Manual:	Administration Corporate Policy and Procedure	Origination Date:	04/01/2005
		Approval Date	08/24/2022
Title:	Financial Assistance Policy	Next Periodic Review:	08/24/2023
		Owner:	Doug Volinski
Duncan Regional Hospital, Inc., d/b/a DRH Health policies apply to Duncan Regional Hospital, Jefferson County Hospital and Rural Health Clinics, Solutions Specialty Clinics and Practice Management, and Advanced Medical Supply.			

POLICY:

It is the policy of DRH Health to provide emergency or other non-elective medically necessary care to all patients living in our service area, without regard to the patient's financial ability to pay for services provided.

In addition, DRH Health is designated as a charitable organization under Internal Revenue Code Section 501(c)(3). Pursuant to IRC Section 501(r), DRH Health is required to adopt and publicize its financial assistance policy in order to remain tax-exempt.

The purpose of this policy is to outline the circumstances under which DRH Health will provide free or discounted care to patients who are unable to pay for emergency or other non-elective medically necessary services and how DRH Health will calculate amounts charged to those patients.

Non-elective medically necessary services are defined as a medical condition that, without immediate attention:

- Places the health of the individual in serious jeopardy, as defined by a physician
- Causes serious impairment to bodily functions or serious dysfunction to a bodily organ, as defined by a physician

Patient types assumed to be covered by this definition include, but are not limited to:

- Emergency Department Outpatients
- Emergency Department Admissions
- Inpatient/Outpatient follow-up related to the previous Emergency visit
- Care management of chronic severe illnesses, ex. Diabetes Mellitus, COPD, etc.

PROCEDURE:

Upon registration, and after all EMTALA requirements are met, hospital patients without Medicare, Medicaid, third-party insurance, other local health care financial assistance or

adequate health insurance shall receive financial counseling assistance from DRH Health staff, including a packet of information that addresses the financial assistance policy and procedures and an application for financial assistance (if requested).

Patients requesting financial assistance will be required to complete the Financial Assistance Application Form in order to establish eligibility (see attached Exhibit). In certain situations, the application process may be initiated by DRH Health. Requests for financial assistance will be honored up to 240 days after the date the first post-discharge billing statement is sent to the individual either by mail or electronic bill presentment.

It is the patient/guarantor's responsibility to provide, to the best of their knowledge, accurate, honest and complete information regarding their application and billing information. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance, Medicare, Medicaid, Workers Compensation, third-party liability (e.g. auto accident or personal injury) and other programs.

All available financial resources shall be evaluated before determining financial assistance eligibility. DRH Health will consider financial resources not only of the patient and other members of the household, but also of other persons having legal responsibility to provide for the patient.

The financial assistance assessment methodology shall consider income of the patient/guarantor/household, assets, family size, historical financial profile, current available resources and the likelihood of future earnings sufficient to pay for health care services (See Eligibility Criteria/Basis for Calculating Amounts Charged to Patients below).

Bad Debt Procedure

After an account is reviewed and the balance is deemed patient responsibility, a statement is sent to the patient within 20 days. The statement includes insurance and patient payments credited to the account if applicable. Thirty days after the initial statement is sent to the patient a follow up statement is sent. If there has been no payment on the account after the fifth statement, a call is placed to the patient to attempt to collect the debt. If the debt is not collected the account is reviewed for presumptive eligibility (see presumptive policy below). Accounts with patient balances and no payment activity for 150 days, accounts are submitted to the Chief Financial Officer (CFO) to review and take to the Board for approval. Upon approval from the Board, the accounts are sent to an outside collection agency. After 90 days of collections efforts, all

unsatisfied accounts are returned from an outside collection agency who conclude that all internal and external collection efforts by mail and telephone are exhausted, and it has been established that there is no likelihood in the future for payment, for commercial payers the bad debt is moved to uncollectible bad debt in the practice management system. If the payer is Medicare, the account is reviewed and the adjusted off to the appropriate adjustment code (AMCRBD).

Presumptive Eligibility:

Individuals who are uninsured may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application (FAA) if:

- Individual is homeless
- Individual is deceased and has no known estate able to pay hospital debts
- Individual is incarcerated for a felony (verified on OSCN.net website)
- Individual has received Medicaid benefits. Service dates for up to one year prior to the Medicaid qualification and six months past the Medicaid eligibility date will be considered for Financial Assistance.
- Individuals with self pay balances that are greater than or equal to $1000 and five or more statement have been sent and no payment activity for 150 days.

A credit report may be generated for the purpose of identifying additional expense, obligations and income to assist in developing a full understanding of the individual's financial circumstances. A third party scoring tool may be used to justify financial assistance eligibility. In the event household size is not indicated on the credit report or third party scoring tool, DRH Health will use the demographic information provided by the patient/guarantor at time of admission. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the presumptive eligibility and will extend an additional six months into the future.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in the Section and throughout this policy would apply as if the individual had submitted a completed a Financial Assistance Application.

