Exhibit 30

Financial Assistance Policy

I. STATEMENT OF POLICY

The purpose of this Financial Assistance Policy (FAP) is to establish standard procedures for the determination of Financial Assistance to patients of Children's National Medical Center (CNMC) and its substantially related entities that are in financial need. Throughout the remainder of the FAP, use of the term "CNMC" refers to Children's National Medical Center and its substantially related entities.

As part of this FAP, CNMC will offer Financial Assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations regardless of age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. A CNMC Financial Counselor, designated business office representative, or committee with authority to offer Financial Assistance will review individual cases and make a determination of Financial Assistance that may be offered.

Accordingly, this FAP:

- Includes eligibility criteria for Financial Assistance
- Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this FAP:
- Describes the method by which patients may apply for Financial Assistance
- Describes how the hospital will widely publicize the FAP within the community served by the hospital

CNMC will provide, without discrimination, care for Emergency Medical Conditions to individuals regardless of whether they are eligible for Financial Assistance. CNMC shall comply with the Emergency Medical Treatment and Labor Act (EMTALA) by providing medical screening examinations and stabilizing treatment and referring or transferring an individual to another facility, when appropriate, and provide emergency services. CNMC prohibits any actions that would discourage individuals from seeking emergency medical care.

This FAP is in compliance with the Patient Protection and Affordable Care Act of 2010.

CNMC Entities Covered by this Policy

The services covered by this FAP include all emergency and other medically necessary care provided by CNMC and its substantially related entities, physicians and medical professionals employed by CNMC and Children's National Medical Associates.

Providers Not Covered by this Policy

The physicians and medical professionals not employed by CNMC or its subsidiaries are not covered by this policy.

II. DEFINITIONS

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

Amounts Generally Billed (AGB): Means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with Treasury Regulations §1.501(r)-5(b).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Family Income: Family 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, includes the income of all family members (non-relatives, such as housemates, do not count).

Financial Assistance: Reduction in the amount of gross charges for patients with demonstrated inability to pay.

Gross Charges: CNMC's full, established price for medical care that it consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Medically Necessary Care: Medical, surgical or other services required for the prevention, diagnosis, cure, or treatment of a health-related illness, condition or disability including services necessary to prevent a detrimental change in either medical, behavioral, mental, or dental health status.

Substantially Related Entities: Companies affiliated or owned by Children's National Medical Center that provide Medically Necessary Care, including Children's National Specialists of Virginia, all hospital facilities, regional outpatient centers, health centers, ambulatory surgery centers, mobile care centers, and offsite emergency rooms, and members of Children's National Medical Associates.

Uninsured: The patient has no level of insurance or is not being represented by an attorney, auto insurance, or filed a workmen's compensation claim to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance, but still has out-of-pocket medical expenses that are greater than 30% of their Family Income less housing expenses.

CNMC Service Area:

Cities
Washington, DC
Alexandria City, Virginia

Maryland Counties
All Counties

Virginia Counties
Arlington County
Fairfax County
Fauquier County
Loudon County
Prince William County
Stafford County

III. PROCEDURES

Eligibility for Financial Assistance
Eligibility for Financial Assistance will be considered for individuals who are uninsured, underinsured, ineligible for any government health care benefit program, or unable to pay for their care, based upon a determination of financial need in accordance with this FAP, and have resided in our service area for at least 6 months. This policy may cover patients that do not reside in our service area when the hospital provides medical service to treat and stabilize the medical condition of the patient before discharge.

The need for Full Financial Assistance will be determined in accordance with procedures that involve verifying income and residency in our service area. The patient or the patient's guarantor will be required to cooperate and complete the FAP Application and provide the following:

1. Documentation of gross monthly Family Income. These documents will include pay stubs for the last six (6) weeks worked, or award letters for unemployment, worker's compensation, or public assistance, alimony, retirement, and/or disability income. This can include notarized support and unemployment statements. If self-employed, provide an income tax return for the past 2 years.

2. Proof of ineligibility for State/Federal/Local medical assistance programs unless applicant is known not to be eligible for such coverage. (If we are unable to determine your eligibility by your income, you must provide proof of a denial)

3. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization or any picture ID with the name and address printed on it.

4. Proof of address – This can include a copy of your lease, mortgage statement, rent receipt, or a notarized letter from your landlord.

5. If applicable, school verification or report card for patient.

The granting of Financial Assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, creed, disability, social or immigrant status, sexual orientation, or religious affiliation. CNMC shall determine whether or not patients are eligible to receive Financial Assistance for deductibles, co-insurance, or co-payment responsibilities.

CNMC will make reasonable efforts to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs. CNMC obtain reports from third parties to determine whether they may be presumptively eligible for Financial Assistance to relieve the financial burden.

A preliminary application stating family size and income will be accepted and a determination of probable eligibility will be made within two business days. Final determination will be provided to each patient or family within 30 business days of inquiry with the submission of a completed application, including all required documentation. Financial Assistance will be denied for patient's that submit an incomplete application, or submit documents that cannot be verified. The grant of Financial Assistance by CNMC will expire one year from the approval date ("Expiration Date"). At that time, patients will need to re-apply for continued Financial Assistance by contacting the Financial Information Center.

Basis for Determining Financial Assistance

Services eligible under this FAP 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. Once a patient has been determined by CNMC to be eligible for Financial Assistance, that patient shall not be responsible for any future bills until the Expiration Date. The basis for the amounts CNMC will charge patients qualifying for Financial Assistance is as follows:

a. Patients who has a Family Income at or below 400% of the FPL, provided all the required documentation, and who have resided in our service area for at least 6 months are eligible for full Financial Assistance.[1]

All patients eligible for Financial Assistance are charged less than AGB as all eligible patients do not receive a bill for emergency or Medically Necessary Care.

[1] This provision is intended to meet the definition of "sliding scale fee" as defined by the DC Health Professional Loan Repayment Regulations (D.C. Code § 7-751.01- §7-751.17, as may be amended from time to time) and applicable Guidelines.

For patients who qualify for Financial Assistance and who are cooperating in good faith to resolve their hospital bills, CNMC will not send unpaid bills to outside collection agencies, and will cease all collection efforts. CNMC will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient.

Method for Applying for Financial Assistance

Referral of patients for Financial Assistance may be made by any member of the CNMC staff including by not limited to 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. For patients requiring surgery, prior to their arrival for surgery, CNMC will address any financial concerns patients may have, and individual notice regarding this FAP shall be provided to the patient.

Contact the following for information about this FAP or assistance with the FAP application process.

Counselors	Location	Phone
Financial Counselors	Financial Information Center	Based on guarantors name: • **A-K:** 202-476-5002 • **L-Z:** 202-476-5505
Customer Service	Patient Accounts Phone Calls	301-572-3542 or 1-800-787-0021

Regulatory Requirements

In implementing this FAP, CNMC 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 FAP.

