



CHARITY CARE DISCOUNT POLICY

POLICY STATEMENT

The Hospital shall contribute appropriate resources, advocacy and community support to promote the health status of the community, which it serves, within its economic ability to do so. Charity care will be provided to patients with a demonstrated inability to pay. The purpose of this policy is to establish criteria for determining if a patient's account qualifies for a charity care discount. The amount of charity care to be made available, as well as any other changes to this policy shall be assessed and determined by the hospital's Chief Executive Officer on an annual basis, and will adhere to state guidelines for non-profit facilities, if applicable. The amount of charity care as well as the other terms of this policy may be changed by the hospital's Chief Executive Officer, subject to the approval of CHC Community Care, LLC.

PROCESS

1. Non-Discrimination. The Hospital is a tax exempt organization offering a charity care program. The Hospital will not discriminate on the basis of race, ancestry, religion, national origin, citizenship status, age, disability or gender in its consideration of a patient's qualification for charity care.
2. Patient Classification. The classification of a patient as being eligible for charity care shall occur at the time sufficient information has been obtained to verify the patient's inability to pay for needed medical services, and as soon as possible after the patient first presents for services or indicates an inability to pay for services.
3. Time of Qualification. Hospital personnel shall attempt to identify all cases that qualify as charity patients at the time of pre-registration or admission. Patients identified as possible charity care patients will be given an application and policy guidelines, together with directions on completing the paper work and any additional documentation needed to consider the application. The patient will also be given contact information for the appropriate personnel to whom they should return the application.
4. Other Payor Sources. Applicants must fully cooperate and comply with eligibility requirements for any other healthcare program(s) for which they may be qualified prior to their evaluation for charity care. Federal and/or State assistance may be available to those who meet qualifications. Before charity care is considered, all available avenues of assistance from third-party payors must be exhausted.
5. Medical Necessity. All services must be medically necessary in order to qualify for a charity care discount (e.g., elective services such as cosmetic surgery do not qualify for a charity designation). Eligible services will be based on those services for which Medicare provides coverage.
6. Income Verification. Patients or the responsible party must verify the income reported on the Financial Assistance Application in accordance with the Documentation Requirements set forth below.
 - a. Required Documentation. Income verification must be obtained regarding each patient considered for charity care. Eligibility documentation must be maintained in the patient's financial file. The Hospital

may obtain, for each patient, one or more of the following documents in order to determine income and assets of the patient.

- i. IRS Form W-2;
 - ii. Wage and earnings statement;
 - iii. Paycheck remittance;
 - iv. Individual tax returns
 - v. Unemployment insurance;
 - vi. Social Security award letter, or copy of Social Security check;
 - vii. Telephone verification by employer of the patient's income;
 - viii. Veterans Administration letter, or copy of VA check;
 - ix. Physician disability statement listing term of disability and documentation or proof of three or more months with no income for the period of disability;
 - x. Bank accounts and records; or
 - xi. Other appropriate indicators of yearly, monthly, weekly or hourly income.
- b. Participation in a Public Benefit Program. By the provision of documentation showing current participation in a public benefit program such as Medicaid, County Indigent Health Program, WIC, Children's Health Insurance Program, or other similar indigency-related programs. Proof of participation in any of the above programs indicates that the patient has been deemed Financially Indigent and therefore, is not required to provide his or her "Gross Monthly Income" on the Financial Assistance Application, or provide any of the income documentation verification listed in Section 6.
- c. Documentation Unavailable. In cases where a patient is unable to provide documentation verifying income, the hospital may verify the patient's income by providing an explanation of why the patient is unable to provide documentation verifying income and:
- i. Obtaining the Patient's Written Attestation. By having the patient or the responsible party sign the Financial Assistance Application attesting to the veracity of the income information provided; or
 - ii. Obtaining the Patient's Verbal Attestation. Through the written attestation of Hospital personnel completing the Financial Assistance Application that the patient verbally verified the Hospital's calculation of the income reported on the Financial Assistance Application.
- d. De Minimis Accounts. If the patient's account is of de minimis value, not to exceed \$500.00, the Hospital may verify the patient's income reported by the patient on the Financial Assistance Application by:
- i. Obtaining the Patient's Written Attestation. Obtaining a Financial Assistance Application signed by the patient attesting to the veracity of the income information provided; and
 - ii. Documenting Efforts to Obtain Documentation. Documenting two attempts by the Hospital to obtain documentation from the patient verifying income.

