Community Hospital Fairfax

COMMUNITY HOSPITAL-FAIRFAX

POLICY # ADMIN2005	TITLE: FINANCIAL ASSISTANCE POLICY
AFFILIATED DEPARTMENT: PATIENT ACCOUNTS	
PAGE 1 OF 15	

PURPOSE:

The guiding principle of Community Hospital Association's (CHA) Financial Assistance Policy is that we care for those in our community regardless of ability to pay. This principle is in alignment with our mission, which is to be "the healthcare provider of choice for the communities we serve".

The purpose of the Financial Assistance Policy is to provide structure and guidance so that those in our community who need financial assistance will understand both our policy and the federal and state guidelines that guide this policy.

CHA does not base eligibility for financial assistance on any federal or state protected classes.

DEPARTMENTS AFFECTED:

Patient Accounts, Admissions, Emergency Department

POLICY STATEMENT:

1. The CHA financial assistance policy is based upon the following criteria:
   - **Residency:** To meet the residency requirement, the patient or guarantor must be a permanent resident in Atchison, Holt, or Nodaway counties.
   - **Immigration Status:** To prove that an applicant lives in our service area if he or she is an immigrant, we need to see an Alien Resident Card or a United States Citizen Identification Card is required. Persons in the United States with a non-immigrant status such as visitors, students or any person who has a "temporary" or "pending" status will not qualify for financial assistance.
   - **Income:** Free care is granted to eligible patients with a household income up to 300% of Federal Poverty Guidelines. It is the patient's or the guarantor's responsibility to present the information CHA needs to determine eligibility for financial assistance
   - **Eligible Services:** Services eligible under this Financial Assistance Policy include:
     - ✓ Emergency medical care given in an emergency setting.
     - ✓ Medically necessary services, for example, inpatient or outpatient healthcare services given to evaluate, diagnose or treat and injury, illness, disease or its symptoms.

- ✓ Medical services that are necessary and given in a non-emergency setting to care for issues that threaten life.

- **Exclusions:** The following services are not eligible for financial assistance include:
  - ✓ Therapy services, including physical therapy, occupational therapy and speech therapy.
  - ✓ Outpatient psychiatry services.
  - ✓ Well visits or exams.
  - ✓ Non-emergent surgery.
- **Other Exclusions:**
  - ✓ Patients or guarantors may be excluded from financial assistance if CHA has referred the patient or guarantor to a collection agency and has incurred legal fees.

2. **Emergency Medical Care:** CHA will provide emergency medical care in accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations. All patients are seen and given care prior to being screened for financial assistance and/or payment ability in an emergency. Care will be provided at an equal level for all patients, regardless of ability to pay.
3. **Full Free Care:** To be eligible for full free care for eligible services, charges are waived and covered for the patient or guarantor if the following guidelines are met:
   - The applicant meets eligibility criteria and has a yearly household income that does not exceed 300% of Federal Poverty Guidelines, and
   - All other payment sources have been explored including private coverage, federal, state and local medical assistance programs, and other forms of financial assistance offered by third parties. The patient will be screened for Medicaid using the Health Benefit Eligibility Tool on the DSS (Department of Social Services) website. http://dss.mo.gov/. The patient can also do the screening and provide the information to the Business Office if they would prefer.
4. **Presumptive Eligibility:** Some patients or guarantors are presumed eligible for financial assistance based on individual life circumstances, for example, those who are homeless or have qualified for needs-based assistance programs. This is called “presumptive eligibility.” These patients or guarantors do not need to complete the CHA assistance application if they provide proof that they qualify for certain programs that exist to benefit people who do not have enough resources

to pay for services and care. Presumptive eligibility will be used to give a 100% discount to patients who meet residency and immigration requirements and who are eligible because:

- They are homeless and/or have received care from a homeless clinic or shelter. The patient or guarantor must provide a written statement from a homeless clinic or shelter.
- They receive care from and/or part of the Women, Infants and Children's (WIC) program. The patient or guarantor must provide the WIC voucher issued by the Family Support Division office.
- They receive Supplemental Nutrition Assistance Program (SNAP) benefits (formerly known as Food Stamps). The patient or guarantor must provide the SNAP (food stamp) eligibility statement issued by the Family Support Division office.
- The patient's family is eligible for and receives free or reduced-cost school lunch as part of the federally funded program. The patient or guarantor must provide a confirmation letter from the Family Support Division to support this.
- The patient's street address is an affordable or subsidized housing program for low-income people, such as HUD section 8 Housing. The patient or guarantor must provide the subsidized housing application approval issued by the Family Support Division office.
- The patient or guarantor's wages are not enough to garnish, as defined by state law. The patient must provide proof, as issued by the state in which he or she lives, exemption from wage garnishment.