IV. COMMUNICATION

Communication of Financial Assistance to Patients and within the Community

CNMC will notify and inform patients of its FAP policy and take steps to widely publicize it. Notification about Financial Assistance available from CNMC shall include a contact number and be disseminated through various means, including but not limited to:

1. Posting notices in emergency rooms, at urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as CNMC may select. Notices will be posted in conspicuous locations.

2. Publishing notices in patient statements.

3. Publishing and widely publicizing a summary of the FAP on facility websites, in brochures which will be available in patient access sites, and at other places within the community served by the hospital, as CNMC may select. Such notices and summary information will be provided in the primary languages spoken by the population serviced by CNMC.

4. Giving plain language summary notices to uninsured patients at registration. Patient families are encouraged to meet with an FIC representative and apply for FAP.

5. Annually publicizing notice of the FAP in the local paper of record.

V. ACCOUNTABLE EXECUTIVE AND REVIEWER(S)

A. Accountable Executive: Vice President of Revenue Cycle
B. Division Responsible for Review: Finance
C. Committee Responsible for Review: Leadership Council

VI. APPROVAL

Approved by:

_____ _____
Leadership Council Date

_____ _____
Chairman of the Board, CNMC Date

VII. APPLICABILITY

All Children's National employees

VIII. REVIEW OR REVISION DATE

July 1, 2016
January 1, 2018
July 1, 2018

Exhibit 31

Financial Assistance Application

CHILDREN'S HOSPITAL
Financial Screening Application Form

In order that we can assist you in a timely and efficient manner, please follow these instructions for completion of the application form.

1. Please Print or Type all requested information.

2. Please Sign and Date the application when completed (both parents must sign if both are in the home).

Request for: Check One

	Presumptive Eligibility – Applicable to one visit or procedure
	Full Financial Assistance – One year eligibility period requires all supporting documentation

PATIENT INFORMATION: Please list below those children for whom you are requesting assistance.

Last Name	First Name	DOB	Male / Female

OTHER DEPENDANTS: Please list below any other dependents (other than the children listed above or the parents listed on the next page) residing in your household.

Last Name	First Name	DOB	Male / Female

PARENT/GUARDIAN INFORMATION: Please complete for both parents/guardians:

Patient/Parent/ Guardian Last Name:		First Name:	
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:		
Employer Name:	Address:		
How Long Employed?:	Occupation:		
Second Parent/Guardian/Spouse Last Name:	First Name:		
Age:	Social Security Number:	Relationship to Child(ren):	
Home Address (if different from above):	City:	State:	Zip Code:
Home Phone:	Work Phone:		
Employer Name:	Address:		
How Long Employed?:	Occupation:		

1. HOUSEHOLD INCOME: (All Applicants) Please indicate the total GROSS INCOME (before taxes and other deductions) from all sources for all family members living in your household. For full financial assistance, we need documentation of all income sources. If you are unemployed and have no income from salary or wages, a Notarized Statement of unemployment must be submitted. If you are living with and/or being supported by relatives or friends a Notarized Statement of Support must be submitted.

SOURCE:

Total Monthly Amount

Salary or wages from full or part-time employment: $_____

Required Documentation for Full Financial Assistance

Copies of check stubs for last 6 weeks OR
Statement from employer on company letterhead verifying gross income for last 6 weeks OR
If self-employed, complete copy of most recent for 1040.

Unemployment compensation: $_____

Required Documentation for Full Financial Assistance

Copies of last unemployment check OR
Copy of unemployment compensation worksheet

Workman's Compensation: $_____

Required Documentation for Full Financial Assistance

Copy of workman's compensation award letter

Social Security/SSI benefits: $_____

Required Documentation for Full Financial Assistance

Copy of last Social Security /SSI checks OR
Copy of Social Security /SSI award letter

Alimony or child support: $_____

Required Documentation for Full Financial Assistance

Copy of divorce decree or court order

Public assistance: $_____

Required Documentation for Full Financial Assistance

Copy of public assistance award letter

SOURCE:

Total Monthly Amount

All Others:

Required Documentation for Full Financial Assistance

Copies of pay vouchers or statements

Veteran's Benefits	$ _____
Survivor Benefit:	$ _____
Pension or Retirement Payments:	$ _____
Interest, Dividends Payments:	$ _____
Income from estates and trusts:	$ _____
Rental Income:	$ _____
Educational assistance:	$ _____
Outside the house hold and other miscellaneous sources:	$ _____

For Full Financial Assistance, please also submit:

2. Proof of ineligibility for State/Federal/Local medical assistance programs unless applicant is known not to be eligible for such coverage. (If we are unable to determine your eligibility by your income, you must provide proof of a denial).
3. A valid current form of identification for the patient, parents, or guardian. This can include a passport, alien registration card, work authorization or any picture ID with the name and address printed on it.
4. Proof of address – This can include a copy of your lease, mortgage statement, rent receipt, or a notarized letter from your landlord.
5. If applicable, school verification or report card for the patient

If you are applying because you are underinsured and need assistance with co-pays, deductible or co-insurance please include information on your medical expenses

Medical Expenses:

Children's Hospital: $ _____

All Others: $ _____

Required Documentation for Full Financial Assistance

1. Copies of medical bills paid or unpaid for all family members for the past 6 months

Certification and Authorization Statement:
I hereby certify that the information given on this application and any supporting documentation is accurate and complete to the best of my knowledge and ability. I authorize Children's National to verify this information as it may deem appropriate in reviewing my application for financial assistance and/or extended payment arrangements. I also understand that submission of incomplete or inaccurate information may result in the reversal of any financial assistance (discount) awarded, and/or the withdrawal of approval for extended monthly payment arrangements.

Patient/Parent /Guardian Signature:	Relationship to Patient:	Date:
Parent/Guardian/ Spouse Signature:	Relationship to Patient:	Date:

Exhibit 32

Financial Assistance Notice – Patient Statements

CREDIT CARD PAYMENT

You may pay this bill by credit card. Complete the form below and return in the enclosed envelope.

AMOUNT: $ _____

CREDIT CARD: _____

CARD NUMBER: _____

CARD EXPIRES: ____/____ MO YR

PRINT CARD HOLDER'S NAME: _____

SIGNATURE: _____

RESPONSIBLE PARTY / ADDRESS CORRECTION

NAME TEL. NO. ( ) –

STREET ADDRESS

CITY/STATE ZIP

INSURANCE INFORMATION, IF REQUESTED

INSURED'S NAME | PATIENT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED'S ADDRESS

INSURED'S DATE OF BIRTH | INSURED'S ID NO.

SOCIAL SECURITY NO. | GROUP ID NO.

EMPLOYER NAME TEL. NO. ( ) –

EMPLOYER'S ADDRESS

CITY/STATE ZIP

INSURANCE CO. NAME TEL. NO. ( ) –

CITY/STATE ZIP

Children's National Medical Center bills separately for hospital charges and professional fees. The hospital bill includes charges related to your child's stay including the room, equipment, medicines used and meals. The bill for physician's fees include charges for the doctors and health professionals who care for your child directly, as well as doctors who support them by reading lab tests and x-rays for example.

