Original Date: 02/19/2013 **Title:** Financial Assistance Policy **Department:** Patient Financial	**Union General Hospital** An Equal Opportunity Employer	**Date Reviewed:** 06/03/2015 **Date Revised: 01/19/2016** **Approval** Board of Trustees Senior Management Department Manager

FINANCIAL ASSISTANCE POLICY

POLICY

Union General Hospital, Inc. dba Union General Hospital (UGH) is committed to providing financial assistance to persons who have healthcare needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situation. Emergency care will be provided to all patients regardless of their or their family's ability to pay. Financial Assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with UGH, procedures for obtaining financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance- free and discounted(partial charity) care;
- The basis for calculating amounts charged to patients;
- Describes the method by which patients may apply for financial assistance under this policy;
- Describes how the hospital will widely publicize the policy within the community served by the hospital;
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed (received by) the hospital for commercially insured or Medicare patients.
- Actions that may be taken in the event of nonpayment, should it be required.

GOVERNANCE

The Financial Assistance Policy is administered by the Business Offices of UGH, Inc. with authority and approval from the Executive Management and Union General Hospital, Inc. Board of Directors.

NON COVERED ENITIES

This policy does not cover providers outside the incorporated Union General Hospital Inc. system: Individual Private Practitioners, Surgeons, Radiologist, Pathologist, and Gastroenterologist.

COVERED ENITIES

This policy covers providers within the incorporated Union General Hospital, Inc. system: ER Physicians, Certified Registered Nurse Anesthetist, Family Nurse Practitioners, Physician Assistance, Facility Charges and Rural Health Clinics.

Union General Hospital, Inc. will provide the following:

- Each individual with an FAP application form.
- Written notice that indicates the availability of financial assistance for eligible individuals and provides the deadline of 240 days after which the hospital or clinics will no longer accept and process and FAP applications for previous care.
- A plan language summary along with the written notice.
- Make a reasonable effort to notify individual's orally about the FAP policy and how to obtain assistance through the FAP application process.

DEFINITIONS

Financial Assistance- Indigent Care and Charity Care are provided to persons who meet UGH, Inc. criteria for financial assistance and are unable to pay for all or a portion of medically necessary services provided by the facility.

Indigent Care - is defined as providing health care for people who do not have enough resources to pay for medical expenses and other related expenses. It is a form of charity wherein the caregiver does not expect payment in return for medical services rendered. Household incomes that are at or below 125% of the FPG are eligible to receive free care. It is not a health insurance.

Charity Care - is a reduction in fee for services provided, due to financial situation of a patient. Household incomes that exceed 125% of the FPG, but are at or below 400% of the FPG qualify for a discounted payment based on a sliding scale

Presumptive Charity - when a patient may appear eligible for charity care discounts (primarily based on lack of housing) but there is no financial assistance form on file and due to a lack of supporting documentation. (See Eligibility for Consideration- G.).

Federal Poverty Guidelines (FPG) -Financial guidelines issued by the federal government at the beginning of each calendar year are used to determine eligibility for poverty programs. The current FPG can be found on the U.S. Department of Health and Human Services website at hhs.gov.

Family Unit size - is defined as the applicant, spouse, and all legal dependents as allowed by the Federal Government. If the applicant is a minor, the family unit will include parent(s), legal guardian(s), and all household dependents as allowed by the federal government.

Family Unit income - is defined as gross income for all members of the family unit for the last three months or the last calendar year, whichever is the lesser. Examples of income are: salary and wages, social security benefits, retirement, pensions, veteran's administration, welfare, workers compensation, sick leave, disability compensation, alimony, child support, stock/certificate dividends, interest, or income from property.
Non-cash benefits (such as food stamps and subsidies) do not count and income.

Disposable income - is defined as available income determined by subtracting the family unit income from the Federal Poverty Guidelines.

Gross Charges- are defined as the total charges at the organization's full established rates for the provision of patient care service before deductions from revenue are applied.

Standard Collection Effort- is defined as a period of 120 days from the date the first bill is sent to the guarantor

Extraordinary Collection Actions- are defined as a legal or judicial process that includes but are not limited to placing a lien on an individual's property, foreclosure on an individual's real property, attach or seize an individual's bank account or any other personal property, commence a civil action against and individual, cause an individual's arrest, cause an individual to be subject to a writ of body attachment, and garnish an individual's wages. However, this does not include standard collection efforts.

Assets- are defined as cash on hand or any tangible item that can be liquidated into cash, typically within 30 days. Cash and checking accounts, IRA's, 401K Savings accounts, stocks, short term bonds will be considered liquid assets. Certificates of deposit, money market funds, bonds, mutual funds, and the cash value of a life insurance policy are examples of investments that could provide quick cash when necessary. Tangible assets may also include fixed assets, such as machinery, buildings, land and inventory. Jointly owned assets, may be considered liquid depending on the type of asset and ownership. For the purpose of financial assistance, an applicant's primary residence will not be considered as an asset for liquidation.

