

OPERATING POLICY & PROCEDURE

TITLE: Credit, Collection, & Charity                      Number: 17-00-02

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POLICY:    It is the policy of (hospital name) to collect its full charges for services rendered from all patients with the ability to pay. In accordance with its basic Christian philosophy, (hospital name) will also provide necessary medical services to patients who do not have the financial resources (as defined by current hospital approved financial guidelines) to pay for such services. Any amount deemed uncollectible because of the patient's genuine inability to pay will promptly be written off by the hospital as charity care services.

Charity Care for residents of (non-medical assisted living and Alzheimer's units) will be provided in accordance with the Section H below. Once admitted, residents will not be denied service or residency due to inability to pay.

This policy does not apply to services covered by government health care programs or other contractual agreements with third parties where the program/agreement obligates the hospital to accept the third parties payment for the service as payment in full.

This policy does not apply to any balance due from the patient in accordance with the terms of the third party program/agreement.

In addition to the third party payer sources mentioned above, any financial instrument put in place by (hospital name) Foundation designated to assist financially challenged residents of (assisted living center) (such as the living trust) will take precedence over this policy and procedure.

PURPOSE:    The purpose of this policy and procedure is to assure that the Hospital has an orderly and reasonable method of collecting from patients who have the ability to pay and for identification of patients who do not have the ability to pay. This policy also establishes the criteria that patients must meet in order to be eligible for charity care services.

PROCEDURE:

I.    Procedures related to Patient Access.

- A.    The hospital's financial requirements will be explained to the patient/guarantor during pre-admission. For those patients not pre-admitted, the information will be given during the registration/admission process. When applicable, Patient Access will refer the patient/guarantor to the Medicaid Eligibility Advocate (Midland Professional Services) for determining eligibility with State and Federal programs.

II. Billing Procedures.

- A.    Disputed/Incorrect Charges.

1. All disputed or incorrect charges will be reviewed with the Director of the department.

(a). \$0.00 - \$499.00 will be resolved and adjusted by the Patient Financial Services Billing Specialist.

(b). \$500.00 - \$999.00 will be resolved and adjusted by the Patient Financial Services Manager

(c). \$1,000.00 - \$1,999.00 will be resolved and adjusted by the Director, of Patient Financial Services.

(d). Disputed charges exceeding \$2000.00 will be reviewed by the Vice President of Finance.

B. Third Party Payor Receivables.

1. All accounts which involve an assignable third party benefit will be billed to the applicable third party payor or federal program.

2. Medicare claims will be filed with the appropriate Federal programs. Other third party payor and/or self-pay portions will be billed after adjudication of the Medicare claim.

3. Medicaid claims will be filed with the appropriate State programs. All claims will be resolved with primary payors prior to submitting the claim to Medicaid.

4. Although Patient Financial Services will submit claims to all commercial third party payors as a courtesy to patients, responsibility for full payment is retained by the patient/guarantor.

C. Liability Receivables

1. All accounts which involve non-assignable third party benefits will be classified as third party liability. Patient Financial Services will file a notice of hospital lien with the person or persons, their attorney, and corporation from whom damages are claimed. The lien will have attached the Hospital statement of services.

2. Patient Financial Services will file all liability claims as a courtesy to the patients. Responsibility for full payment of the account is retained by the patient/guarantor.

D. Self Pay Receivables

1. The Hospital will utilize the National Account Systems, Inc. (NAS) Accounts Receivable Management (ARM) Program to process self-pay patient accounts. This includes self-pay balances after insurance payment, as well as straight self-pay. ARM assumes complete responsibility for self-pay accounts from the day they become self-pay until they are processed to conclusion.

E. Payment Arrangements on Accounts Receivable.

Accounts Receivable Management (ARM) will be utilized to efficiently process self-pay patient accounts. Accounts will be concluded over the specified period as follows:

- (a) Account Paid in Full.
- (b) Insurance Identified & Returned to Patient Financial Services for Billing.
- (c) Charity Identified & Returned to Patient Financial Services for Processing.
- (d) Long-term Payment Arrangements Established.
- (e) Bad Debt.