Approved Financial Assistance:

Patients/Guarantors will be notified by U. S. mail when DRH Health determines the amount of financial assistance discount eligibility related to emergency or other non-elective medically necessary services provided by DRH Health. This eligibility does not extend to services provided by non-facility employees or other independent contractors (physicians, physician practices, anesthesiologists, radiologists, pathologists, etc.) unless noted in the attached Addendum that the provider is participating in this policy. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the application approval and will extend an additional six months into the future. After that, a new verification of financial status shall be required to continue financial assistance discounts. Accounts will be adjusted at the time the Financial Assistance is approved.

Denied Financial Assistance:

Patients/Guarantors will be notified by U. S. mail if financial assistance is denied along with a brief explanation of the reason for the determination.

Eligibility Criteria/Basis for Calculating Amounts Charged to Eligible Patients:

Charges for emergency or other non-elective medically necessary care provided to patients eligible for financial assistance under the policy will be limited to not more than the amounts generally billed (AGB) to those individuals who have insurance. Charges, as defined in this policy, are considered the amount the patient is personally responsible for paying, after all deductions, discounts and insurance reimbursements have been applied. Discounts under this policy will be applied according to the following sliding scale:

Annual Household Income Amount of Discount for Uninsured:

Annual Household Income	**Amount of Discount**
Up to 100% of FPG	100%
101-150% of FPG	75%
151-300% of FPG	Account reduced to Medicare Allowable

Actions under Billing and Collection Policy in the Event of Non-Payment:

DRH Health will not engage in extraordinary collection actions (ECA) for up to 120 days after the date of the patient's first statement. During that time, DRH Health will make reasonable efforts to determine whether an individual who has an unpaid amount from DRH Health is eligible for financial assistance.

Extraordinary collection actions include:

- Reporting a patient's delinquent debt to a credit bureau
- Selling a patient's debt to a third party
- Placing a lien on a patient's real property
- Attaching or seizing a patient's bank account or other personal property
- Commencing a civil action against a patient
- Causing a patient's arrest due to the debt
- Garnishing a patient's wages

DRH Health will publicize the availability of financial assistance (see next section). Also, notices will be printed on statements to the patient/guarantor, directing the patient/guarantor to contact the DRH Central Business Office to discuss financial arrangements and the availability of financial assistance.

Also, the patient/guarantor will be sent a written notice 30 days after the initial statement that extraordinary collection efforts (ECA) may be initiated if a complete financial assistance application is not submitted, the bill is not paid, or an arrangement to pay the bill has not been agreed to by both patient and provider within 150 days after the first billing statement. Although DRH Health may undertake ECAs after this 150 day period, if we have not yet determined whether an individual is FAP-eligible, we will still accept and process an FAP application for an additional 90 days. The total period during which DRH Health must accept and process FAP application is 240 days from the date of the first billing statement. If DRH Health receives an FAP application during the application period, we will suspend any ECAs we have started until

we have processed the application and made a determination of eligibility. If the individual is FAP-eligible, we will reverse the ECAs. While debts may be referred to third parties to assist with collection actions at any time, including during the initial 120 day notification period, they will not be sold to third parties during the notification period unless and until an eligibility determination has been made.

Publicizing the Availability of Financial Assistance:

- DRH Health will post complete and current versions of the following on the DRH Health website:
    - Financial Assistance Policy (FAP)
    - Financial Assistance Application Form (FAA)
    - Plain Language Summary of the Financial Assistance Policy (PLS)
    - Contact information for DRH Financial Counselors
- Signs will be posted in English to advise patients of the availability of financial assistance. Signage will be displayed in all points of admission and will contain the following:
    - DRH Health website address where the FAP, FAA, and PLS may be accessed http://duncanregional.com/billing-finance
    - Telephone number and physical location that individuals may call or visit to obtain copies of the FAP, FAA and PLS or to obtain more information:
        - Patient Accounts Management Department/Central Business Office at Duncan Regional Hospital (580)251-8918
          Signage, the FAP, FAA and PLS will be in other languages in instances where the lesser of 1,000 individuals or 5% or more of the local population speaks said foreign language.
- Paper copies of this information will be available upon request at all points of admission.

- A notice will be included on billing statements that notifies and informs recipients about the availability of financial assistance for eligible individuals under DRH's FAP and includes the telephone number of the Financial Counselor who can provide information about the FAP and application process and the website address where copies of the FAP, FAA and PLS may be obtained.

- DRH Health will distribute Financial Assistance information at Community Health Fairs.