If you have any questions concerning charges rendered by Children's National Medical Center, please call from 9:00 a.m. to 4:00 p.m. Monday through Friday:

301-572-3542 or 1-800-787-0021

Email: bearbill@childrensnational.org

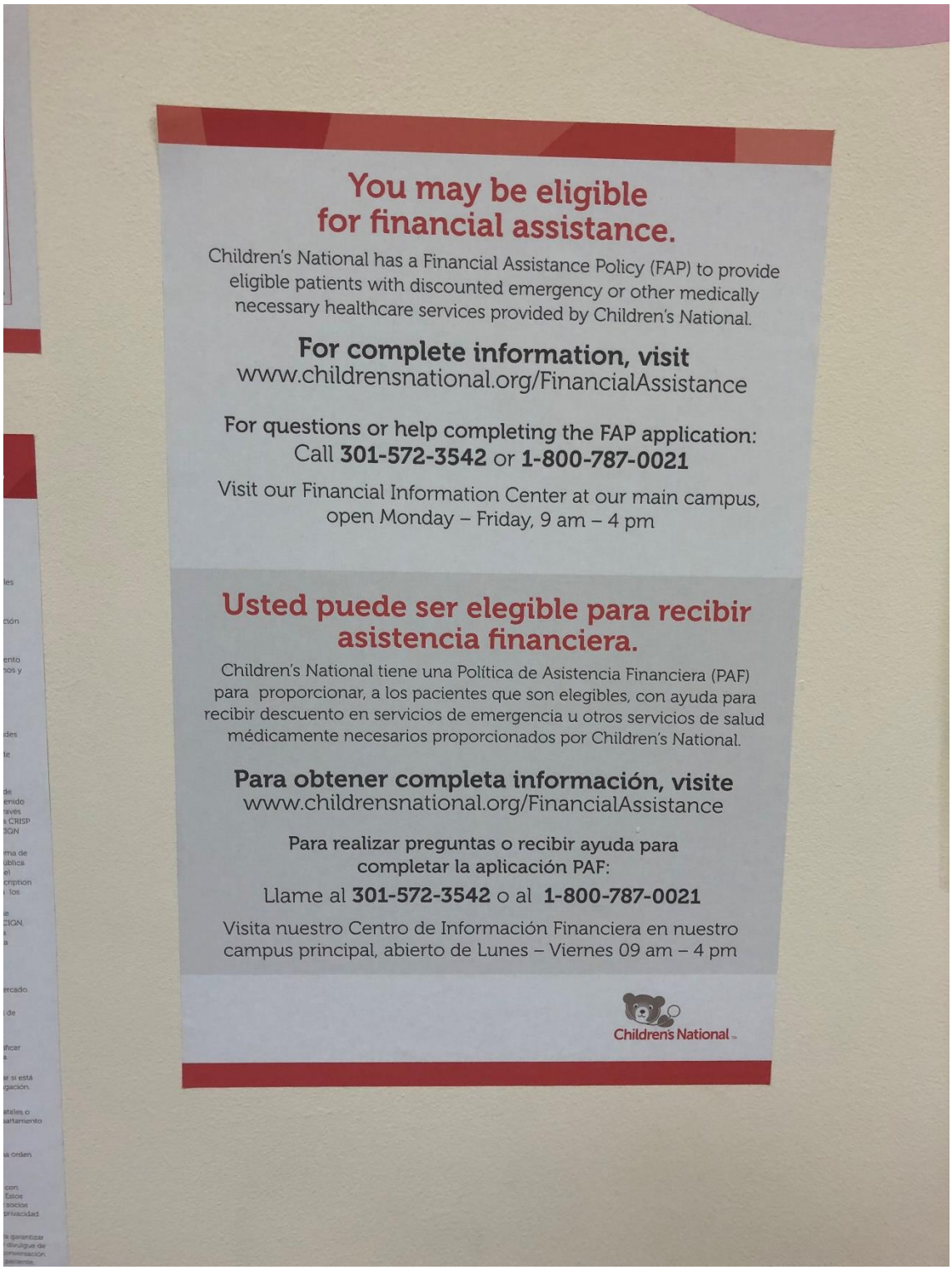
If you need help paying your deductible, co-insurance or co-pay, you may be eligible for financial assistance. Visit www.childrensnational.org/FinancialAssistance, send an email to bearbill@childrensnational.org or call us at 301-572-3542 or 1-800-787-0021 for a copy of the Financial Assistance Policy (FAP), the FAP Plain Language Summary, the FAP Application or for assistance with the process.

Recyclable Paper

Exhibit 33

Financial Assistance Notice – Public Posting

Financial Assistance Notice – Pulmonary Clinic



You may be eligible for financial assistance.

Children's National has a Financial Assistance Policy (FAP) to provide eligible patients with discounted emergency or other medically necessary healthcare services provided by Children's National.

For complete information, visit
www.childrensnational.org/FinancialAssistance

For questions or help completing the FAP application:
Call **301-572-3542** or **1-800-787-0021**

Visit our Financial Information Center at our main campus, open Monday – Friday, 9 am – 4 pm

Usted puede ser elegible para recibir asistencia financiera.

Children's National tiene una Política de Asistencia Financiera (PAF) para proporcionar, a los pacientes que son elegibles, con ayuda para recibir descuento en servicios de emergencia u otros servicios de salud médicamente necesarios proporcionados por Children's National.

