Effective:	*12/2015*
Approved:	*12/2015*
Last Revised:	*12/2015*
Next Review:	*12/2018*
Owner:	*Johnathan Wilker: Vice President*
Policy Area:	*Finance*
References:	
Applicability:	*Faith Regional Health Services*

Patient Financial Assistance Policy

Purpose:

To further the charitable mission of Faith Regional Health Services by providing financially disadvantaged and other qualified patients with an avenue to apply for and receive free or discounted care consistent with requirements of the Internal Revenue Code and implementing regulations.

Scope:

This policy is applicable to all Faith Regional Health Services patients

Policy:

A. **Eligibility Criteria. The following classes of individuals and categories are eligible for financial assistance under this policy.**

1. Financially Indigent. To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or less than 100% of the IRS Federal Poverty Level provided, however, that patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of Two Hundred percent (200%) of total outstanding medical bills may not qualify as Financially Indigent. The following definitions apply to such eligibility criteria:
    a. "Uninsured": A patient who has no health insurance or coverage under governmental health care programs, and is exempt from the Affordable Care Act (ACA) or any other third party payment such as worker's compensation or claims against others involving accidents.
    b. "Underinsured": A patient who has limited health insurance coverage for medically necessary services provided by the Hospital or has exceeded the limitation under his/her insurance coverage.
    c. "Household Income": The total income of all adult members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.
    d. "Net Worth": Net asset value (assets minus liabilities (excluding Hospital liabilities) of all adult members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

B. Failure to Apply for Medicaid. Patients who may be eligible for Medicaid, ACA, MASH, or other sources of financial assistance and fail to apply for such sources of financial assistance within thirty (30) days of the Hospital's request are not considered eligible for financial assistance under this policy.

C. Categories of Care Eligible for Financial Assistance. Provided that the patient qualifies as Financially Indigent, both emergency medical care and medically necessary care are eligible for financial assistance under this policy. Regardless of a patient's status as Financially Indigent, cosmetic procedures and fertility procedures are not eligible for financial assistance under this policy.

D. Covered Providers. Care provided by the Hospital and Hospital-employed physicians and practitioners is covered by this policy. Care provided by independent community physicians and other independent service providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance. Patients may obtain a current list of providers who are subject to this policy at no charge by visiting patient financial counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska, by calling 402-371-4880 or by visiting www.frhs.org.

E. Limitation on Charges and Calculation of Amount Owed. Patients who are deemed to be eligible for financial assistance under this policy will not be charged for care covered by this policy more than Amounts Generally Billed by the Hospital to individuals who have health insurance covering such care. Discounts granted to eligible patients under this policy will be taken from gross charges.

F. Calculation of Amounts Generally Billed. The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is the Hospital's gross charges multiplied by the AGB Percentage. Patients may obtain the Hospital's most current AGB Percentage and a description of the calculation in writing free of charge by visiting patient financial counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska, by calling 402-371-4880 or at www.frhs.org.
The Hospital calculates its AGB Percentage on an annual basis. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.

G. Amount of Financial Assistance/Discount. Patients who do not qualify as Financially Indigent may be eligible for financial assistance based upon a Patient Financial Assistance Determination Worksheet. If financial assistance provided to the patient results in a charge of greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

Procedure:

A. Application Process and Determination. Patients who believe they may qualify for financial assistance under this policy are required to submit an application on the Hospital's financial assistance application form during the Application Period. Completed applications must be returned to patient financial counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska.
For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 240th day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date the Hospital provides the patient the requisite final notice to commence extraordinary collection actions ("ECAs").
Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial

assistance application free of charge (i) by mail by calling 402-371-4880, (ii) by download from www.frhs.org, or (iii) in person at patient financial counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska.

B. Completed Applications. Upon receipt, the Hospital will suspend any ECAs taken against the patient and process, review and make a determination on completed financial assistance applications submitted during the Application Period as set forth below. The Hospital may, in its own discretion, accept complete financial assistance applications submitted after the Application Period.

C. Determination of eligibility for financial assistance shall be made by the following individual(s):

Potential Write-Off Amount	Approval Authority
$0.00 to $5,000.00	Manager
$5,000.00 to $10,000.00	Department Director
$10,000.00 and Above	Chief Financial Officer

Unless otherwise delayed as set forth herein, such determination shall be made within 30 days of submission of a timely completed application. Patients will be notified of the Hospital's determination as set forth in the Billing and Collection provisions detailed in the separate Billing and Collection Policy.
To be considered "complete" a financial assistance application must provide all information requested on the form and in the instructions to the form.
The Hospital will not consider an application incomplete or deny financial assistance based upon the failure to provide any information that was not requested in the application or accompanying instructions, or mailed request for additional clarification of information. The Hospital may take into account in its determination (and in determining whether the patient's application is complete) information provided by the patient other than in the application.
For questions and/or assistance with filling out a financial assistance application, the patient may contact the financial counseling office at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska, or call 402-371-4880.