F. Bad Debt.

The Hospital will utilize National Account Systems, Inc. (NAS) bad debt collection program for all applicable accounts. NAS will seek recovery of the bad debt accounts according to the terms agreed upon by the Hospital.

G. Charity (See H for Assisted Living Facility)

1. An application for financial assistance may be given to interested patient's by any employee of (hospital name), (clinics), and Midland Professional Services. Recommendations for financial assistance will be accepted from sources such as physicians, community or religious groups, external social services or financial counseling personnel.

2. The application for financial assistance will be processed by Patient Financial Services.

3. The patient or responsible party is asked to supply the following items for their application to be considered for financial assistance:

- (a). Financial Assistance Application
- (b). Current W-2 Form
- (c). Previous year's income tax return
- (d). Previous three (3) month's salary history

For those individuals who have already qualified for programs that are by nature operated for the benefit of individuals without resources sufficient to pay for their treatment will not be required to complete a financial assistance application. In lieu of the completed financial assistance application, written verification of eligibility and participation in the program(s) will be accepted. Examples of such programs are: Women's, Infants, and Children's (WIC) programs, clinics for the homeless, etc.

4. The Director or Manager of Patient Financial Services will determine eligibility for charity services by using the financial information in the application as follows:

- (a). The financial application will be used to determine liquid assets available for payment of the financial obligation.

- (b). Monthly income and living expenses will be evaluated to determine the ability for payment of the financial obligation.
- (c). Copies of the required documents will be evaluated to substantiate income levels.
- (d). Eligibility for financial assistance will be determined based upon the HUD Geographic Very Low Income Guidelines. Separate determinations of eligibility for financial assistance will be made for each date of service; confirmation on continued eligibility will be updated every ninety (90) days for patients who require ongoing health care services.

5. Charity care will be approved and adjusted off to charity care services when:

- (a). Annual gross income is below the HUD guidelines and there are no significant liquid assets.
- (b). Annual gross income is above the HUD guidelines however living expenses indicate an inability to repay the debt and there are no significant liquid assets.
- (c). Presumptive circumstances apply (e.g. patient is deceased with no known estate; patient is homeless, etc.)

6. Financial assistance will be applicable only to the balance remaining after (hospital name) has received payment from all other available sources.

7. Financial Assistance approval limits are:

\$0	\$1,499	PFS Manager
\$1,500	\$3,999	Director of PFS
\$4,000	\$7,999	Vice President of Finance
\$8,000	\$12,999	Chief Executive Officer
\$13,000 and above		Board of Directors

8. Patient Financial Services will notify the patient/guarantor in writing when the amount of charity care eligibility has been determined. The patient/guarantor will also be informed of the requirement for periodic verification of their financial status in the event that future services are provided.

Patient Financial Services will notify the patient/guarantor in writing in the event that financial assistance is denied. A brief explanation for the determination will be provided.

#### H. Charity Care - Assisted Living Residents

- 1. Referral to the hospital charity program may originate from Social Service personnel, Patient Financial Services Representatives, or any other appropriate source.
- 2. The request for charity care will be taken by the Patient Financial Services department. The Business Office at (Assisted Living Facility) will facilitate the application process.

3. Information/documentation necessary to apply for charity care.

Initial application must include the following:

- (a). Copy of completed Nebraska Health and Human Services Application for Assistance (EA117) or GSH Financial Assistance Application
- (b). Response from the Nebraska Health and Human Services
- (c). Previous three years' income tax return
- (d). Credit reports will be requested as needed (provided by the hospital using local reporting agency)

Residents must reapply for charity care annually in conjunction with Good Samaritan Hospital's fiscal year. Application must be completed by April 30 for the upcoming fiscal year beginning on July 1. Notice will be communicated to the applicants no later than June 30.