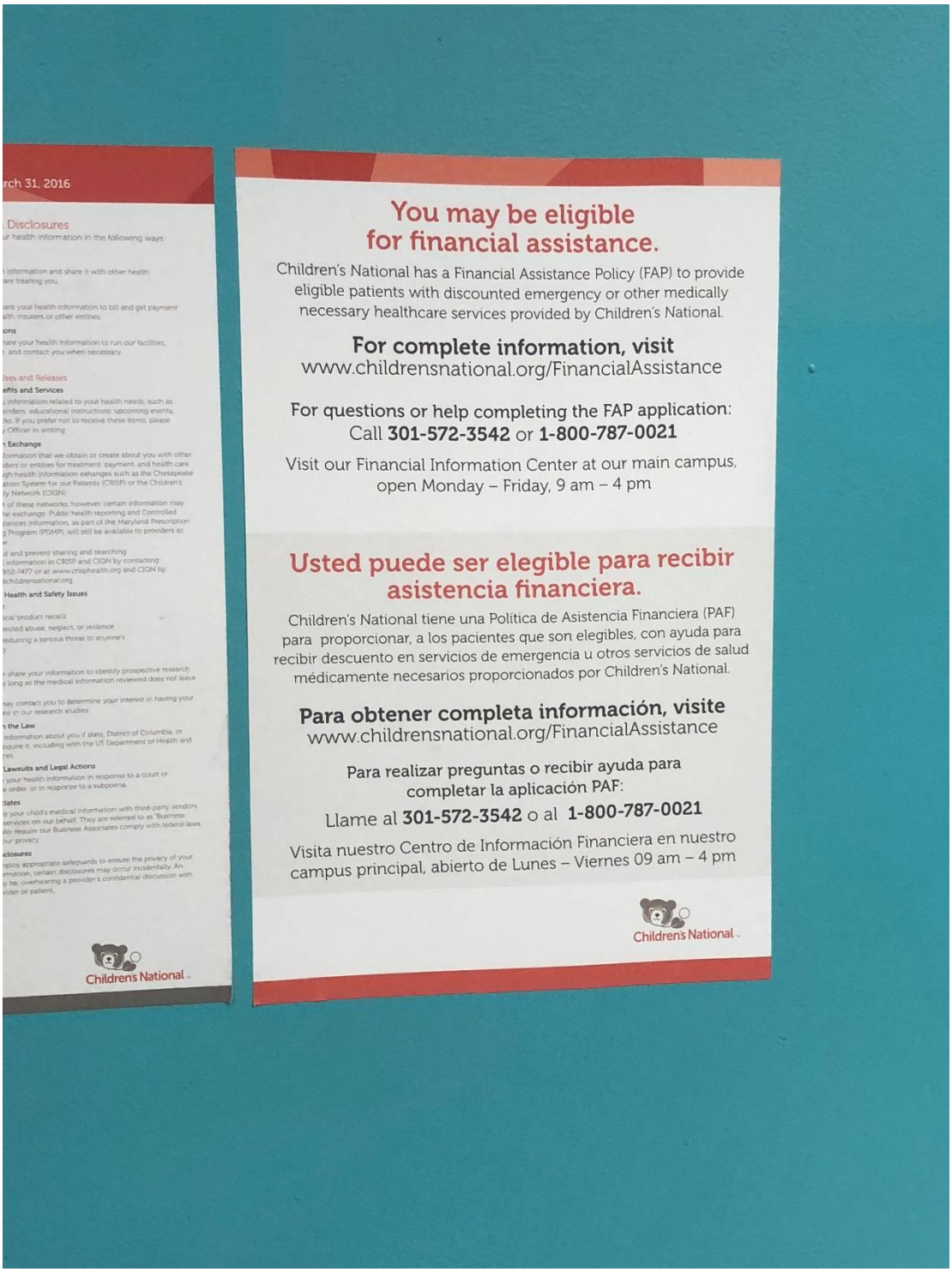
Para obtener completa información, visite
www.childrensnational.org/FinancialAssistance

Para realizar preguntas o recibir ayuda para completar la aplicación PAF:
Llame al **301-572-3542** o al **1-800-787-0021**

Visita nuestro Centro de Información Financiera en nuestro campus principal, abierto de Lunes – Viernes 09 am – 4 pm

Children's National

Financial Assistance Notice - Emergency Department



rch 31, 2016

Disclosures

Children's National

You may be eligible for financial assistance.

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For questions or help completing the FAP application:
Call **301-572-3542** or **1-800-787-0021**

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Children's National

Exhibit 34

Completeness Questions, Table 1

Table 1 - Individual Physician's Submission

Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
HemOnc - Drs. Shana Jacobs & Evelio Perez-Albuerne	35	3,360	50	4,500	25	2,250	26	2,340	52	4,680	Main campus/Sheikh Zayed

5 most frequently performed surgeries,	two most recent years	
Surgical Procedure*	Yr 1	Yr2
38220-Bone Marrow Aspiration	8	14
38221 Bone Marrow Biopsy	6	9
62270 Spinal Puncture, Lumbar Dx	2	2
38240 Bone Marrow Transplantation	1	4
11100 Bx-Skin, SQ/MM; SGL	1	

* List in descending order based on the cumulative 2 year volume

notes:
add 25 min/case for set-up & turnover
rotating hematologists/oncologists performing LP in sedated OR setting

I hereby declare and affirm under the penalties of perjury that the facts stated in this affidavit are true and correct to the best of my knowledge, information and belief.

Signature S Calliott
Print Name: S Calliott

Exhibit 35

Completeness Questions, Table 2

Table 2 - Historical and Projected Surgical Volumes Related to Ambulatory Surgical Facility CON Application, by Physician

Physician Data, Aggregated											
Physician Name	Surgical Volume Latest 2 complete years				Projections						Facility(s) from which these cases will migrate from
	Year FY16		Year FY17		Year 1		Year 2		Year 3		
	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	Cases	Minutes	
Dr. Alexandra Espinel*	n/a	n/a	533	20,029	121	4,547	128	4,810	140	5,261	Main campus/Sheikh Zayed
Dr. Pamela Mudd	501	23,547	592	29,090	107	5,136	112	5,076	130	6,240	Main campus/Sheikh Zayed
Dr. Maria Pena	488	20,556	564	23,821	119	5,026	123	5,166	125	5,250	Main campus/Sheikh Zayed
Dr. Diego Preciado	416	19,865	479	25,387	73	3,869	73	5,329	125	6,625	Main campus/Sheikh Zayed
New ENT MD's-Drs. Gittman & Lawlor	-	-	-	-	-	-	85	4,505	280	14,840	Main campus/Sheikh Zayed
Dr. Mikael Petrosyan	649	35,695	672	47,712	334	21,710	344	22,360	385	25,025	Main campus/Sheikh Zayed
Gen Surgery Physician(s) to be recruited	-	-	-	-	-	-	-	-	303	19,695	Main campus/Sheikh Zayed
Dr. Sravan Matta	-	-	83	3,320	84	3,360	86	3,440	172	8,428	Main campus/Sheikh Zayed
HemOnc - Drs. Shana Jacobs & Evelio Perez-Albuerne	35	3,360	50	4,500	25	2,250	26	2,340	52	4,680	Main campus/Sheikh Zayed
Dr. Marlet Bazemore	97	7,828	63	5,696	38	3,116	39	3,159	40	3,240	Main campus/Sheikh Zayed
Dr. Heather deBeaufort	46	3,548	75	6,349	39	3,198	40	3,360	42	3,528	Main campus/Sheikh Zayed
Dr. Emily Niu	-	-	143	19,747	30	3,750	31	4,278	32	4,000	Main campus/Sheikh Zayed
Orthopedic Surgery Physician(s) to be recruited	-	-	-	-	-	-	-	-	50	6,250	Main campus/Sheikh Zayed
Dr. Gary Rogers	159	10,702	168	12,629	84	6,132	100	7,300	120	8,760	Main campus/Sheikh Zayed
Dr. Nadia Kalloo	213	17,713	156	15,288	117	9,711	122	10,126	137	11,371	Main campus/Sheikh Zayed
Urology Physician(s) to be recruited	-	-	-	-	62	5,146	62	5,146	128	10,624	Main campus/Sheikh Zayed
Dr. Sarah Evans	166	4,131	205	4,752	58	1,334	60	1,380	139	3,197	Main campus/Sheikh Zayed
All Community physicians					-	-	-	-	155	16,895	Main campus/Sheikh Zayed
Total	2,770	146,945	3,783	218,320	1,291	78,285	1,431	87,775	2,555	163,909	
turnover time per case		69,250		94,575		32,275		35,775		63,875	
total minutes w/turnover		216,195		312,895		110,560		123,550		227,784	

notes:

*n/a means that this surgeon did not start until fiscal year where volume listed

These projections have been supplied to me by surgeons who have expressed interest in providing services at our proposed Ambulatory Surgical Facility (and whose individual data is included herein).