Patients who are covered under CHA's financial assistance policy and determined to be eligible for financial assistance will not be expected to pay gross charges for any eligible services received while covered under the CHA financial assistance policy.

For providers covered under the Financial Assistance Policy, see Appendix A and Appendix B.

DEFINITIONS:

The following definitions apply to all sections of this policy:

- **Bad debt:** An account that goes unpaid for more than 180 days after CHA has determined the amount the patient or guarantor owes and is sent the initial patient statement, or the remaining amount that a patient or guarantor fails to pay after establishing an agreed-upon payment plan.

- **Emergency medical condition:** As defined in Section 1867 of the Social Security Act (42 U.S.C 1395dd), the term "emergency medical condition" means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    1. Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy,
    2. Serious impairment to bodily functions, or
    3. Serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions:
        a. There is inadequate time to effect a safe transfer to another hospital before delivery, or
        b. Transfer may pose a threat to the health or safety of the woman or the unborn child.
- **Federal poverty guidelines:** The Federal Poverty Guidelines (FPG) used income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Resources under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
- **Financial assistance:** Assistance is given to eligible patients or guarantors, who might otherwise have financial hardship, to dismiss of all or part of their financial requirements for medically necessary care provided by CHA.
- **Free care:** All patient amounts due that are a result of having received eligible services given at CHA, to eligible patients, or their guarantors, with yearly household income at or below 300% of the Federal Poverty Level.
- **Guarantor:** The patient or person other than the patient, who is responsible to pay the patient's account.
- **Gross charges:** Total charges at the full established rate for patient care services before deductions from revenue are applied.

- **Household:** Family of one is a person who may be the only one living in a housing unit or who may be living in a housing unit in which one or more persons also live but are not related to the applicant by marriage, birth or adoption. For example, people who live with others include a lodger, a foster child, a ward or an employee. A family of more persons includes people who are related by marriage, birth or adoption who live together; all such related persons are thought of as members of one family; an unmarried couple with a mutual child. If a household includes more than one unrelated family, the poverty guidelines are applied separately to each family and not to the household as a whole. Sometimes, a copy of a divorce decree or court documents proving legal separation may be required. If married, but not living together, income documents will be required from both people.
- **Income:** Income is how much everyone who lives in the household makes, before taxes are taken out, from all sources (gross income).
- **Medically necessary:** As defined by Missouri Medicaid HealthNet Division as services that a patient could or must receive for the diagnosis or treatment of illness or injury.
- **CHA service area:** The primary service area includes Atchison, Holt and Nodaway counties in Northwest Missouri.
- **Presumptive eligibility policy:** In certain cases, patients or guarantors may be eligible for financial assistance programs that are based upon need. Proof of enrollment in such programs will be sufficient documentation for determining eligibility.
- **Supporting Documentation:** Applicants will be responsible for providing one month of income verification, if self-employed their most current tax return and asset/liability statement, or if the patient has no income, a statement describing how they pay their bills and why they are not employed. The patient will also be responsible for filling out the pre-screening eligibility tool on the DSS website and bringing in a paper stating they do not qualify.
- **Qualification period:** Applicants who are eligible for financial assistance will be given this assistance for 90 days. Assistance will also be applied to past unpaid accounts for eligible services as long as legal action has not been taken into account.
- **Uninsured patient:** A patient with no third-party coverage such as commercial third-party insurance, and ERISA plan, a Federal Health Care Program (including without limit Medicare,

Medicaid, SCHIP, and CHAMPUS), Worker's Compensation or other third-party assistance to assist with meeting a patient's payment obligations.

- **Unrelated individual:** An unrelated individual may be the only person living in a housing unit, or may be living in a housing unit in which one or more persons may reside, but are not related to the applicant by marriage, birth or adoption. Examples of unrelated individuals living with others include a lodger, a foster child, a ward or an employee.

RESPONSIBILITIES:

Patient-The patient will ultimately be responsible for completing the eligibility screening tool on the Medicaid website, the credit/collections clerk (CCC) can help with this process. The patient will be responsible for turning in a completed application, along with all supporting documentation within 240 days from the date of the first post-discharge billing statement.

