

Unique Identifier: HWP12027	DAY KIMBALL HEALTHCARE Hospital-Wide Policy Manual Section – Leadership Page 1 of 6
TITLE: Financial Assistance Policy	RESPONSIBLE PARTY (IES): Director of Revenue Cycle Vice President and CFO
FORMERLY KNOWN AS: Charity Free Care, Charity Care/Financial Assistance	
EFFECTIVE: 1/99	REVISED: 2/02, 1/03, 11/1/04, 2/1/05, 5/2/05, 10/16/06, 3/21/07, 3/1/08, 5/1/10, 4/11, 09/16, 02/17, 2/18
REVIEWED: 4/11, 4/14, 2/17	
REGULATORY STANDARD:	

I. GENERAL STATEMENT OF PURPOSE:

It is the philosophy and policy of Day Kimball Hospital that emergency and medically necessary health care services should be available to all individuals regardless of their ability to pay. The policy has been written in accordance with Section 9007 of the Patient Protection and Affordable Care Act (Act), signed into law on March 23, 2010, which adds new sections 501(r) and 4959 to the Internal Revenue Code. Section 501(r) includes a series of specific requirements for hospitals to receive and maintain Section 501(c)(3) (“tax exempt”) status.

II. POLICY STATEMENT:

Day Kimball Hospital’s Patient Accounts Department will maintain procedures to assist both uninsured and underinsured patients with meeting their financial obligations to the hospital.

III. POLICY:

Discounted Balances using Amounts Generally Billed Calculation

It is the policy of Day Kimball Hospital to utilize the Amounts Generally Billed (AGB) calculation in determining financial liability for those patients who qualify for financial assistance. AGB is calculated as the percentage of the Medicare allowable amount for emergency and medically necessary services divided by the total associated Medicare charges using the “look back” method for the most previously filed Medicare cost report year.

A. Uninsured Patients

All Day Kimball Hospital patients who are determined to have no active insurance for a given date of service will have their associated charges adjusted to the hospital’s most recently calculated AGB as described in above.

1. Financial Assistance Eligibility for the Uninsured

Uninsured patients who show proof of denial from the State of Connecticut Department of Social Services (DSS) office may qualify for financial assistance if they meet all of the following criteria:

- a. Single account balance of \$250 or greater OR accounts spanning six months totaling \$500 or greater (individual) OR accounts spanning six months totaling \$1000 or greater for 2 or more family members (under same guarantor).
- b. Qualifying Annual Income Levels.
 - i. 0 – 100% of Federal Poverty Level 100% discount
 - ii. 101% - 200% of Federal Poverty Level 100% discount
 - iii. 201% - 250% of Federal Poverty Level 100% discount
- c. Liquid assets must not exceed \$100,000 (includes stocks, bonds, cash, 401K, IRA, CD, property and business value, and recreational vehicles). Liquid asset test will not be applied to Behavioral Health Patients applying for Financial Assistance.

DKH will consider the total medical expenses faced by an uninsured family and the family's ability to pay for those expenses, and offer greater assistance when possible to those individuals or families facing catastrophic medical expenses.

B. Insured Patients

1. Insured patients may qualify for a 75% financial assistance discount on the remaining balance after insurance payments are made. After this discount is approved and applied, the remaining amount of the balance that the patient will be responsible for shall be no more than the amounts generally billed (AGB) to individuals who have Medicare for emergency or medically necessary care.
2. In order to qualify for a financial assistance discount, an insured patient must meet all of the following criteria:
 - a. Single account balance of \$250 or greater OR accounts spanning six months totaling \$500 or greater (individual) OR accounts spanning six months totaling \$1000 or greater for 2 or more family members (under same guarantor).
 - b. Qualifying Annual Income Limits
 - i. 0 – 100% of Federal Poverty 75% discount
 - ii. 101% - 200% of Federal Poverty 75% discount
 - iii. 201% - 250% of Federal Poverty 75% discount

- c. Liquid assets must not exceed \$100,000 including (Stocks, bonds, cash, 401, IRA, CD, property and business value and recreational vehicles). Liquid asset test will not be applied to Behavioral Health Patients applying for Financial Assistance.
3. Insured patients who have exhausted their insurance benefits during the time period during which services were rendered, and who can produce documentation to confirm benefits exhaustion, will be deemed “uninsured” under Section A of this policy. If approved for financial assistance, it will be an episodic granting.

C. Processing Guidelines:

1. Patients have 240 days from the date of their first post-discharge bill to apply for financial assistance.
2. All self-employed applications must submit the entire tax return including all schedules as well as the most recent Profit and Loss statement. The Director of Revenue Cycle or designee will review these documents to determine income.
3. Notification of financial assistance application determinations will be mailed to the patient/guarantor within 30 days of receipt of a completed application.