I hereby declare and affirm under the penalties of perjury that the facts stated in this affidavit are true and correct to the best of my knowledge, information and belief.

Signature J Collins

Print Name and Title: Scott Collins 6-7-18

Exhibit 36

Financial Assistance Policies – Top Children's Hospitals

Boston Children's Hospital
Credit and Collection Policy

Table of Contents

I. General Policy Statement

In its long tradition of service to the children of Boston, New England and beyond, Boston Children's Hospital (the "Hospital") has always been committed to being a resource for children in need of care, regardless of ability to pay. Each year, thanks to the support the Hospital enjoys from the community and the thoughtful action of the Board of Trustees, the Hospital and its physicians extend millions of dollars in Charity Care to children and families.

The Hospital has a strong commitment to assuring that children have insurance coverage whenever possible. Hospital financial counselors are available to answer families' questions about public coverage available for uninsured children, and to assist families with the completion of necessary applications.

The Hospital evaluates each patient's medical needs and the family's financial status, and tries to be as generous and responsive as possible to all children applying for services. In order to sustain the Hospital's ability to respond to genuine need, sensitive but consistent billing and collection practices are applied to patients and their families. The policies and procedures set forth in this document are adopted in an effort to ensure that billing and collection practices and procedures are reasonable and consistently applied. This Credit and Collection Policy applies to all Boston Children's Hospital sites operated under the Hospital's license.

The Hospital also makes every effort to be flexible and responsive to individual circumstances. In turn, it is expected that families will honor their financial obligations so that the Hospital remains able to provide care for those children whose circumstances in life are less fortunate.

Finally, the Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status as determined by the Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

This Credit and Collection Policy is developed to ensure compliance with (1) the Health Safety Net Eligible Services regulation 101 CMR 613.00;
The Centers for Medicare and Medicaid Services Medicare Bad Debt requirements (42 CFR 413.89); and (3) the Medicare Provider Reimbursement Manual (Part I, Chapter 3).

II. Definitions

Charity Care: Hospital or Community Health Center costs for medically necessary services provided to low-income patients that are not eligible for payment from the Health Safety Net Trust Fund or other public or private payment sources. The Hospital also maintains specific Charity Care programs as set forth in policies maintained by the Chief Financial Officer.

Eligible Services: Hospital or Community Health Center charges that are eligible for payment from the Health Safety Net Trust Fund pursuant to regulations promulgated by the Commonwealth of Massachusetts.

Emergency Medical Condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services: Medically necessary services provided to an individual with an Emergency Medical Condition.

Low Income Patient: An individual who meets the criteria for determination as a Low Income Patient set forth in Health Safety Net regulations promulgated by the Commonwealth of Massachusetts. In order to be determined a Low Income Patient, an individual must be a resident of the Commonwealth and document family income equal to or less than 400% of the Federal Poverty Level (FPL), and may not be enrolled in MassHealth Standard or MassHealth Family Assistance/Direct Coverage programs; may not have been determined eligible for MassHealth and failed to enroll; and may not have had MassHealth or Commonwealth Care enrollment terminated due to failure to pay premiums.

Medical Hardship: A category of eligibility for coverage of certain charges by the Health Safety Net Trust Fund, for patients/families whose allowable medical expenses have so depleted the family's income that the patient/family is unable to pay for Eligible Services (as defined in regulations). Terms and conditions of Medical Hardship eligibility and payments from the Health Safety Net Trust Fund for services provided to patients eligible for Medical Hardship are specified in regulations promulgated by the Commonwealth of Massachusetts.

Urgent Care: Medically necessary services provided in a hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably be expected to result in: placing a patient's health in jeopardy; impairment to bodily function, or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

III. Classification of Services

Persons may present themselves, or may be presented, for unscheduled treatment in the Hospital's Emergency Department or in other clinical service locations of the Hospital. Any patient presenting for emergency services will be evaluated without regard to the patient's insurance coverage or ability to pay, consistent with the federal Emergency Treatment and Labor Act (EMTALA). After providing services to a patient in the Emergency Department, the treating physician in the Emergency Department classifies the services as Emergency Services or Urgent Care (according to the definitions set forth above), or as Non-Urgent.

Elective services and scheduled services are Non-Urgent, and as such are neither Emergency Services nor Urgent Care, regardless of the setting in which they are provided. These classifications are used by the Hospital for purposes of determining emergency and urgent care bad debt coverage under the Health Safety Net Fund.

The Hospital prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

IV. Help in Obtaining Financial Assistance

The Hospital will provide to patients, guarantors, or other identified responsible parties information about and assistance with applying for public and other financial assistance programs, including MassHealth, Commonwealth Care, Low Income Patient status according to the Health Safety Net regulations, and other government-sponsored programs, as well as the Hospital's charity care and discounting programs for uninsured patients. The Hospital will make reasonable efforts to provide translator services for patients, guarantors or other responsible parties with limited English proficiency.

The Hospital will assist patients/guarantors in completing applications for public programs. Patients or guarantors must provide documentation required for such applications. The Hospital has no role in the determination of program eligibility, which is made by the Commonwealth. It is the patient's or guarantor's responsibility to inform the Hospital of all coverage decisions made by the Commonwealth and of any change in the patient's eligibility for such programs.

A. Public Notice of Availability of Financial Assistance. The Hospital will post signs notifying patients of the availability of financial assistance and of other programs of public assistance and the Hospital location at which patients and families may apply for such assistance. These signs will be posted in inpatient, outpatient and emergency admissions/registration areas as well as business offices customarily used by patients. Posted signs are 8 ½ x 11 inches in size, printed in font size 22, in English and Spanish.

B. Individual Notice of Availability of Financial Assistance. The Hospital will provide an individual notice of the availability of financial assistance programs, including Medical Hardship, and assistance in applying for such programs, to any patient expected to incur charges (exclusive of personal convenience items or services) that may not be paid in full by their third party coverage. The Hospital will also include a notice about the availability of financial assistance programs, including Eligible Services to Low Income Patients and other public assistance programs, and the availability of assistance in applying for such programs, in its initial bill and all other written collection actions.

V. Deferral/Refusal of Services

The Hospital will not defer or refuse treatment of patients who present for emergency or urgent care or who are recipients of governmental benefits such as MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or other public programs, solely due to financial considerations.

The Hospital reserves the right to defer or refuse the provision of non-emergency, non-urgent services to a patient, including in situations in which the patient/family refuses to comply with deposit requirements or lacks resources to pay for services either privately or through third party sources and refuses to apply for available public programs, including MassHealth and Health Safety Net, or refuses to supply required documentation for such application(s).