Credit/Collections Clerk-The CCC will make a reasonable effort to explain Medicaid benefits, health insurance exchange and coverage, and other public and private coverages that may apply. They will also ensure the patient is aware and does not qualify for any of the presumptive eligibility requirements. At this time the CCC will help the patient fill out the Medicaid Screening application on the DSS website, if they may qualify for Medicaid, the patient will have to start that process and receive a denial before they can apply for charity. If the screening says they are not eligible for Medicaid the process will continue. The CCC will provide an application and explain what supporting documentation is needed to complete the application (listed in the definitions section under supporting documentation). After all documents are received the CCC will review them, the CCC will hand them over to the Revenue Cycle Manager (RCM) and wait for a reply. After the CCC gets a response from the RCM, they will make contact with the patient and informing them of their approval or denial for the Financial Assistance Program at CHA.

Revenue Cycle Manager- The RCM will receive the completed application and all supporting documentation from the CCC to review. After the review by the RCM an approval or denial will be given to the application, the RCM will sign off on all approved applications by initialing and dating the application and returning it to the CCC. If there is a denial, the RCM will communicate with the CCC to

either collect more information from the patient or to see if the patient qualifies for the non-financial assistance policy. If there are extenuating circumstances that need to be considered CHA reserves the right to take these circumstances into account and approve an FAP with the proper documentation. Cases of extenuating circumstances will be considered on a case by case basis by the Chief Financial Officer (CFO) at the request of the RCM.

Chief Financial Officer-The CFO will review applications with extenuating circumstances and make a final determination on a case by case basis. In the absence of the CFO, the CEO, COO and CNO can also review and approve cases of extenuating circumstances.

PROCEDURES:

The following are the procedures CHA staff will follow to determine eligibility for financial assistance:
Admitting Staff-Upon admission, if a patient is listed as a self pay patient, the admissions staff will provide a copy of the plain language portion of the FAP and the non-FAP policies, along with the application. They will also ask if they have any questions and direct them to the CCC for any questions regarding the policies.

Credit/Collections Clerk- When sending out first time statements, the CCC will include an application and plain language summary to all patients that fit the criteria for the FAP program. When an application is received back either by mail or in person, the CCC will ensure that it is properly filled out and that the supporting documentation is adequate. This includes ensuring that the patient has been pre-screened for Medicaid, and will assist them in completing this process if necessary. The CCC will use the information to figure the Federal Poverty Level (FPL) to see what level of write off is appropriate. After this is completed the CCC will get the application and supporting documents to the RCM for review.

Revenue Cycle Manager- The RCM will review the entire application, including the supporting documentation for accuracy and will initial, date, and the write off amount. If the application has an error or is incomplete it will be handed back to the CCC for clarification and completion. If there are

extenuating circumstances in which the application cannot be fully completed, the RCM will discuss with the CFO to determine on a case by case basis if the application will be approved.

Chief Financial Officer-The CFO will review applications at the request of the RCM and make a final determination on a case by case basis. The CFO reserves the right to approve any application based on information he/she receives.

PUBLICATION OF FINANCIAL ASSISTANCE POLICY

CHA's Financial Assistance Policy (FAP) is to be published in the following manner as to reach the widest possible patient or guarantor population:

- Website: The FAP along with the plain language summary of the policy will be published at the following URL of CHA's website: http://www.fairfaxmed.com/contactus/payments/charity-care/
- Emergency Department: Copies of the plain language summary (PLS) will be available in the emergency department. Applications will be available as well.
- Admissions: Admissions staff will have available copies of the FAP and PLS for patients upon request.
- Credit/Collections Clerk: The CCC will have available copies of the FAP and PLS for patients upon request.

DETERMINATION OF ELIGIBILITY

Eligibility determinations will be made in accordance with the CHA policy. Every effort will be made to issue a decision within 14 business days after we receive a completed application and all necessary information. CHA financial counselors will record the reason for the denial in our electronic billing system.

Determination for financial assistance will be made after the patient has been pre-screened for Medicaid or other public programs have been exhausted. If a decision on such coverage is pending, CHA will not begin extraordinary collection actions.

QUALIFICATION PERIOD

Once an applicant is approved for financial assistance, the decision is good for 90 days from the date the applicant is notified. Assistance will be automatically applied to the unpaid accounts for eligible services as long as legal action has not already been taken on any of the accounts.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on the CHA financial assistance policy is offered in the patient admission or discharge information package. Information on the assistance policy and how to contact CHA for further information or help in applying is posted in hospital or clinic admitting locations, as well as the hospital emergency department. Financial assistance information is conspicuously included on monthly statements. CHA's financial assistance policy is also given to agencies and non-profit organizations serving people who have limited financial resources in the CHA Primary service area.

