FINANCIAL ASSISTANCE POLICY

APPROVED BY:
CEO
CFO
Board of Directors

DISTRIBUTED TO:
Finance

REVIEW FREQUENCY:
Annual

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FINANCE_Financial Assistance Policy

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REFERENCE:

PURPOSE:

Harrison Memorial Hospital (HMH), a 501(c)3 tax exempt organization, is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the related regulations, consistent with our mission to deliver compassionate, high quality, affordable health care services. HMH shall strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care at their community hospital.

Although financial assistance care is important, it is only one component of the community benefit that hospitals provide. Other components of community benefit include, but are not limited to:

- Unpaid public health, wellness, and educational programs
- Unpaid cost of Medicaid and other public programs
- Provision of essential healthcare services such as emergency rooms and specialty provider clinics
- Unpaid senior citizen education, outreach, and "meals on wheels" programs
- Cash and in-kind donations on behalf of the poor and needy to community agencies
- Unreimbursed cost of training health professionals and clinical and community health research

Patients are expected to cooperate with procedures for obtaining financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so for their overall personal health, and for the protection of their individual assets. This policy describes the eligibility criteria for financial assistance whether free or discounted and the method for applying.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

***Financial Assistance*:** Free or discounted services provided to eligible Financial Assistance Policy (FAP) individuals who meet the established criteria.

Household: You, your spouse and your tax dependents as defined by Internal Revenue Service rules.

***Household Income*:** Household Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family and is a tax dependent, include their income.

***Uninsured*:** The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

POLICY:

In order to manage its resources responsibly and to allow HMH to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient financial assistance.

Uninsured patients will be referred to the Financial Counselor who will aid in determining eligibility for Medicaid or other state and federal programs. For those who do not qualify for any such programs, the Financial Assistance process will begin.

A. Exclusions: The FAP does not apply to charges for services provided by contracted providers. Including but not limited to Radiologist, Pathologist, Anesthesiologists, Hospitalist, and Emergency Room Physicians.

PROCEDURES:

A. Services Eligible Under this Policy:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting;
4. Medically necessary services, evaluated on a case-by-case basis at HMH's discretion; and

Services Not Eligible Under the Policy:

1. Experimental procedures, including non-FDA approved procedures and devices or implants; and
2. Services for which prior authorization is denied by the patient's insurance carrier.

B. Eligibility for Financial Assistance. Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

C. Determination of Financial Need.

1. The annual gross income of the patient is considered and compared to the household size. Eligibility is based upon 200%, then follows a sliding scale of the federal poverty guidelines as annually published by the federal government. An individual assessment of financial assistance will be determined using the following.
    a. Complete an application. Applications will be valid for 6 months from the date of approval and will be applied to dates of service 6 months prior and patient balances generated within the past 6 months.
    b. Applicants who do not have a change to household size or income after 6 months can complete an income verification form to extend assistance for another 6-month period. Full financial assistance applications will be required every 12 months.
    c. Include the use of external available data sources that provide information on a patient's or a patient's guarantor's ability to pay.
    d. Take into account the patient's available assets, and all other financial resources available to the patient, not to exceed the annual Medicaid resource limit.
    e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
2. HMH's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be

processed promptly and HMH shall notify the patient or applicant in writing within 30 days of receipt of a completed application.
3. Applications and documents not returned within 30 days will be abandoned.

D. Determination of Assistance. Services eligible under this Policy will be made available to the patient, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination, as follows:
1. Patients whose family income is at or below 400% of the Federal Poverty Level are eligible to receive free care or discounted care as follows: under 200% = 100% write-off; 200-250% = 75% write-off; 250-300% = 50% write-off; 300-400% = 25% write-off.
2. A patient's bill will have the gross charges adjusted with the appropriate discount to reflect the net charges due and payable.