Whenever the Hospital elects to exercise its right to defer or refuse the provision of services to a patient, and prior to the exercise of that right, the clinician identified as the patient's physician will be contacted to assess the medical/clinical implications of the deferral or refusal of services, and to acknowledge or approve the deferral or refusal of services from a medical/clinical perspective.

In cases in which a patient is denied or refused services, documentation will be retained of the reason for the denial or refusal of services; the patient's physician's assessment of the medical/clinical implications of the deferral or refusal of services and approval from a medical/clinical perspective; and the physician's acknowledgement or approval of the deferral or refusal of services.

VI. Procedures for Collecting Patient/Guarantor Financial Information

A. Acquisition of Information: Prior to the delivery of any health care services (except for cases of emergency or urgent care level of service), the patient/guarantor is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductible or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information will include:

1. Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and

residency information, and the patient's/guarantor's applicable financial resources that may be used to pay their bill;

2. Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and

3. Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowner's insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, among others.

It is ultimately the patient's/guarantor's obligation to keep track of and timely pay their unpaid hospital bill, including any existing copayments, co-insurance and deductibles. The patient/guarantor is further required to inform either their current health insurer (if they have one) or the agency that determined the patient's eligibility status in a public health insurance program of any changes in family income or insurance status.

Patients/guarantors are required to notify the state public program (e.g., Office of Medicaid and the Health Safety Net) of information related to any lawsuit or insurance claim that will cover the cost of the services provided by the Hospital. A patient is further required to assign the right to a third party settlement that will cover the cost of the services paid by the Office of Medicaid or the Health Safety Net.

When the information is not provided at the time an admission or outpatient visit is scheduled, successive attempts will be made to collect the needed information through post discharge/post service.

B. Data Collection Points: The following identifies the points at which an attempt to collect this information will be made and by whom:

1. **While scheduling an Admission or Outpatient Visit:** The physician office or hospital staff member scheduling the service will request financial information.
2. **During Verification of Patient Information:** Patient Financial Services staff, physician office or hospital staff verifying patient information prior to service will request financial information.
3. **Day of Admission/Time of Service:** Patient Financial Services, or Patient Care Coordinators as applicable. When any aspect of the patient/guarantor financial information is in question, the patient/guarantor may be referred to Patient Financial Services to clarify the information. This process applies to both scheduled and emergency services (as soon as reasonably practicable after the service or admission, consistent with EMTALA).
4. **During the Hospital Stay:** Patient Financial Services staff or Patient Care Coordinators.
5. **At the Time of Discharge:** Patient Financial Services staff.

6. **Post Discharge/Post Service:** Patient Financial Services staff or financial management agents of the Hospital.
7. Emergency Services: Department registration staff will interview, obtain and verify all necessary patient and financial information as soon as permitted by EMTALA regulations. Information not obtained at time of admission will be pursued through patient and/or guarantor contacts and interviews throughout the patient's stay, or at time of discharge if all other attempts are unsuccessful. If authorized by the patient or guarantor, contacts to other individuals will be made to obtain information to assess their ability to pay for services provided.
8. **Validation of MassHealth Eligibility**: For services provided to an uninsured patient, Patient Financial Services staff will check through the MassHealth EVS system and/or the Virtual Gateway maintained by the Massachusetts Executive Office of Health and Human Services whether the patient is eligible for or has submitted an application for MassHealth, Commonwealth Care, or other programs.

C. Hospital Verification of Patient **Financial** Information: **Patient Financial Services staff, clinical department administrative staff, or Patient Care Coordinators will make reasonable and diligent efforts to verify patient-supplied financial information** as soon as possible after it is provided, until the time of discharge or provision of an outpatient service. If information cannot be verified prior to that time, the Patient Financial Services Department or its agents may attempt to verify the information during the billing and collection process.

Given the age of the Hospital's patient population, it is typically the parent or guardian supplying patient insurance and financial information. If additional information is required while the patient is in the Hospital, Patient Financial Services staff members or Patient Care Coordinators contact the patient's primary care nurse or his or her designee for permission to contact the patient or the patient's family.

The Hospital's reasonable and diligent efforts will include, but are not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, following the billing rules of a known third party payer, and appealing a denied claim when the service is payable in whole or in part by an insurer.

The Hospital will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the Hospital, including but not limited to: (1) a motor vehicle or homeowner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, and (4) student insurance policies, among others. Hospital will inform patients of their responsibility to inform the appropriate public program of any changes in income or insurance status. In accordance with applicable state regulations or the insurance contract, for any claim where the Hospital's reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, the Hospital

will report the recovery and offset it against the claim paid by the private insurer or public program. If the Hospital has prior knowledge and is legally able, it will attempt to secure assignment of a patient's right to third party coverage of services provided due to an accident

D. Release of Information/Assignment of Benefits: The patient/guarantor may be requested to sign an assignment of insurance benefits or other third party payment sources (e.g., payments resulting from tort actions) directly to the Hospital for services provided, and an authorization to release information as necessary to accomplish the assignment of those benefits. The authorization shall also indicate that the patient/guarantor may be financially responsible for charges not covered by the assignment.

E. Confirming Financial Responsibility for Non-covered Services: When an authorization required by the patient's insurer has not been obtained prior to the service, the patient/guarantor will be requested to sign a statement acknowledging that he or she has been notified of the absence of the required authorization and informing him or her of his or her potential financial responsibility for services ultimately determined to be non-covered services.

VII. Payment

In general, payment in full is expected upon receipt of a bill from the Hospital.

A. Deposits

1. Emergency Services: The Hospital will not require a pretreatment deposit from any patient or guarantor as a condition of receiving emergency care, regardless of the patient's or guarantor's ability to pay.

2. Non-Emergency Services: The Hospital may require a preadmission deposit for non-emergent inpatient or outpatient services from a patient (or the patient's guarantor) who lacks sufficient insurance coverage for the service to be provided, is not exempt from collection actions, and has not entered into a Payment Plan with the Hospital.

3. Special Provisions for Patients Eligible for Health Safety Net: No patient determined to be a Low Income Patient will be required to pay a deposit. A patient/guarantor determined to be a Low Income Patient with a deductible requirement may be requested to provide a deposit up to 20% of his or her deductible amount up to $500. A patient/guarantor eligible for Medical Hardship may be requested to provide a deposit up to 20% of his or her Medical Hardship contribution up to $1000. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08

B. Discounts: Discounts on patient accounts are not eligible for and will not be submitted to the Health Safety Net. The Hospital offers discounts of up to 40% off charges to uninsured individuals, depending upon timeliness of payment.

Discounts are not available on copayment and deductible amounts. The Hospital's Discounting Policies are maintained by the Chief Financial Officer.

C. Payment Plans: In the event that a patient/guarantor cannot pay his or her Hospital bill upon receipt and is determined not to be eligible for Health Safety Net or other applicable public programs, the Hospital may offer the patient/guarantor an arrangement for payments over an extended period of time.