This 180-day timeframe may be shortened if a decision has been made on financial assistance, or when a payment plan has been established and agreed upon but the patient or guarantor is no longer making the required payments.

If a statement is sent to a patient or guarantor, and mail is returned undeliverable, CHA will attempt to find a correct address. If the correct address cannot be found, CHA will attempt to contact the patient or guarantor by telephone at the number listed by the patient or guarantor. If efforts to communicate with the patient or guarantor fail, accounts will be sent to collection agency.

Reasonable efforts to inform patient of financial assistance: Prior to sending an account to a collection agency, the patient or guarantor will generally receive a minimum of six written statements including the first post-discharge statement and five subsequent statements. These statements will include a phone number for information on paying patient balances and a conspicuous notice about financial assistance.

If an agreement has not been made to resolve the account, a seventh and final statement will be sent to the patient or guarantor. This statement acts as a notice of the amount owed to CHA and that the account will be placed with a third-party collection agency in 30 days. This statement will include a plain language summary and will outline any collection actions that may be taken if a plan is not put in place to settle the account. Oral notification will be attempted at this time as well to ensure the patient or guarantor is aware of CHA's Financial Assistance Policy as well as the debt they owe.

There are other times when accounts may be placed in collection including when:

1. The patient or guarantor has not made timely payments according to the agreed-upon payment plan.
2. The patient or guarantor has received a financial assistance discount but is no longer working with CHA in good faith to pay off the remaining amount owed.

Extraordinary collection activities: Once an account is with the collection agency, the following actions can be taken to make sure the debt for services and care is paid. They are "Extraordinary Collection Activities:"

1. Seizing the patient or guarantor's bank account.
2. Civil actions.
3. Property liens.
4. Property foreclosures.
5. Garnishing of wages.
6. Reporting adverse information to credit bureaus.

Before Extraordinary Collection Activities can begin, the account must be reviewed and approval must be given by CHA's Chief Financial Officer. When one of these actions is to be taken against a patient or guarantor, the patient or guarantor will be given a 30-day written notice of the exact action to be taken. The patient or guarantor will also be informed of the CHA financial assistance policy and how to apply for it. A plain language summary of the financial assistance policy will be included with the notice.

ENFORECEMENT

CHA staff are expected to uphold the highest ethical standards. At no time should any staff member use false information or lie in an attempt to collect an account. All business must be conducted in the name of the caller or CHA. By no means should staff lie about being an employee of a credit bureau, collection agency, law firm, etc. Everything a staff member says must be true and correct using a professional approach. CHA staff as well as all third-party vendors working on behalf of CHA, will uphold and adhere to the Fair Debt Collections Practices Act.

CONFIDENTIALITY

CHA will protect the privacy of each patient's financial assistance and personal health information.

REGULATORY REQUIREMENTS

CHA will comply with all federal, state and local laws, rules and regulations as well as reporting needs that may apply to work and actions done as a result of our financial assistance policy. Information on financial assistance given under this policy will be reported once a year on Internal Revenue Service Form 990 Schedule H.

POLICY APPROVAL

CHA's Board of Directors has approved the CHA financial assistance policy at their May 28, 2025 board meeting. This policy is subject to review at any time. Any substantial changes to the policy must be approved by both CHA's executive team and, after that, the Board of Directors.

RELEVANT REFERENCES:

CFR 26 §1.501(r)-4

TITLE, POLICY OWNER:

Chief Financial Officer

Supersedes:

APPENDIX A – COVERED PROVIDERS – Updated 04/01/2025

Burke, Richard

Carpenter, Dustin

Masonbrink, Melissa

Massey, Mina

Heits, Rebecca

Osborn, Kelly

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Kreifels, Renee

Burke, Joanna

Aberger, Michael

Fleming, James

Schleicher, Paul

Tally, Amy

Auxier, Amanda

Griffth, Natasha

Williamson, Melissa

LeRoy, Omer

Masters, Summer

APPENDIX B – PROVIDERS NOT COVERED – 04/01/2025

None

Record Changes:

Review/Revised Date	Title	Description of Change
01/20/20	CFO	Added providers covered and not covered.

04/17/24	CFO	Added Appendix C. Added CEO, CNO COO has officers who can approve cases of extenuating circumsances.