for Financial Assistance has been made, all of the Patient's accounts will be handled in the same manner for six months following the date of such determination, without the need for completing a new application for Financial Assistance. In addition, WCH will consider patients eligible for Financial Assistance discounts on all uninsured balances looking back 240 days from the eligibility determination date. A new application will be required for services provided six months or more after the initial (or other prior) determination or if indications are received that the Patient's financial status has significantly changed from the initial evaluation period.

D. Patient Responsibilities

To be eligible for Financial Assistance, patients must complete the required application form truthfully and submit all applicable documentation. Patients must respond to a request for information or documentation in a timely manner. If a patient is asked to apply for Medicaid or other state or federal programs but does not cooperate fully with the application and eligibility determination process will not be eligible for participation in the Financial Assistance Program. Patients must notify WCH promptly of any change in financial situation so that WCH can assess the change's impact on that individual's eligibility for Financial Assistance or a payment plan. If a patient knowingly provides untrue information, he or she will be ineligible for financial assistance, any financial assistance that has been granted may be reversed, and the individual may become responsible for paying their entire bill.

E. Payment Plans

Wayne County Hospital, Inc. will offer interest free payment plans for patients for the amounts that they are personally responsible for paying, after applying any insurance reimbursements. To participate in a payment plan, the Patient's remaining balance must be a minimum of \$25 a month and/or paid off in 36 months. Example: Remaining balance on an account total \$1,250. The monthly minimum payment of \$34.72 would meet the criteria of being more than \$25 a month and being paid off within 36 months.

F. Charges/Self-Pay discount

Wayne County Hospital, Inc. limits the amount charged for any emergency or other medically necessary care it provides to all self-pay patients to no more than the amounts generally billed to individuals with insurance that covers their care (AGB). WCH's AGB is determined annually using the look-back method.

G. Collection of Balances Owed by Patients

1. Wayne County Hospital, Inc. prohibits the use of extraordinary collection actions on patients qualifying for financial assistance per Federal Regulation 501(r)(6).
2. Financial Assistance Counselors are available during normal business hours to assist patients with completing the Financial Assistance Program application. Once the completed application is received, a determination will be made within 30 days. Patients will be notified in writing of the approval or denial by the Financial Assistance Counselor. A monthly statement will cease on all

Wayne County Hospital

approved cases, and the account balance will be written off. A monthly statement will continue on all denied cases.

3. During the notification period, monthly statements will be sent every 30 days for collection of self pay accounts until such time the account reaches the age of 120 days from the first billing statement and will be mailed to the last known address of each responsible individual before the end of the notification period. By this time, all reasonable attempts to contact the patient will have exhausted. Patients with an incomplete application, denied application, or cases of “no response” will be sent a final notice letter. The letter will inform patients that their account will be sent to an outside collection agency, if they do not respond within 10 business days. If no response or payment, the account will be outsourced to a collection agency.
4. WCH will continue to accept FAP applications from patients for an additional 120 days from the first billing statement. The total period of time the hospital will accept and process a FAP application is 240 days from the date of the first billing statement. If the FAP application is approved, the patient will be refunded for any personal payments made on the account. If the account has been outsourced to an outside collection agency, the account will be recalled.

NAME

TITLE

DATE

NAME

TITLE

DATE

Origin:								
Reviewed:								
Revised:								