Self-Employment Income - is defined as the amount remaining after business operating expenses. A personal monthly income and expense form and a previous quarterly income statement are needed to assist with the determination of eligibility.

Uninsured patients -are defined as patients without third-party insurance coverage for health services.

Under-insured patients - are defined as patients who have some level of insurance or third-party assistance but still has out of pocket expenses that exceed his/her financial abilities.

Emergency Medical Conditions - is defined as 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 placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ.

Medically necessary - as defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Medically Underserved- is defined as populations "at risk of not receiving adequate medical care as a result of being underinsured or uninsured or due to geographic, language, financial or other barriers.

ELIGIBILILTY FOR FINANCIAL ASSISTANCE CONSIDERATION

A. To begin the process for financial assistance, the patient or responsible party should complete a "Financial Assistance Application" and provide the necessary documentation to support their financial situation.

B. The granting of financial assistance shall be based on the determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation, or religious affiliation.

C. Applicants should fully cooperate and comply with all verification of income and assets to be considered.

D. The applicant's medical care should be medically necessary to be considered for financial assistance. Care for emergency medical conditions (as defined in EMTALA) will be administered to all individuals regardless of their eligibility under the FAP.
It is preferred but not required that the request for charity and determination of financial need occur prior to rendering non-emergent medically necessary services. Medical services solely for cosmetic purposes, and services or procedures that are elective will not be considered.

E. An applicant's accounts that have progressed to legal action after 240 days will not be considered. However, prior to legal action, external collection agencies will notify the hospital of any accounts that may qualify for financial assistance or accounts where the patient/guarantor has requested financial assistance.

F. Financial assistance adjustments will be applied to qualifying accounts prior to referral to an external collection agency. Assistance may take the form of indigent or charity care.

G. If there is adequate information provided by the patient or through other sources, the patient may be deemed Presumptive charity without a formal application. In the event there is no evidence to support a patient's eligibility for charity care, UGH could use outside agencies in determining estimated income amounts for the basis of determining charity care eligibility or potential discount amounts. Presumptive Financial Assistance will be determined prior to any outside collection activity. The following types of accounts may be considered eligible for financial assistance without documentation under the Presumptive Charity Program (1) Referrals from approved community agencies; (2) No estate (deceased); (3) Eligible for Medicaid in states other than Georgia; (4) Eligible for State/Federal Programs where program funding has been exhausted; (5) Food Stamp eligibility; (6) Low income or subsidized housing; (7) Participation in the Women, Infants and Children programs (WIC); (8) State funded prescription programs; (9) Unemployed persons with no Third Party insurance coverage.

H. Requests for financial assistance from other than Union or Towns County residents will be considered on a case-by-case basis.

DETERMINATION OF FINANCIAL ASSISTANCE

A. Financial assistance will be determined through an individual assessment that may include:

1. A completed financial assistance application in which the applicant is required to cooperate and provide documentation necessary to make a financial assistance determination.
2. The use of external sources to help determine an applicant's ability to pay, and the value of assets. Non-physical assets such as bank accounts, bonds, etc., will be used to help determine ability to pay, while the physical assets such as real estate, automobiles, etc., will be used to help determine debt ratios.
3. A reasonable effort by the UGH facilities to explore and assist patients in applying for alternative sources of payment and coverage from public and private payment programs.
4. Use of a data analytics model (such as Propensity to Pay) may be used to identify patients who may qualify for financial assistance but have not requested this assistance.

B. Financial assistance determinations will be made timely, no longer than 5 business days after receipt of **all** required documentation. If all necessary documentation is provided during an interview with a financial counselor, the applicant may be informed of the determination at that time. A written determination will be mailed to the applicant within 5 business days.

C. Non-emergent surgical services and other non-emergent scheduled procedures will not be considered eligible for financial assistance.

D. The financial assistance may be re-evaluated at any time additional information relevant to the eligibility of the patient becomes known. Patients will be notified of the availability of financial assistance at time of registration. Financial assistance applications will be accepted up to 240 days after the first billing statement is submitted to the patient notifying him/her of the patient financial responsibility. A financial assistance application will be valid for dates of service incurred up to three months/90 days after the application is approved. No extraordinary collection actions (ECA) will be pursued during the first 120 day period following submission of the first billing statement to the patient. If no financial assistance application is received during the 120 day period, ECA may begin.

E. Financial assistance account adjustments posted before payments are received from insurance companies, Medicare, Medicaid, third party liability carriers, or court settlements, will be reversed. This situation would occur when the hospital is not aware of other payers or when coverage is retroactively applied.

F. A credit check may be processed for applicants and household members to assist in determining the overall financial status and value of the assets. A credit report may be used solely in the determination of charity when a financial application cannot be obtained. If the applicant's credit report indicates the family unit income provided by the applicant is unrealistic, financial assistance may be denied.