D. Notification to Patients

1. Signage indicating the availability of financial assistance is posted in English and Spanish in Patient Accounts, Patient Access, the Lab, Physician Practices and Satellite locations. Financial Assistance policy documents are also widely available on the hospital’s public website.
2. Patient Financial Counselors will attempt to visit all non-psychiatric inpatients registered as uninsured at a point in time deemed appropriate by the clinical care providers attending to a given patient. Patient Financial Counselors will assist patients in securing a payment source through Connecticut Medicaid enrollment, locating coverage through the healthcare marketplace, or, as a last resort, assisting them with the financial assistance application process and guidelines.
3. Psychiatric inpatients will be counseled while in-house for Connecticut Medicaid enrollment or financial assistance application assistance only.
4. A series of monthly statements will be sent to patients with a balance following discharge. Each statement will remind the patient of the availability of assistance through the hospital’s financial assistance program if the eligibility criteria are met. At least 30 days prior to referral for any extraordinary collection activity (ECA), a final statement and a copy of the Financial Assistance Policy Plain Language Summary will be mailed to the patient/guarantor. For further information about the ECA process, please refer to the Credit and Collection Activity Policy HWP 12048.

E. Gross Family Income

1. For the purpose of determining gross family income and qualifying accounts for financial assistance, the following rules apply:
 - a. Family members are only immediate family members when they are the applicant, spouse, children under the age of 18 or students to the age of 26, and stepchildren under the age of 18 or students to the age of 26. Other dependents claimed on the federal income tax return may be considered.
 - b. Unmarried couples do not qualify as a family unless tax returns are filed as married. Only the applicant's income will be looked at for qualification for funds and only the applicant's accounts will be awarded financial assistance if qualified.

F. Eligibility Determinations

The provision of health care should never be delayed pending an assistance eligibility determination.

1. Patients must be a Connecticut resident in order to qualify. Non-Connecticut residents will only be eligible for financial assistance if their services at Day Kimball Hospital were provided via the emergency room or through an emergency admission. The Connecticut residency requirement is waived for behavioral health patients or for students boarding at area private schools whose permanent residence is out of state.
2. Day Kimball Hospital will make every attempt to conduct all eligibility determinations within 30 days of receiving a completed financial assistance application.
3. Patients must submit all required pieces of documentation within 30 days of application submission to be considered complete. A letter of the hospital's intent to deny and close an application due to missing information will be mailed to the applicant at day 31. Applicants will be given an additional 14 calendar day grace period to provide all outstanding materials before the application will be terminated.
4. Application to the DKH Financial Assistance Program can be submitted up to 240 days from the date of the first post-discharge bill and will be in effect for six months forward from the last date of service listed on the application at the time of approval.
5. Acceptable verification of income includes the following:

- a. Most recent federal tax return including all schedules when applicable along with at least one of the following:
 - Last 3 months payroll check stubs
 - Most recent P&L statement if self employed
 - Schedules C from tax return if self employed
 - Schedule E from tax return for other real estate or rental income
 - Written verification from employer (or pay stubs) verifying income for the last 3 months
 - Copies of any pension, alimony or other sources of income
 - Copies of social security earnings
 - Any other information felt to be pertinent
 - b. If a patient claims that he/she does not submit a federal tax return or has lost his/her most recent tax return, we can require that the patient complete IRS form 4506-T (request for transcript of tax return). Through this form, the patient can either request a copy of their federal tax return or a confirmation that he/she has not filed a federal tax return.
 - c. As financial assistance is a program of last resort, an application will not be considered until the applicant has been screened for other insurance or assistance programs, and it has been validated that all other sources of payment have been exhausted.
6. In extenuating circumstances where the situation reasonably demonstrates that a financial hardship exists, Day Kimball Hospital may offer financial assistance at its own determination without a completed application. Either the Director of Revenue Cycle or the CFO must approve these requests. Example: homeless patients or undocumented immigrants.
 7. Applications will remain in effect for up to six months from date approved. Day Kimball may request updated financial information at any time during the eligibility period and adjust assistance accordingly.
 8. Day Kimball Hospital reserves the right to change its benefit determination if financial circumstances have changed. The patient or guarantor will be notified in writing when this occurs (within 7 business days from date of change).
 9. Falsification of application will result in the prospective or retrospective denial of financial assistance benefits.

G. Appeals

1. Responsible parties may appeal a financial assistance determination by providing additional information, such as insurance verification or an explanation of

extenuating circumstances to Patient Accounts within 30 days of receiving notification of a denied application.

2. First Level of Appeal should be made to the Director of Revenue Cycle who will review the appeal and the responsible party will be notified of the appeals outcome.
3. Second Level of Appeal should be made to Administration (CEO, CFO, or CNO) who will review the appeal and the responsible party will be notified of the appeals outcome.

H. Financial Assistance Balance Approval Guidelines

Approvals will be as follows:

- Balances up to \$10,000.00 will be approved by the Credit and Collections Supervisor
Balances between \$10,001.00 to \$25,000.00 will be approved by the Director of Revenue Cycle.
- Balances above \$25,000.00 will be approved by the Vice President and CFO.

Approval Signatures:

Director of Revenue Cycle

Date

Vice President and CFO

Date