- e. Verification Procedure. In determining a patient's total income, Hospital staff will determine an applicant's gross annual household income as well as the applicant's gross monthly household income from one or more sources of documentation (listed in 6. (a) above) the applicant provides. The applicant's gross annual household income will provide the basis for determining eligibility according to the process provided in the Financial Assistance Approval Worksheet. The Hospital may also consider other financial assets and liabilities of the patient, as well as the patient's family income and the ability of the patient's family to pay. If a determination is made that a patient has the ability to pay the remainder of the bill, that determination does not preclude a re-assessment of the patient's ability to pay upon presentation of additional documentation.
 - f. Classification Pending Income Verification. During the verification process, while the Hospital is collecting the information necessary to determine a patient's income, the patient may be treated as a private-pay patient in accordance with the Hospital's policies. However, the Hospital may classify the account as bad debt only after 150 days from the date of admission and only if the Hospital has been unable, after following the document collection policies detailed in section 16. below, to obtain the documentation necessary to verify patient's eligibility for charity care, except that if Hospital receives proof that patient is eligible for participation in a public benefit program (as referenced in section 6(b) above), after 150 days from the date of admission have passed, the Hospital may classify the account as charity at that point, even though 150 days from the date of admission have elapsed.
 - g. Information Falsification. Falsification of information may result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance, the Hospital finds material provision(s) of the Financial Assistance Application to be untrue, charity care status may be revoked and financial assistance may be withdrawn.
7. Administrative Approval. All charity care applications shall be forwarded to the appropriate personnel or designee for approval adhering to this policy. The Director of Patient Financial Services shall review and approve all charity care application files involving write-off amounts over \$5,000 for accuracy of eligibility determination and write-off amount, as well as completeness of documentation required to verify income. Charity care application files are to be reviewed and approved per the Hospital's signature authorization policy. The Director of Patient Financial Services shall complete a final review and approval of all charity care applications, regardless of write-off amount, before final classification and write-off of account to charity.
8. Notification Process. The process of application review, approval or denial, and patient notification of decision shall not take more than thirty (30) days from the date that the application is received with all required information. All patients that request charity care shall receive a letter stating if the patient was approved or denied for a charity care designation, and if approved, the amount of charity care discount the patient will receive as well as conditions for the charity care.
9. Patient Account Adjustment. Once a favorable determination is made to provide charity care to the patient, an adjustment should be made to the patient's account accordingly. If an account is found to be with a collection agency subsequent to a patient's becoming eligible for charity care, the account will be recalled and all records on the patient's credit report will be adjusted for the accounts approved for a charity care discount.
10. Guidelines. Eligibility for free or discounted care shall be provided according to the attached addendums:
- a. Eligibility Guidelines ([Addendum A](#)).
 - b. Approval Period.
 - c. Remaining Charity Care Balances.

11. Automatic Qualification. The following categories of patients are deemed to have no annual household income and shall automatically qualify for charity care and receive a 100% discount on charges: patients who are deceased with no estate in probate and patients determined to be homeless. Documentation of "Yearly Income" on the Financial Assistance Application is not required for expired patients.
12. Denial of Services. Denial of future non-emergent services may also be considered for patients who refuse to cooperate and/or habitually access the acute care system for non-acute care episodes.
13. Publication of Policy. The Hospital's Charity Care Discount Policy must be available to the public. In addition to the prominent posting of a charity care notice in the admissions and emergency room area, a copy of the Charity Care Discount Policy should be disseminated to all patients who request it.
14. Approval Procedures. The Hospital will complete a Financial Assistance Approval Worksheet ([Addendum B](#)) for each patient granted status as Financially Indigent or Medically Indigent. The Financial Assistance Approval Worksheet allows for the documentation of the administrative review and approval process utilized by the Hospital to grant financial assistance.
15. Document Collection and Retention Procedures. The Hospital will maintain documentation sufficient to identify each patient granted status as Financially Indigent or Medically Indigent, the patient's income, the method used to verify the patient's income, the amount owed by the patient, and the person who approved granting the patient status as Financially Indigent or Medically Indigent. At the time of patient registration, immediately after a patient is provided a charity care application as a potential candidate for charity care, Hospital staff will create a patient file with patient's first and last names and patient account number clearly labeled on the file. As soon as practicably possible, the following items should be placed in the file:
 - a. completed charity care application;
 - b. completed Financial Assistance Approval Worksheet, signed by the preparer as well as the reviewer authorizing the write-off eligibility and amount;
 - c. documentation providing proof of household financial income information; and
 - d. any other information to substantiate the write-off eligibility and amount if documentation does not suffice to verify income.
 - i. Hospital staff will review files on an annual basis to ensure files related to accounts eligible for or written-off as charity are complete.
 - ii. If the patient has not provided all required documentation within ten (10) days of preadmission or admission, Hospital staff will contact patient to obtain missing documentation, and follow-up periodically thereafter until patient file is complete.
16. Reservation of Rights. The Hospital reserves the right to limit or deny financial assistance at its sole discretion.
17. Non-covered Services. The Hospital reserves the right to designate certain services that are not subject to this Charity Care Policy.
18. No Effect on Other Hospital Policies. This Policy shall not alter or modify other Hospital policies regarding efforts to obtain payments from third-party payers, patient transfers, or emergency care.