D. If a patient submits a completed financial assistance application during the Application Period and the Hospital determines that the patient may be eligible for participation in Medicaid, the Hospital will notify the patient in writing of such potential eligibility and request that the patient take steps necessary to enroll in such program. In such circumstances the Hospital will delay the processing of the patient's financial assistance application until the patient's application for Medicaid is completed, submitted to the requisite governmental authority, and a determination has been made. If the patient fails to submit an application within thirty (30) days of the Hospital's request, the Hospital will process the completed financial assistance application and financial assistance will be denied due to the failure to meet the eligibility criteria set forth herein.

E. Incomplete Applications. Incomplete applications will not be processed by the Hospital. If a patient submits an incomplete application, the Hospital will suspend ECAs and provide the patient with written notice setting forth the additional information or documentation required to complete the application. The written notice will include the contact information (telephone number, and physical location of the office) of patient financial assistance. The notice will provide the patient with at least 10 days to provide the required information; provided, however, that if the patient submits a completed application prior to the end of the Application Period, the Hospital will accept and process the application as complete.

F. Presumptive Eligibility.The Hospital reserves the right to provide financial assistance even though an application has not been submitted for the applicable care. The Hospital may utilize FAP applications

submitted within 90 days of the date of service to determine the assistance provided to the patient. If the patient is provided less than the maximum possible level of financial assistance, the Hospital will:

1. Notify the patient regarding the basis for the presumptive financial assistance
2. Notify the patient as to how to apply for potentially more financial assistance
3. Give the patient the full application period to apply for more generous assistance before initiating ECAs
4. If the individual submits a completed application seeking additional financial assistance during the Application Period process the application in accordance with this policy.

G. Collection Actions
For further information on the actions the Hospital may take in the event of non-payment, please see the Hospital's Billing and Collection Policy. Patients may obtain the Billing and Collection Policy free of charge by contacting patient financial counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska, 402-371-4880, or by download at www.frhs.org.

H. Emergency Medical Care. Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under the financial assistance policy. The Hospital will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with Hospital policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

Other FRHS Policy References:

Emergency Medical Treatment and Active Labor Act
Billing and Collection Policy

Other References:

Internal Revenue Service Rule 501(r)

Associated Documents:

A. Patient Financial Assistance Policy Plain Language Summary
B. Patient Financial Assistance AGB Calculation
C. Patient Financial Assistance Checklist
D. Patient Financial Assistance Application
E. Patient Financial Assistance Determination Worksheet
F. Patient Financial Assistance Determination Decision

Attachments:

- Patient Financial Assistance AGB Calculation
- Patient Financial Assistance Application
- Patient Financial Assistance Checklist
- Patient Financial Assistance Determination Decision

Patient Financial Assistance Determination Worksheet

Patient Financial Assistance Plain Language Summary

Approver	Date
Johnathan Wilker: Vice President	12/2015
Jennifer Hamilton: Registration Superviser	12/2015
Johnathan Wilker: Vice President	12/2015
Brenda Vildusea: Interim Director	12/2015
Johnathan Wilker: Vice President	12/2015

Patient Financial Assistance
Plain Language Summary

2700 Norfolk Avenue | Norfolk, Nebraska 68701 | www.frhs.org

It is the policy of Faith Regional Health Services (the "Hospital") to provide financial assistance to qualifying patients with their outstanding bills for medically necessary and emergency care provided at the Hospital.

PATIENTS THAT QUALIFY FOR FINANCIAL ASSISTANCE

To receive financial assistance under the Financial Assistance Policy (the "Policy"), you must be *financially indigent*.

Financially Indigent

To be "financially indigent," you must be uninsured or underinsured and have a household income equal to or less than 100% of the IRS Federal Poverty Level ("FPL"). However, even if your household income equals or is below the required FPL, you may not qualify as "financially indigent" if your net worth exceeds 200% of your total medical bills from the Hospital. Net worth is determined based on your assets, including any homes, land, or property, etc. net of any liabilities other than your Hospital bills. If you qualify as "financially indigent," financial assistance will be provided based on a sliding fee scale comparing household income to a percent of FPL as set forth in the Policy.

If you are eligible for financial assistance, you will not be charged more than amounts generally billed to patients who have health insurance. You may be given more financial assistance if the discount for which you qualify does not satisfy this requirement.

