WARNER HOSPITAL & Health Services

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Last Approved:	*02/2022*
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Owner:	*Donna Wisner: CFO*
Policy Area:	*Administration*
References:	

Financial Assistance and Uninsured Patient Discounts

POLICY:

It is the policy of Warner Hospital and Health Services to follow specific guidelines related to financial assistance and uninsured patient discounts for hospital services and to establish the presumptive eligibility criteria used to deem a patient eligible for financial assistance discounts so that all patients are treated fairly in accordance with government regulations.

STAFF:

All Staff

EQUIPMENT, FORMS & LOCATIONS:

Determination of Eligibility for Financial Assistance Form #712.

PROCEDURE:

1. **Presumptive Eligibility:**

   Presumptive eligibility shall be applied to an uninsured patient as soon as possible after receipt of hospital services by the patient and prior to issuing any bill for those hospital services. Presumptive eligibility may be determined on the basis of individual life circumstance documentation. In these situations, a patient is deemed to be eligible for 100% write off. A patient in this situation is presumed to be eligible and therefore does not need to complete a Warner Hospital and Health Services Determination of Eligibility for Financial Assistance Application if they meet one or more of the following criteria listed below:

   a. Homelessness;
   b. Deceased with no estate;
   c. Mental incapacitation with no one to act on patient's behalf;
   d. Medicaid eligibility, but not on date of service or for non-covered service;
   e. Incarceration in a penal institution;
   f. Personal bankruptcy within the past six (6) months.

2. The policy is for uninsured balances or balances that remain after a third party benefit program or insurance has paid.
3. The financial assistance and uninsured discounts are available to patients regardless of their immigration status or residency.
4. Administration will establish income guidelines based upon federal income poverty guidelines by the United States Department of Health and Human Services to assess the eligibility for discounted or free care. Income is defined as a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support.
5. The financial assistance and uninsured discount may be contingent upon the patient first applying for coverage under public programs, such as Medicare, Medicaid, or any other program, if there is a reasonable basis to believe that the patient may be eligible for such a program.
6. A patient or guarantor must apply for financial assistance/uninsured discount for each episode of medical care within 90 days following date of discharge or receipt of outpatient care or may be denied for untimely application. The application applies only to open accounts that the patient is responsible for at the time hospital staff reviews the application.
7. Accounts turned over to a collection agency may qualify for financial assistance.
8. Eligibility will be determined without regard to race, color, creed, religion, national origin or handicap.
9. The uninsured patient or financial assistance discount eligibility will be based on the patient having a family income of not more than 400% of the federal poverty income guidelines and includes all emergency and other medically necessary health care services. Scheduled, elective, non-emergent surgeries of self pay patients are not eligible services under this policy.
10. Patients are required to submit one of the following forms of family income documentation listed below in order of preference:
    a. Copies of the 2 most recent pay stubs
    b. Copy of the most recent tax return
    c. Copy of the most recent W-2 form and 1099 form
    d. Written verification from an employer if paid in cash
    e. One other reasonable form of third party income verification deemed acceptable to the hospital.

    If applicable, patients are required to submit a form of asset verification, which may include a financial institution statement, or other third party verification of an asset's value. Asset information is not used to determine discount eligibility for outpatient services. Patients are requested to complete a Warner Hospital and Health Services Determination of Eligibility for Financial Assistance Form #712, however, eligibility is not dependent upon completion of this form.
11. For all health care services in any one inpatient admission or outpatient encounter, the hospital will not collect from a patient who is eligible for the financial assistance and uninsured patient discount more than charges less the amount of the discount.
12. The maximum collectible amount that may be collected in a 12-month period from patients eligible for the uninsured or financial assistance discount is 20% of the patient's family income and is subject to the patient's continued eligibility under this policy. The 12-month period to which the maximum amount applies begins with the first date of service that is considered eligible under this policy. To be eligible to have this maximum amount apply to subsequent charges, the patient shall inform the hospital in subsequent inpatient admissions or outpatient encounters that the patient previously received health care

services from the hospital and was determined eligible for the uninsured or financial assistance discount. The business office will keep an accounting of patient amounts eligible under this maximum amount. Patients who own assets (not including the patient's primary residence, amounts held in a pension or retirement plan, or other assets exempt by law) in excess of the 450% of the federal poverty guidelines may not be eligible for the application of the maximum collectible amount. Asset information is not used to determine discount eligibility for outpatient services.

13. Financial assistance applicants will be referred to the hospital's business office. The business office will provide information to patients about the financial assistance and uninsured discount policy and evaluate eligibility.
14. Following are the income level guidelines and discount calculations for the uninsured and financial assistance discounts:

Family
Unit

Size	No Charge	60%	43%
1	$27,180	$40,770	$61,155
2	$36,620	$54,930	$82,395
3	$46,060	$69,090	$103,635
4	$55,500	$83,250	$124,875

Each additional member add:

$ 9,440	$14,160	$21,240

Percent of federal poverty level income guidelines:

200%	300%	450%

The discount for 450% of the federal poverty level is the greater of:

1) Medicare cost report Worksheet C Part I, line 202, col. 1 cost / Worksheet C Part 1, line 202, col. 8 charges = ratio of cost to charges (RCC)
[1-(RCC X 1.35)] X charges = discount

or

2) The average generally billed (AGB) discount: Medicare and private health insurers allowed charges over a 12-month fiscal year period divided by the associated gross charges for those claims = AGB %
100% - AGB % = discount

15. The following providers deliver emergency or other medically necessary care in the hospital facility and are not covered by this policy: EPSS L.L.C. – East Series; K.M.B., S.C.; Clinical Radiologists; and all outpatient clinic providers.

DOCUMENTATION:

Approval for financial assistance and uninsured discounts will be documented appropriately by the Business Office Manager.

REQUIRED DEPARTMENTS:

All Departments

Attachments

No Attachments

Approval Signatures

Approver	Date
Paul Skowron: CEO	02/2022
Donna Wisner: CFO	01/2022