ADDENDUM A
CHARITY CARE DISCOUNT

- A. **Eligibility Guidelines:** The Hospital and Clinic shall provide free or discounted care to persons who are uninsured or underinsured, and meet the Hospital's indigency guidelines
1. **Classification as Financially Indigent:** A financially indigent patient is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the Hospital's eligibility criteria set forth in this policy.
- a. To be eligible for charity care as a financially indigent patient, a person's gross annual household income¹ shall be at or below 200 percent of the federal poverty guidelines and have no alternative resources available. The Hospital may consider other financial assets and liabilities of the person when determining eligibility. If the Hospital accepts a patient as Financially Indigent, the patient may be granted financial assistance in accordance with Schedule A of the Hospital's Financial Assistance Eligibility Discount Guidelines.
 - b. The Hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The poverty income guidelines are published in the Federal Register in February of each year and for purposes of this policy will become effective the first day of the month following the month of publication.
 - c. In no event will the Hospital establish eligibility criteria for financially indigent patients which set the income level for charity care [lower than that required for counties under the Texas Indigent Health Care and Treatment Act, or (include in Texas Hospitals only)] higher than 200 percent of the federal poverty income guidelines. The Hospital may, however, adjust the eligibility criteria from time to time based on the financial resources of the Hospital and as necessary to meet the charity care needs of the community.

¹ For purposes of these eligibility guidelines, **Household Income** is all income of the patient's household, defined as, all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household. **Income** includes total annual cash receipts before taxes from all sources, with the exceptions noted below. **Income includes** money wages and salaries before any deductions; net receipts from nonfarm self-employment; net receipts from farm self-employment; regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families. Supplemental Security Income, Emergency Assistance money payments, and non-federally-funded General Assistance or General Relief money payments) and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household, private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings. **Income does not include** the following types of money received; capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car; and tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments or compensation for injury. Also excluded are noncash benefits; food or housing received in lieu of wages; the value of food and fuel produced and consumed on farms; the imported value of rent from owner-occupied nonfarm or farm housing; and such Federal noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance.

A person's eligibility will be based on household income for the most current months coordinating with the service date.

2. **Classification as Medically Indigent:** A medically indigent patient is a person who's medical or Hospital bills after payment by third-party payers exceed a specific percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill. The Hospital may consider other financial assets and liabilities of the person when determining ability to pay.
- a. To be eligible for charity care as a medically indigent patient, the patient's gross annual household income must be greater than 200 percent but less than or equal to 400 percent of the federal poverty level and the amount owed by the patient on the Hospital bill after payment by third-party payers must exceed 10 percent of the patient's gross annual household income. In these instances, the Hospital may determine the amount of financial assistance granted to these patients in accordance with Schedule B of the Hospital's Financial Assistance Eligibility Discount Guidelines.
 - b. **Catastrophic Medical Indigence:** To qualify as Catastrophic Medical Indigence, the patient's income must be greater than 400 percent of the federal poverty guidelines. In these instances, the Hospital may determine the amount of financial assistance granted to these patients in accordance with Schedule C of the Hospital's Financial Assistance Eligibility Discount Guidelines.
 - c. A determination of a patient's ability to pay the remainder of the bill will be based on whether the patient reasonably can be expected to pay the account in full over a two year period.
 - d. If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a re-assessment of the patient's ability to pay at a later date.
- B. **Approval Period:** Qualifying applicants will be approved for a six month period from the date of approval for both the Hospital based services and Clinic services.
- C. **Remaining Charity Care Balances:** Accounts with remaining balances after charity care adjustments will follow the Collection of Accounts Policy and will be eligible to set up a payment plan for patient balances as determined in the Payment Plan Policy.
- D. **Eligibility Schedules:** See Eligibility Schedules A - C for income guidelines.