HOW TO APPLY

The Hospital encourages patients who may qualify to apply for financial assistance. Patients can apply for financial assistance by completing and submitting a financial assistance application to Financial Counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska.

A copy of the Policy and a financial assistance application may be obtained at no charge by going to the Hospital's website, www.frhs.org, or by visiting the Hospital's Patient Financial Services at 2700 Norfolk Avenue, Norfolk, Nebraska. The Policy and a financial assistance application may also be sent to you by mail free of charge by contacting Financial Counseling at 402-371-4880.

FURTHER INFORMATION & ASSISTANCE WITH APPLYING

If you have questions about financial assistance or need assistance with applying for financial assistance, you may contact Financial Counseling at 2700 Norfolk Avenue, Norfolk, Nebraska or by calling 402-371-4880.

Spanish translated copies of this summary, the policy and a financial assistance application are available on the Hospital’s website at www.frhs.org, upon request from Financial Counseling at 2700 Norfolk Avenue, Norfolk, Nebraska or by calling 402-371-4880.

Patient Financial Assistance Amounts Generally Billed (AGB)

2700 Norfolk Avenue | Norfolk, Nebraska 68701 | www.frhs.org

An individual who applies for and has been determined to be eligible for financial assistance will not be charged more than the amounts generally billed (AGB) to individuals who have insurance coverage for that same care.

Faith Regional Health Services will apply the “look-back method” for determining the AGB. The look-back method will include all claims that have been paid in full by Medicare/Medicaid/Commercial Health Insurers for emergency/medically necessary care provided by Faith Regional Health Services during a prior twelve (12) month period.

The AGB will be determined by multiplying the Gross Charges for these claims by an AGB Percentage. Gross Charges are defined as the full established rate for the provision of healthcare services and items. (Gross Charges x AGB Percentage = AGB)

The AGB Percentage is calculated by dividing the actual amount paid to Faith Regional Health Services for these claims by the sum of the associated Gross Charges for those claims. (Actual Amount Paid ÷ Sum of Gross Charges = AGB Percentage)

Patient Financial Assistance Checklist

2700 Norfolk Avenue | Norfolk, Nebraska 68701 | www.frhs.org

1. **Completely fill out the Patient Financial Assistance Application**
   - You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Faith Regional Health Services.
   - If all of the required information is not submitted with your application a request letter will be sent to you. You will have ten (10) days from the date of the letter to supply the required information. If the required information is not returned in the time frame requested your application will be denied.
   - Failure to complete and/or cooperate with all other FRHS or governmental assistance programs; such as MASH, Medicaid, and the Healthcare Reform which began January 1, 2014, disqualifies you from the financial assistance program offered by Faith Regional Health Services.
   - Additional documentation may be requested at any time in order to properly evaluate your financial needs for assistance. If the additional information is not returned in the time frame requested your application will be denied.
   - Your cooperation in completing this application is important. The amount of assistance you receive is determined by your gross income, family size, and assets so please complete the form accurately.

2. **Provide proof of household income for the <u>previous three months</u>**
   - <u>Gross Income</u> Provide three months of paycheck stubs. If you do not have paycheck stubs provide a letter from your employer stating the income information.
   - <u>Self Employed</u> Provide a complete copy of your most current federal tax return, <u>and</u> a profit and loss statement for the last three months.
   - <u>Unemployment, Disability and/or Social Security</u> Provide a copy of the notification of benefits letter.
   - <u>Workers compensation</u> Provide copies of a notification letter, report of workers compensation benefits, <u>or</u> copies of check stubs.
   - <u>Military Income</u> Provide a notification of benefits letter <u>or</u> a bank statement if directly deposited.
   - <u>Alimony</u> Provide copies of the checks received <u>or</u> a bank statement if directly deposited.
   - <u>Child Support</u> Provide documentation from Child Support Services <u>or</u> a bank statement if directly deposited.
   - <u>Food Stamps</u> Provide documentation from Health and Human Services.

3. **Provide a complete copy of your most recent tax return, plus all supporting documents**
   - Federal **<u>and</u>** State income tax returns

4. **Provide bank statements for the previous 3 months**
   - <u>Bank Statements</u> Provide <u>three months</u> of bank statements. This includes all checking, savings and health savings accounts.
   - <u>IRA, Stocks, Bonds, Life Insurance</u> Provide documentation from your bank or your most current federal tax returns.