The Hospital will offer patients with a balance of $1,000 or less, after initial deposit, at least a one-year payment plan interest free with a minimum monthly payment of no more than $25. Patients with a balance of more than $1,000, after initial deposit, will be offered an interest free payment plan of at least two years. In cases of extraordinary circumstances, requests for payment plans over two years will be considered on a case-by-case basis. The Hospital shall not require any payment plan for patients who are fully exempt from collection action under this Credit and Collection policy.

The Hospital and its licensed satellite locations, including Martha Eliot Health Center, do not offer deductible payment plans for patients eligible for Health Safety Net – Partial.

D. Account Adjustment Approval Authority: Administrative adjustments to accounts and refunds to patients/guarantors or other payers in the amounts noted below may be authorized by the individuals noted below:

1. Up to $1000: Supervisor, Patient Financial Services
2. Up to $10,000: Manager, Patient Financial Services
3. Up to $50,000: Director, Patient Financial Services
4. $50,000 or more: Chief Financial Officer

VIII. Billing, Collection Practices and Bad Debt Determination

The Hospital applies the same continuous billing and collection efforts to all accounts for uninsured patients as it does to accounts for any other patient classification.

A. Eligible Service Determinations. The Hospital follows regulations and guidelines issued by the Commonwealth of Massachusetts in the administration of the Health Safety Net claim eligibility and other programs of public assistance.

The Hospital maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the Hospital determines were the result of a Serious Reportable Event (SRE). SREs that do not occur at the Hospital are excluded from this determination of non-payment. The Hospital also does not seek payment from a Low Income Patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the Hospital. The Hospital further maintains all information in accordance with applicable federal and state privacy, security and ID theft laws.

B. Patients/Guarantors Exempt from Collection Actions: The Hospital does not bill or otherwise engage in collection action with regard to any patient who establishes that he or she is:

1. Enrolled in MassHealth, receiving benefits under the Emergency Aid to the Elderly, Disabled and Children program, or a participant in the Healthy Start program (except that the Hospital may bill such patients for co-payments and deductibles required under these programs of assistance). The Hospital may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation; upon receipt of such proof (including receipt or verification of a signed application), the Hospital shall cease collection activities.
2. A participant in the Children's Medical Security Plan (CMSP) whose family income is equal to or less than 400% of the Federal Poverty Income Guidelines. The Hospital may initiate billing for a patient who alleges that he or she is a participant in the CMSP but fails to provide proof of such participation; upon receipt of such proof (including receipt or verification of a signed application), the Hospital shall cease collection activities.
3. A Low Income Patient is exempt from collection action for any Eligible Services received during the period for which he or she has been determined to be a Low Income Patient (except for co-payments and deductibles related to such Eligible Services). The Hospital may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, but only after their Low Income Patient status has expired or otherwise been terminated.
4. A Low Income Patient with family income between 201-400% FPL is exempt from collection actions for the portion of the bill that exceeds the deductible and may be billed for co-payments and deductible amounts consistent with state regulations.
5. A patient or family eligible for Medical Hardship, with respect to that amount of the bill that exceeds the Medical Hardship contribution (as calculated in accordance with applicable regulations). If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the Hospital will cease collection activity on the patient for those services.

Low Income Patients are not exempt from collection actions for services other than Eligible Services that are provided at the request of the patient or guarantor and for which the patient or guarantor has agreed to be responsible. The Hospital must obtain the patient or guarantor's written consent to be billed for such services.

C. Initial Billing: Except for patients exempt from collection action as specified above, the Hospital will provide an initial bill to the patient/guarantor or a specified third party. The portion of the account for which the patient/guarantor is responsible and for which the patient/guarantor will be billed excludes that amount covered by the Health Safety Net and the portion exceeding the Medical Hardship contribution, as applicable.

D. Collection Follow-Up: The Hospital uses external agencies to perform collection activities on self-pay accounts, and holds any such agency to the standards specified in the Hospital's Patient Financial Services policies on collection practices in effect from time to time, which shall be consistent with this Credit and Collection Policy**.** All self-pay accounts will be subject to continuous collection activity and will receive a minimum of three collection actions. Collection actions by the Hospital or its designated agent may include, but are not restricted to, the following:

1. Initial bill
2. Statements (sent every 30 days following the determination of a self-pay liability)
3. Follow-up letter (sent via first class mail or certified mail)
4. Telephone calls
5. Meetings with guarantor or other responsible party

E. Returned Mail: Accounts for which returned mail is received will be investigated to locate the patient and/or guarantor. Efforts to obtain a current address will include, at a minimum:

1. Review of all inhouse records and appointments to determine if a more current address is documented;
2. Contact with any known relatives or friends; and
3. Review of current telephone directory.

The Hospital may engage outside agencies to perform additional skip tracing activities. Documentation of efforts to locate the party responsible for the obligation will be retained.

F. Bankruptcies: Upon receipt of legal notification of the patient's/guarantor's bankruptcy, all collection activity will cease and the account will be adjusted. Bankruptcy cases will not be eligible for and will not be submitted to the Health Safety Net.

G. Bad Debt Determination: After reasonable collection efforts have failed to yield payment of charges on an account, the balance on the account may be classified as bad debt in accordance with this Credit and Collection policy and any other applicable finance department policies (which shall not be inconsistent with this Credit and Collection Policy).

Conditions for Immediate Bad Debt Determination: When information is obtained to designate an account as bad debt at any time during the follow-up collection process, the account may be immediately considered as bad debt without any further collection action. Included in this category are the following:

1. Unsuccessful attempt to identify the cause for failure of delivery of mail that is returned as undeliverable. Undeliverable or "bad address" accounts are categorized for follow-up by the mail personnel in Patient Financial Services staff and researched for correct address/contact prior to placing the account in a bad debt status. Follow-up activities are documented.
2. Unsuccessful attempt to identify a working telephone number after patient's/guarantor's telephone has been disconnected.

3. Written or verbal notification of the patient's/guarantor's unwillingness or refusal to pay.
4. Receipt of official notification from an insurance company that benefits were paid to the subscriber, and at least one unsuccessful attempt has been made to contact the patient/guarantor after such notification from the insurer.

H. Billing Emergency Services Bad Debt to the Health Safety Net: In addition to following the collection practices outlined above, the Hospital will send a certified letter to any patient (except a patient for whom notices have been returned as "undeliverable" or "incorrect address") with an outstanding balance of more than $1,000 in emergency and related services before billing the balance to the Health Safety Net. The balance of the account will be billed to the Health Safety Net only after it has remained unpaid for more than 120 days from the date of the initial billing notice, and reasonable collection efforts undertaken during that period will be documented in the patient's financial record. For services provided to an uninsured patient, Patient Financial Services staff will validate through the MassHealth EVS system and/or the Virtual Gateway that the patient is either not eligible for or has not submitted an application for MassHealth and that the patient is not a Low Income Patient.