Date Issued: _____

Approval: _____

Date: _____

FINANCIAL ASSISTANCE ELIGIBILITY DISCOUNT GUIDELINES

Based on Current Federal Poverty Guidelines

Schedule A Financially Indigent Classification

ANNUAL INCOME	Up to 200%
Discount Amount	100%

Schedule B Medically Indigent Classification

ANNUAL INCOME	250%	300%	350%	400%
Discount Amount [Balance due must be equal to or greater than 10% of Income]	90%	80%	70%	60%

*For households with more than eight persons add \$3,740 for each additional member.

Schedule C Catastrophic Eligibility as Medically Indigent

The Patient's Gross Household Income must exceed 400% to qualify for Catastrophic Medical Indigence.

Balance Due	Discount
Balance Due is equal to or greater than 50% of the patient's annual income	90%
Balance Due is equal to or greater than 40% and less than 50% patient's annual income	80%
Balance Due is equal to or greater than 30% and less than 40% patient's annual income	70%
Balance Due is equal to or greater than 20% and less than 30% patient's annual income	60%
Balance Due is equal to or greater than 10% and less than 20% patient's annual income	50%

ADDENDUM B
CHARITY APPLICATION INSTRUCTIONS

PERSONAL INFORMATION:

- Print your full legal name.
- Write your home and work telephone number and give a daytime telephone where you can be reached most often.
- Write your current address and which country you presently live in.
- If you are completing this application for someone other than yourself, write the full legal name and social security number of the patient for whom this application is being completed.

HOUSEHOLD MEMBERS AND MONTHLY INCOME:

- Print the names of everyone in your household along with their ages, whether they have income or not.
- Include yourself, other related and unrelated people in your household. (use another piece of paper if you need more space.)
- Write the amount of income each household member received last month, before taxes or anything else is taken out, and where it came from, such as earnings, welfare, child support, social security and other income.
- If any amount last month was more or less than usual, write that person's usual monthly income.

PROOF OF INCOME, RESIDENCY, AND IDENTIFICATION:

- ALL APPLICANTS SHOULD ATTEMPT TO PROVIDE PROOF OF ANY OF THE FOLLOWING TO VERIFY INCOME:
 - IRS Form W-2
 - Wage and Earnings Statement Paycheck Remittance
 - Bank Statement/Records
 - Individual Tax Return
 - Social Security, Workers Compensation or Unemployment Compensation letter
 - Proof of eligibility for Government Program
 - Physician disability statement listing term of disability and documentation or proof of three or more months with no income for period of disability
 - Telephone verification by employer of patient's income

- Other
 - You may also verify your income by: (a) having your employer provide written verification; (2) having your employer speak with a Hospital representative; or (3) providing a written or verbal statement to Hospital representative verifying your gross annual household income.
- If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in the INCOME VERIFICATION section of the Financial Assistance Application.

MONTHLY EXPENSES:

- Write the usual amount of household expenses.

SIGNATURE AND SOCIAL SECURITY NUMBERS:

- All applications should have the signature of an adult household member (unless medical problems or situations, i.e. isolation, I.C.U., etc. are certain.). If it is not possible or feasible to obtain a signature, please explain to hospital staff why signature is unavailable.
- The application must have the social security number of the adult who signs.
- If the adult does not have a social security number, write "NONE" to show that the adult does not have a social security number.
- Additional information may be required to determine your eligibility, depending upon the program for which you are applying.

ELIGIBILITY DETERMINATION:

- Eligibility will be determined based on 200% Poverty Income Guidelines.
- Approved applications cover charges at ContinueCARE Hospital at Hendrick Medical Center only.

APPLICATION FOR FINANCIAL ASSISTANCE

To apply for financial assistance, on the bill from ContinueCARE Hospital, complete this application, sign your name, and return the application to the Financial Department within 30 days of your visit. Call the Financial Department If you need help at (____) _____, _____.

PERSONAL INFORMATION

Name: (Please Print)	Name and Social Security Number of Patient (if different from person completing application):
Home Phone #:	Work Phone#:
Address:	City/State/Zip Code:
What County do you live in?	Is Address Permanent or Temporary?