5. **Sign, Date and Return the application along with proof of all income and all bank statements.**
   - You may contact one of our Financial Counselors at (402) 644-7366 or (402) 844-8320 if you have any questions

Patient Financial Assistance Application

2700 Norfolk Avenue | Norfolk, Nebraska 68701 | www.frhs.org

DUE BY:

[ ] PRE-DETERMINATION

Include with this application (if relevant)

- ☐ Last 3 months of paycheck stubs or if self-employed, a profit and loss statement for last 3 months
- ☐ Notification of benefits letter for unemployment, disability and/or social security
- ☐ Notification letter for Workers Compensation, report of benefits or copies of check stubs
- ☐ Notification letter for military income or a bank statement if directly deposited
- ☐ Copy of alimony checks or a bank statement if directly deposited
- ☐ Documentation from Child Support Services or a bank statement if directly deposited
- ☐ Documentation from Health and Human Services for food stamps received
- ☐ Most recent Federal income Tax Return with all supporting documents
- ☐ Most recent State Income Tax Return with all supporting documents
- ☐ Last 3 months of bank statements for checking, savings and health savings accounts
- ☐ Documentation of all IRA, Stocks, Bonds, Life Insurance policies

#1 Responsible Party

Last name | First name | Middle name

Address | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow/Widower

#2 Spouse

Last name | First name | Middle

Address (if different from Patients) | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

#3 Dependents

Number of legal dependents _____ Ages of legal dependents _____

#4 Insurance Information

Does anyone in the household have health insurance? [ ] Yes [ ] No

Insured Name #1 Health Ins. Name Policy number

Insured Name #2 Health Ins. Name Policy number

#5 Household Monthly Gross Income

	Responsible Party	Spouse
Employment **(Gross Earnings)**	$	$
Self Employment *Business Type_____	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment- Date Ended _____	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Food Stamps	$	$
Other	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed

#6 Savings and Investments

☐ I do not have a checking account
☐ I do not have a savings account
☐ I do not have a health savings account

	Responsible Party	Spouse
Checking Account Balance	$	$
Savings Account Balance	$	$
Health Savings Account Balance	$	$
Retirement	$	$
CD/IRA/403b/401k/Annuities/IRA's	$	$
Stocks/Bonds/Interest/Life Ins./Land	$	$
Other Savings and Investments *_____	$	$
TOTAL	$	$

Use additional paper to include any other household members savings or investments not listed

#7 Other Assets

Land				$	$
	Acres		Owner/How Held	Balance Remaining	Assessed Value
Boat				$	$
	Year	Make	Model	Balance Remaining	Book Value
Camper/RV				$	$
	Year	Make	Model	Balance Remaining	Book Value
Motorcycle				$	$
	Year	Make	Model	Balance Remaining	Book Value
ATV				$	$
	Year	Make	Model	Balance Remaining	Book Value
				$	$
				TOTAL	**TOTAL**

#8 Monthly Expenses (please round to nearest dollar)

Housing

[ ] Rent payment	$
[ ] Mortgage payment	$
*Value of Home	$
Additional mortgage payment	$
*Remaining balance	$
Lot rent (mobile homes)	$
Renters insurance	$
Homeowners insurance (If not included in mortgage)	$
Property tax (If not included in mortgage)	$

Housing Utilities

Electric	$
Water	$
Gas	$
Garbage removal	$
Telephone (land line)	$
Telephone (cellular)	$
Cable and Internet	$

Transportation/Vehicles

Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Insurance	$
Gasoline/Diesel	$

Medical

Health insurance	$
Life insurance	$
Dental insurance	$
Medications	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$

#8 Monthly Expenses (continued)

Credit Cards		***Other Expenses***	
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$

Miscellaneous			
Food and Paper Products	$	Child Care	$
Clothing/Shoes	$	Child Support	$
Entertainment	$	Alimony Paid	$
Charity Contributions	$	Lawn Care	$
Newspaper	$	Snow Removal	$

TOTAL EXPENSE (For Office Use Only) $ X 12 = $

#9 Other Comments

#10 Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined.

I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld I understand the hospital may take whatever action is appropriate. This action may include denial of this application up to and including denial of all future applications.

I agree that I will repay the assistance I was rewarded if I receive payment of any kind for the medical services covered by this application. Examples of this would be: insurance payments, payments from government programs, lawsuit settlements, or any other source of payment received.

Signature Date

Signature Date

Faith Regional Health Services will not grant financial assistance on procedures that are not deemed medically necessary such as; fertility testing, fertility treatment, cosmetic procedures, etc.

You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Faith Regional Health Services

Failure to complete and/or cooperate with all other FRHS and governmental assistance programs; such as MASH, Medicaid, and/or the Healthcare Reform which began 1/1/14, disqualifies you from the financial assistance program offered by Faith Regional Health Services.

In the future if your financial situation improves and you would like to remember the assistance you received please consider making a donation to the Faith Regional Health Services Foundation.