E. Patient Responsibilities.
1. Complete and return Financial Assistance application or Income Verification Form and provide required documentation within 30 days of receipt.
    a. Last 3 months of checking and savings bank account statements
    b. Last 2 months of pay stubs
    c. Most recent tax return, showing dependents
    d. Benefit award letters for Social Security, Disability, Workers' Compensation and Veteran's Administration benefits
    e. Proof of amount for child support
    f. Proof of amount for alimony
    g. Investment or Retirement Account statements
    h. Provide additional documentation as requested
2. Patients are required to notify the Financial Counselor as soon as possible with any changed to their financial situation.
3. Harrison Memorial Hospital will offer interest-free payment plans for balances not covered by financial assistance. A monthly minimum payment of $50.00 will be required to participate in a payment plan.
4. Failure to pay balances not covered by assistance or minimum monthly payments may result in collection actions and reporting to credit agencies.

F. Communication of the Financial Assistance Policy to Patients and the Public. Notification about Financial Assistance available from HMH, which shall include a contact number, shall be disseminated by HMH by various means, which may include, but are not limited to, the publication of notices in patient bills, HMH website and by posting notices in emergency rooms, specialty physician clinics, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as HMH may elect. Such information shall be provided in the primary languages spoken by the population serviced by HMH. Referral of patients for Financial Assistance may be made by any member of the HMH staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws. Patients may phone the Financial Counselor to request Financial Assistance. Applications will be mailed to the patient free of charge.

G. Regulatory Requirements. In implementing this policy, HMH management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

ATTACHMENTS:

- Financial Assistance Application Instructions
- Application for Financial Assistance
- Income Verification Form
- Plain Language Summary
- List of Providers Covered by Financial Assistance Policy

PLAIN LANGUAGE SUMMARY

Harrison Memorial Hospital provides financial assistance to patients with no insurance or patients with insurance who have out-of-pocket responsibility that they are unable to pay. Anyone needing assistance will be required to complete the Financial Assistance application and provide all required documentation. Harrison Memorial Hospital may request additional information needed for application review by phone or mail.

Uninsured patients or insured patients with out-of-pocket balances will most likely qualify for **free** emergency or medically necessary care through the financial assistance policy if the following circumstances apply.

- The patient's annual household income is less than 200% of the Federal Poverty Level.
- The patient lacks a way to pay for charges using other assets.
- The patient has applied for Medicaid or other state and federal programs.
- The patient fully cooperates in the application process.
-

Uninsured patients or insured patients with out-of-pocket balances will most likely qualify for **discounted** emergency or medically necessary care under the financial assistance policy if the following circumstances apply.

- The patient's annual household income is 200% but not exceeding 400% of the Federal Poverty Level.
- The patient lacks a way to pay for charges using other assets.
- The patient has applied for Medicaid or other state and federal programs.
- The patient fully cooperates in the application process.
-

If a patient is approved for Financial Assistance, they will not be required to pay more than the amount Harrison Memorial Hospital generally bills patients that have insurance coverage for the same emergency or medically necessary care. Patients will also never be asked to make payments prior to or set up a payment plan to receive emergency services. For non-emergency services, a patient may be asked to make a payment on the day of service or establish a payment plan.

Services provided by contracted providers such as Radiologist, Anesthesiologist, Hospitalist, Pathologist and Emergency Room Providers will not be covered under the Financial Assistance policy.

Patients may obtain a free copy of this summary, the Financial Assistance Policy and the Financial Assistance Application from the Harrison Memorial website at www.harrisonmemhosp.org. Copies are also available through the Financial Counselor's office. All information can also be mailed directly to the patient by contacting the Financial Counselor at 859-235-3596.

The Financial Counselor is available to answer any questions or assist with the application process.

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a regional medical center

PROVIDERS COVERED UNDER THE FINANCIAL ASSISTANCE POLICY

Any professional services rendered by a medical provider employed by Harrison Memorial Hospital (MD, APRN, or PA) will be covered under the Financial Assistance Policy. Services provided by contracted, non-employed providers are not covered under the Financial Assistance Policy. This includes but is not limited to services performed by radiologist, pathologist, anesthesiologist, hospitalist and emergency room physicians. Patients who qualify for financial assistance are highly encouraged to contact the financial counselor prior to service to confirm if the provider is employed by Harrison Memorial Hospital. The Financial Counselor can be contacted by calling 859-235-3596.

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FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

1. If uninsured, you must apply for Medicaid and receive a denial. The denial letter should be included with the application. Harrison Memorial Hospital's financial counselor will assist any patient with the Medicaid application process.