HOUSEHOLD MEMBERS AND MONTHLY INCOME

Name of Household members	Relationship to Household Member	Age and Date of Birth	Gross MONTHLY Income	MONTHLY Welfare/Child Support	MONTHLY Payments, Pensions, Retirement, Social Security	Any Other Monthly Income

INCOME VERIFICATION

Please provide any of the following types of documentation to verify your income. (This information will be used solely for the purpose of assessing eligibility for medical assistance.)	
IRS Form W-2, Wage and Earnings Statement Paycheck Remittance	Bank Statement/Records
Individual Tax Return	Government Program
Social Security, Work Comp or Unemployment Comp letter	Telephone verification by employer
Physician Disability Statement	Patient deceased
	Other
If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:	
Other Resources: Please provide the total amount of other \$ _____ resources available to you, including such things as _____ savings accounts, checking accounts, stocks, bonds, etc.:	

MONTHLY EXPENSES

Rent/Mortgage payment		Car/Truck Payment	
Electric and/or Gas Payment		Child Care Expenses	
Telephone Cell Phone		Loans	
Cable/Satellite		Other: Water/Auto Insurance	

SIGNATURE AND SOCIAL SECURITY NUMBER:

I certify that all of the above is true and correct and that all income is reported. I understand that this information is being given for the determination of CHARITY CARE for services rendered at ContinueCARE Hospital; and that hospital officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to immediate denial.

X _____ X _____
SIGNATURE OF ADULT HOUSEHOLD SOCIAL SECURITY NUMBER

DO

NOT WRITE BELOW THIS LINE — FOR HOSPITAL USE ONLY
(Monthly income conversion: weekly x 4.33, Every 2 weeks x 2.15, Twice a Month x 2)
(Yearly income conversion: monthly x 12)

Total Household Size:	Monthly Income:	Yearly Income:
Food Stamps: Y / N		
Eligibility Determination: Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending <input type="checkbox"/>		
Reason for Denial: Income too much <input type="checkbox"/> Incomplete Information <input type="checkbox"/> Other <input type="checkbox"/>		
Account This Application Applies To:	Patient:	
Signature of Determining Official:	Date:	
	Other:	
Reason applicant did not complete application (if applicable):		
Reason verbal attestation of income necessary (if applicable)		

FINANCIAL ASSISTANCE APPROVAL WORKSHEET

Office use only

Name: _____

Patient Account Number(s): _____

Date of Birth: _____

Social Security Number _____

Gross Annual Household Income: \$ _____

Charges: \$ _____

Number in Household: _____

Amount Due: _____

Circle type of documentation or income verification provided:

- | | |
|--|--|
| • IRS Form W-2, Wage and Earnings Statement
Paycheck Remittance | • Physician Disability Statement |
| • Individual Tax Return | • Written Attestation (Patient signed Assistance
Application verifying Total Yearly Income) |
| • Social Security, Work Comp or Unemployment Comp letter | • Verbal Attestation (Patient verbally verified Total
Yearly Income) |
| • Government Program | • Patient deceased |
| • Telephone verification by employer | • Other |
| • Bank Statement/Records | |

Circle appropriate answer in response to the following questions:

1. Is Total Gross Annual Income equal to or less than 200% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Guidelines — Schedule A)

YES Approved for 100% financial assistance as Financially Indigent

NO Does not qualify for assistance as Financially Indigent. Continue to Step 2.

2. Is balance due after payment by all third party payors equal to or greater than 10% of Total Yearly Income?

YES Continue to Step 3.

NO Patient does not qualify for Financial Assistance.

3. Is Total Gross Annual Household Income equal to or less than 500% of the Federal Poverty Guidelines?

(See Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B.)

YES Total Yearly Income is less than % of the Federal Poverty Guidelines. Approved for ____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule B

NO Continue to Step 4.

4. Is balance due after payment by all third party payors equal to or greater than 50% of Total Yearly Income?

YES Balance due is __ % of the total yearly income. Eligible for _____ % discount as Medically Indigent pursuant to Hospital Financial Assistance Eligibility Discount Guidelines — Schedule C.

NO Patient does not qualify for Financial Assistance.

I. (\$ _____) X (_____ %) = \$ _____ 2. (\$ _____) - (\$ _____) = \$ _____
Balance Due % Discount Discount Amount Balance Due Discount Amt. Remaining Bal. Due

Employee Signature _____

If Discount = \$1 - \$2,000: Approval by: _____ or above

If Discount = \$2,001 - \$5,000: _____ Approval by: _____ or above

If Discount = Above \$5,000: Director of Patient Financial Services

Date: _____

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