Renewal applications must include the following information:

- (a). Copy of the most recently completed Nebraska Health and Human Services Application for Assistance (EA117) or Financial Assistance Application (attachment B)
- (b). Response from the most recent application for Medicaid Waiver from the Nebraska Health and Human Services
- (c). Most recent year's income tax return.
- (d). Credit reports will be requested as needed (provided by the hospital using local reporting agency).

4. The Director or Manager of Patient Financial Services will determine eligibility for charity care by using the financial information in the application. As a general guideline, eligible status will be attained when residents:

- (a). "Spend down" to a net worth of \$2,000 for individuals, or \$4,000 for couples.
- (b). Must have applied for Nebraska Medicaid Waiver.
- (c). Income criteria must be less than HUD guidelines.

5. Restriction/exclusions to charity care are as following:

- (a). Recipients of Charity Care or Medicaid will reside in suites designated for Charity Care/Medicaid.
- (b). Personal care needs not required to maintain life's basic needs are excluded from Charity Care/Medicaid.

6. Charity care amounts awarded will be based on the following:

- (a). Resident's contribution will be the greater of an amount equivalent to the current Nebraska Medicaid Waiver payment or 50% of monthly eligible charges.
- (b). Charity care in the aggregate will be limited to budgeted amounts. When budgeted dollars are not sufficient to cover all approved applicants, applicants will receive a prorated portion.
- (c). Ten percent of budgeted charity care will be held as contingency funds for applications received outside the annual

process.

7. Charity assistance will be applicable only to the balance remaining after Good Samaritan Hospital has received payment from all other available sources.

8. Charity care write off annual approval limits are:

\$0 - \$3,999	Director of Patient Financial Services
\$4,000 - \$7,999	Vice President of Finance
\$8,000 - \$12,999	Chief Executive Officer
\$13,000 and above	Board of Directors

(Hospital Name), (city), NEBRASKA will make charity care services available on a first request basis to eligible persons who are unable to pay for medically needed hospital services. Charity Care for residents of (non-medical assisted living and Alzheimer's units) will be provided in accordance with Section H above. Eligibility for charity care will be limited to persons whose family income, expenses, and available financial resources meet the Hospital's Charity Care Guidelines as established by it's Board of Directors. The following are the 2003 HUD Geographic Very Low Income Guidelines.

FAMILY SIZE	GROSS ANNUAL INCOME
1	\$17,429
2	\$19,900
3	\$22,418
4	\$24,893
5	\$26,896
6	\$28,868
7	\$30,871
8	\$32,868

\*EACH ADDITIONAL MEMBER \$ 1,997

Charity Care Eligibility at HUD Geographic Very Low Income Guidelines - 2003  
Average Very Low Income Guidelines  
GSHS Primary and Secondary Service Area

Discount Eligibility Size of Family	100% Gross Annual Income	75% (Less than or Equal to)	50%	25%
1	\$ 17,429	\$ 20,340	\$ 23,250	\$ 26,144
2	\$ 19,900	\$ 23,223	\$ 26,547	\$ 29,850
3	\$ 22,418	\$ 26,162	\$ 29,906	\$ 33,627
4	\$ 24,893	\$ 29,050	\$ 33,207	\$ 37,340
5	\$ 26,896	\$ 31,388	\$ 35,879	\$ 40,344
6	\$ 28,868	\$ 33,689	\$ 38,510	\$ 43,302
7	\$ 30,871	\$ 36,026	\$ 41,182	\$ 46,307
8	\$ 32,868	\$ 38,357	\$ 43,846	\$ 49,302
For each additional family member	\$ 1,997	\$ 2,330	\$ 2,664	\$ 2,996

Note: Patients/Guarantors are eligible for partial discounts as income increases up to 150% of the HUD Geographic Very Low Income Guidelines.

DOCUMENT RETENTION FOR FINANCIAL ASSISTANCE

The following documentation will be retained by Patient Financial Services in a central file by each guarantor:

1. Account Summary
2. Completed Financial Assistance Application
3. Copy of the previous year's income tax return
4. Copy of previous three month's salary history
5. W-2 Form
6. Approval/Write-Off Form
7. Copy of written notification