G. The value of assets and household income will be added together to total the gross income. The gross income will be compared to the Federal Poverty Guideline Sliding Scale and discounts will be applied accordingly.

AMOUNTS CHARGED TO PATIENTS

Once a patient has been determined by UGH, Inc. to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges, UGH, Inc. uses the Federal Poverty Guidelines (FPG) in effect at the time an application is completed and submitted to determine eligibility for financial assistance. Criteria are set as follows:

- Household incomes that are at or below 125% of the FPG are eligible to receive free care. This is classified as indigent care.
- Household incomes that exceed 126% of the FPG, but are at or below 400% of the FPG qualify for a discounted payment based on a sliding scale. This is classified as charity care. The patient may be approved for a payment plan.
- Household incomes that exceed 125% of the FPG, but are at or below 400% of the FPG, may receive a larger discounted payment based on an ability to pay. This is determined using a calculated methodology including gross income, debt, and an ability to pay.

- Household incomes that exceed 400% of the FPG, where the patient is medically indigent or has unusual financial circumstances, such as catastrophic illness or accident, are evaluated based on their financial situation. This is classified as medically indigent or charity hardship care. The patient may be approved for a payment plan. Some examples include: (1) The size of the patient's medical bills based on a catastrophic illness or otherwise have resulted in patient liabilities for which payment is impossible based on current financial status of a household; or (2) The patient's subsistence is threatened resulting in an ability to meet patient liabilities.

NON-PAYMENT PROCESS (related to a partial account adjustment)
In the event of non-payment by a patient for their portion of their account, the hospital or its representative will send two notices within 60 days and make two phone calls before sending the account to a collection agency. The collection agency will continue collection activities up to 120 days before beginning ECA by reporting to the credit bureau and the use of collection attorneys. As allowed by the State of Georgia, when a patient presents for services following an accident or injury, UGH, Inc. may place a hospital lien against the third party settlement.

APPEAL PROCESS FOR FINANCIAL ASSISTANCE DENIALS
An applicant may appeal a financial assistance determination within 15 days of a denial notice. An appeal must be submitted in writing, either by letter or email, and sent to the Business Office.

Written appeals should be sent to:
Union General Hospital, Inc
Attention: Business Office Manager
35 Hospital Road
Blairsville, GA 30512

Email appeals should be sent to: CBO-UGH@uniongeneral.org

The Business Office Manager will respond to the appeal within 10 business days.

COMMUNICATION OF THE FINANCIAL ASSISTANCE PROGRAM
UGH, Inc. makes information readily available to patients about its financial assistance program by posting and distributing information in the patient registration areas, other public places throughout the hospitals, on patient bills, and on its website. The postings are provided in English and are available on the website or upon request as follows:

- By asking at a hospital admission area or financial counselor office
- By telephone at 706-745-2111
- By emailing CBO-UGH@uniongeneral.org

The Financial Counselor is available Monday through Friday from 8:30 am to 4:30 pm on a scheduled or walk-in basis to interview applicants and accept financial assistance applications.

ATTACHMENTS
Financial Assistance Application (English)
Sliding Scale
Addendum

FOR MORE INFORMATION CONTACT
CFO
Business Office Manager

APPROVAL BODIES
Union General Administration
Compliance Department
Union General Board of Directors

Addendum to revise annually

CALCULATION OF CHARGES- according to the IRS 501(c) 3 Rule under the ACA rule 501(r)

CHARGES BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

Patients approved for financial assistance will not be billed gross charges. The charges billed will be discounted to the actual **Medicare payment rate**. This discount will be updated annually when new Medicare rates are determined. For fiscal year 2015-2016, beginning May 1, 2015, the IRS mandated discount percentage is:

Inpatient - 53%
Outpatient- 62%

Example calculation (1):
If a patient's gross charges for outpatient services are $1,000.00, the charge will be discounted to the Medicare reimbursement ($1,000.00*62%=$620.00 IRS 501(c) 3 Rule write-off) ($1,000.00-$620.00=$380.00 patient liability). If a patient qualified for 100% Financial Assistance, the following adjustment would be made; $620.00 would be written-off to the IRS 501(c) 3 Rule and $310.00 would be written-off to Indigent Care.

Example calculation (2):
If a patient's gross charges for outpatient services are $1,000.00 and the patient qualified for 25% Charity Care the following adjustment would be made ($1,000.00*62%=$620.00 IRS 501(c)3 Rule write-off) ($380.00*25%=$95.00 charity write-off, $285.00 would be patient liability).

In Summary:

1) $620.00 IRS 501(c) 3 Rule write-off
   $380.00 Indigent write-off

2) $620.00 IRS 501(c) 3Rule write-off
   $95.00 Charity write-off
   $285.00 Patient Liability