POLICY TITLE: Financial Assistance Policy

I. Policy:

It is the policy of the hospital to provide free, or partially free, medically necessary health care services to patients who have demonstrated that they are uninsured, under-insured or medically indigent. All patients will be treated fairly and respectfully regardless of their ability to pay. The hospital does not discriminate against any person on the grounds of race, creed, color, national origin, or on the basis of disability or age.

II. Definitions:

"Financial assistance" is the portion of patient care services provided by the hospital for which a third-party payer is not responsible and the patient has demonstrated the inability to pay or qualifies for special circumstances charity care".

Financial assistance does not include bad debt contractual allowances, or self-pay discounts. The term medically necessary is used to define that services are necessary in the continued treatment of the patient's condition and are emergent.

"Financially qualified patient" means a patient who is both of the following:

- A patient who is a self-pay patient or a patient with high medical costs, or a special circumstance patient, as defined herein.
- A patient who has a family income that does not exceed 400 percent of the federal poverty level

"Full Charity Care" is a 100 percent write-off of the hospital's undiscounted charges for hospital services. Full charity care is available to patients:

- Whose family incomes are at or below 200 percent of the most recent federal poverty level guidelines and
- Who is a self-pay patient, as defined herein.

"A patient with High Medical Cost" means a person whose medical cost at the hospital exceed 20% of gross family income and the individual does not receive a discounted rate from the hospital as a result of his or her third party coverage. For these purposes, "high medical costs" means any of the following:

- Annual out-of-pocket costs incurred by the individual at the hospital exceed 20 percent of the patient's family as defined herein, income in the prior twelve months.
- Documented annual out-of-pocket total medical expenses that exceed 30 percent of the patient's family income, as defined herein, in the prior twelve months.

"Partial Charity Care" is a partial write-off of the hospital's undiscounted charges for hospital services. Partial charity care is available to patients:

- Care discounted at to 135% of hospital cost for uninsured Illinois residents with family incomes up to 600% FPL in urban areas, and 300% FPL in rural areas.
- Who is a self-pay patient, as defined herein.
- For patients whose family Incomes are between 201%-400% of the most recent federal poverty income guidelines the hospital shall limit expected payments, as determined by the Reduced Fee Schedule delineated herein;

"Patient's family" means the following:

- For persons 18 years of age and older: spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not.
- For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

"Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients. Where appropriate, the term "self-pay patient" may also refer to the patient's representative or the patient's guarantor.

"Special Circumstances Charity Care" refers to self-pay patients who are unable to follow specified hospital procedures to receive a complete or partial charity write-off of the hospital's undiscounted charges for services and who receive the approval of the Director of Patient Services, or their designee. Special circumstances charity care may be considered as presumptive eligibility for charity care and does not require a charity care application to be on file. The hospital must document the decision, including the reasons why the patient did not follow the regular charity care process criteria.

The following is a non-exhaustive list of some situations that may qualify as special circumstances charity care:

- Bankruptcy: self-pay patients who are in bankruptcy;
- Homeless Patients: self-pay emergency room patients, if the patient does not have a mailing address and/or residence.
- Deceased: self-pay deceased patients without an estate.

- Medicaid: income-eligible (As determined by Section IV)/Medicaid patients are eligible for special circumstance charity care for denied stays, denied days of care, and non-covered services; however, patients may not receive charity care for the Medicaid share of cost. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered are eligible for charity care.
- Uninsured patients that were screened, stabilized, or admitted through the emergency room department that cannot be reached will be classified as charity care.

III. Procedure:

Every effort will be made to ensure that patients with an inability to pay are provided the self-pay charity request application ("Application") and information regarding financial assistance available. The Application (Attachment B) shall request documentation supporting the patient's or the patient's family monetary assets.

Patients will be instructed to complete the forms and return them by mail or in person to a Patient Accounts representative. If a patient does not complete the application within 30 days of delivery, the hospital will notify the patient that the Application has not been received and will provide the patient an additional 30 days to complete the application. Failure to complete and return the Application within these timeframes may result in the self-pay patient being denied charity care.

Supporting documentation includes verification of income. Verification of income includes (1) the most recent Federal income tax return or Form 1722 from the Internal Revenue Service confirming no tax return was filed and/or (2) check stubs from the last month or a letter from the employer confirming income.
Information on dependents, expenses and assets should also be provided. Monetary assets shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. The first $10,000 of a patient's monetary assets will not be counted in determining eligibility.

The Medicaid application or the Medicaid eligibility screening application can be used in lieu of the Application. Information can be independently verified; misrepresentation can result in denial of financial assistance.

Financial assistance determination is based upon income, assets and family size utilizing the Department of Health & Human Services Annual Poverty Guidelines published in the Federal Register. Financial assistance is provided for 100% of the patient's responsibility when their income is less than 200% of the Annual Poverty Guidelines. A reduced fee schedule is available from 200% to 400% of the Annual Poverty Guideline. A partial charity care patients' responsibility may not exceed the Medicare reimbursement amount for a similar service and encounter. Patient's annual out-of-pocket liability to the hospital shall not exceed 30% of their annual gross income.

Patients must be ineligible for coverage by Medicaid to be considered for financial assistance. While the Poverty Guidelines are the primary determinant of eligibility, financial assistance may include evaluation of assets, whether for the wage-earner, small business owner or farmer. Financial evaluations forms are active for one year of approval date.

Reduced Fee Schedule

Federal Poverty Guideline	200%	300%	400%
Fee Reduction	100%	80%	68%

Financial assistance may be provided for the entire account balance for self-pay patients or for coinsurance, deductibles and non-covered, non-elective services, if the patient meets the eligibility criteria.

Determination of eligibility or denial of financial assistance will be communicated to the responsible party within 30 days of receipt of all required documentation Services not covered by non-par MC+ plans, out-of-state Medicaid programs and non-covered Medicaid services are also classified as financial assistance. Accounts falling within 90 days of Medicaid eligibility can be considered for financial assistance without completion of a financial evaluation form.

Accounts previously placed with collection agencies will be given consideration for financial assistance.

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 the hospital's general financial assistance guidelines.

V. Emergency Care

In addition to the Emergency Department Core Policy in compliance with EMTALA, the hospital will provide, without discrimination, stabilizing 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 eligibility under this Financial Assistance Policy.