2. Complete the Financial Assistance Application.

3. Include all monthly income, monthly expenses, and assets required on the form.

4. Provide the following required documentation:
    a. Last 3 months of checking and savings bank account statements
    b. Last 2 months of pay stubs
    c. Most recent tax return, showing dependents
    d. Benefit award letters for Social Security, Disability, Workers' Compensation and Veteran's Administrative benefits
    e. Proof of amount of child support
    f. Proof of amount for alimony
    g. Investment or Retirement Account statements

5. If you do not have monthly income, provide an explanation of how you meet living expenses.

6. Sign the Financial assistance application.

For any questions or assistance with the application, please contact the Financial Counselor.

- Phone (859) 235-3596
- Email financialcounseling@hmhosp.org
- Visit office located on the ground floor, beside the Emergency Room

Mail completed application and required documentation to:

Harrison Memorial Hospital
Attn: Financial Counseling Office
1210 KY Highway 36 E
Cynthiana, KY 41031

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APPLICATION FOR FINANCIAL ASSISTANCE

RESPONSIBLE PARTY INFORMATION

Guarantor Name_____ SSN_____ Date of Birth_____

Spouse Name_____ SSN_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Daytime Phone Number_____ Evening Phone Number_____ Cell Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Insured Person_____

Secondary Insurance_____ ID#_____ Insured Person_____

EMPLOYMENT INFORMATION

Does your employer offer health insurance? ☐ Yes ☐ No

Employer_____ Position_____ Date of Employment_____

Spouse Employer_____ Position_____ Date of Employment_____

HOUSEHOLD INFORMATION

Household Member's Name	Relationship	SSN	Date of Birth

(use separate page for additional Household Members)

Total Number of People in the household (including patient) _____

HOUSEHOLD MONTHLY INCOME

Guarantor's Gross Wages from paychecks/W2s	$
Spouse's Gross Wages from paychecks/W2s	$
Bonuses/Tips	$
Unemployment Benefits	$
Public Assistance	$
Social Security	$
SSI/Disability/K-Tap	$
Retirement/Pension	$
Worker's Compensation	$
Alimony	$
Child Support	$
Rental Property Income	$
Income from all other sources	$
Total Monthly Income	**$**

HOUSEHOLD ASSETS

Cash on Hand	$
Checking Account Balance	$
Savings Account Balance	$
Stocks/Bonds/IRS/401(k)	$

Other assets? ☐ Yes ☐ No

If yes, list_____

_____

_____

Total Assets **$**

MONTHLY EXPENSES

House Payment or Rent	$
Utilities	$
Prescriptions	$
Childcare	$
Health Insurance	$
Medical Bills	
1	$
2	$
3	$
4	$
5	$
Total Monthly Expenses	**$**

If you indicate that you have no income, please explain how you meet your day-to-day expenses.

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold information in applying for assistance, my application may be denied, and Harrison Memorial Hospital may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify HMH of any changes to the information provided in this form including address, telephone number, and income.

Guarantor Signature_____ Date_____

Spouse Signature_____ Date_____

For questions, please contact:
HMH Financial Counseling Office
Phone: (859) 235-3596
Email: financialcounseling@hmhosp.org

Please return application to:
Harrison Memorial Hospital
Attention: Financial Counseling Office
1210 KY Highway 36 E
Cynthiana, KY 41031

OFFICE USE ONLY

Account Number	A/R Amount

Discount % Approved:
Date Submitted:
FC Signature:
Approval Signature:
Date Approved:

FINANCIAL ASSISTANCE INCOME VERIFICATION

Patient/Guarantor Name_____ Date of Birth_____

I, the above-named patient/guarantor, hereby certify there have been no changes to my financial status since my previous application for financial assistance from Harrison Memorial Hospital was completed and approved. By signing below, I verify the following assistance measures have not changed:

- Insurance Coverage
- Household Size
- Employment Information
- Gross Wages
- Social Security
- SSI/Disability
- Retirement/Pension
- Household Assets
    - Cash on Hand
    - Average Checking & Savings Account Balances

Patient/Guarantor Signature_____ Date_____

OFFICE USE ONLY
FAP Original Approval Date_____ FAP Approved Discount %_____ Financial Counselor Signature_____

1-2024/ldr