I. Bad Debt Authorization Criteria: Authorization to classify any account as bad debt varies according to the amount of charges on the account, as follows:

1. Up to $5000: Supervisor, Customer Service/Self Pay
2. Up to $10,000: Manager, Customer Service/Self Pay
3. Up to $50,000: Director, Patient Financial Services
4. $50,000 or more: Chief Financial Officer

J. Extraordinary Collection Efforts and Legal Execution: In general, the Hospital does not undertake "extraordinary collection actions". Extraordinary collection actions include selling debt to another provider, reporting adverse information about an individual to a consumer credit reporting agency or credit bureau, deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care under the Hospital's Financial Assistance policy, placing a lien on or foreclosing on an individual's personal residence or motor vehicle property, garnishing wages, and/or filing a civil action. Any decisions to execute on any extraordinary collection actions shall require a Board of Trustee vote. The Hospital and its agents would be required to demonstrate to the Board of Trustees reasonable efforts have been made to determine a patient's eligibility for assistance under its Financial Assistance Policy prior to recommending extraordinary collection actions. Extraordinary Collection Actions would not be initiated until at least 120 day from the date the Hospital provides the first post-discharge billing statement for the care, and would require demonstration of written notification to the patient of the availability of financial assistance at least 30 days prior to execution. The written notification would need to also indicate the extraordinary collection activity the Hospital would intend to initiate, as well as a start date for the activity. In the event of executed extraordinary collection

actions, the Hospital would suspend all actions in the event a Financial Assistance Application is received to enable a period of review not to exceed 30 days.

Prior to seeking legal execution, the Hospital and its agents shall make reasonable efforts to determine a patient's eligibility for assistance under its Financial Assistance Policy. Reasonable effort shall include written notification of the availability of financial assistance that shall include a deadline after which such legal execution may be initiated. Said deadline shall be no earlier than 30 days from notification. Legal execution will not be initiated until at least 120 days from the date the Hospital provides the first post-discharge billing statement for the care.

K. Documentation: The Hospital will document the activity involved in classifying and reporting of an account as bad debt. As the Hospital maintains a "paperless" system for handling both inpatient and outpatient accounts, documentation of activity for these services may be maintained on the Hospital's computer system in comprehensive notes as opposed to on paper.

L. Motor Vehicle Accidents: The Hospital will submit a claim for Eligible Services provided to a Low Income Patient injured in a motor vehicle accident only if (1) it has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy; (2) has made every effort to obtain the third party payer information from the patient; (3) has retained evidence of such efforts, including documentation of phone calls and letters to the patient; and (2) where applicable, it has properly submitted a claim for payment to the motor vehicle liability insurer. For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the Hospital will report any recovery to the Health Safety Net Office. The recovery will be offset against the claim for Eligible Services.

IX. Patient Rights and Responsibilities

A. The Hospital must advise patients of the right to:
   1. Apply for MassHealth, Commonwealth Care, Low Income Patient determination and Medical Hardship; and
   2. A payment plan, as described in this Credit and Collection Policy and applicable regulations, if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

B. A patient who receives Eligible Services must:
   1. Provide all required documentation;
   2. Inform MassHealth of any changes in Family Income or insurance status, including but not limited to income, inheritances, gifts, and distributions from trusts, the availability of health insurance and third-party liability. The patient may, in the alternative, provide such notice to the Hospital; and
   3. Track the patient Deductible and provide documentation to the Hospital that the deductible has been reached when more than one family member is

determined to be a Low Income Patient or if the patient or family members receive Eligible Service from more than one provider; and

4. Inform the Division of Health Care Finance and Policy or MassHealth when the patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. The patient must:

a. File a claim for compensation;

b. Agree to comply with all requirements of M.G.L. ch. 118G, including but not limited to:

(1) assigning to the Division the right to recover an amount equal to the Health Safety Net payment provided form the proceeds of any claim or other proceeding against a third party;

(2) providing information about the claim or any other proceeding, and fully cooperating with the Division or its contractor, unless the Division determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the patient;

(3) notifying the Division or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding; and

(4) repaying the Health Safety Net from the money received from a third party for all Health Safety Net eligible services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, only Health Safety Net payment provided as a result of the accident or other incident will be repaid.

c. The Division only recovers sums directly from a patient to the extent that the patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101 CMR 613.06(5)

1.0 POLICY

1.1 CCHMC will provide care for emergency medical conditions to any patient without discrimination and regardless of financial assistance eligibility or ability to pay. CCHMC further prohibits any actions that would discourage individuals from seeking emergency medical care, such as demand for payment before receiving treatment for emergency medical conditions or debt collection activities that interfere with the provision, without discrimination, of emergency care.

1.2 CCHMC will provide financial assistance for medically necessary services to any patient who resides in Ohio or CCHMC's Primary Service Area and will work with eligible patients and families to secure government health care program assistance.

1.2.1 For those patients with a family income at or below 200% of the Federal Poverty Level (FPL), as demonstrated by completion of a Financial Assistance Application, services will be provided at no charge to the patient/family.

1.2.2 For those with a family income above 200% of the FPL, services will be provided at a 48% discount on Charges Billed to the patient/family. A Financial Assistance Application is not required to receive this 48% discount.

1.3 Patients residing in the United States, but outside of Ohio or CCHMC's Primary Service Area, will receive a 25% discount on Charges Billed for medically necessary services.

1.4 If a patient has out-of-pocket expenses that total more than 25% of the patient's/family's Gross Income in any one year, CCHMC will work with them on a payment plan such that they will not be required to pay more than 25% of their Gross Income to CCHMC in that year.

1.5 CCHMC will not take any extraordinary collection efforts on any amounts due by individuals (patients and individual guarantors) for medically necessary services.

2.0 DEFINITIONS

2.1 **Amounts Generally Billed (AGB)** means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. To determine AGB, CCHMC sums all claims for emergency and other medically necessary care allowed by insurers or government payers over a twelve-month period (i.e., April 1 of Year 1 to March 31 of Year 2), then divides that by the sum of the gross charges related to those claims for that same period. The result is the **AGB Percentage**, and it will be applied to all services provided over the next twelve-month period (i.e., from July 1 of Year 2 to June 30 of Year 3).

2.2 **Charges Billed** means those charges for which a patient/family is responsible. For uninsured

patients, that is the price associated with services provided by CCHMC. For patients with commercial insurance, it is amounts not covered by the insurer, excluding fixed amount co-payments. For patients covered by a state or federal program (for example, Medicare or Medicaid), Charges Billed does not include those charges associated with co-insurance (inclusive of deductible, co-insurance, and/or co-payment) amounts.

2.3 An **emergency medical condition** is one that manifests 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 health of the individual (if pregnant, the mother or unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or, with respect to a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or unborn child.

2.4 **Extraordinary collection efforts** is any of the following: (1) sale of the individual's debt; (2) report of adverse credit information about the individual or responsible guarantor; (3) the deferral or denial of, or requirement of payment before, subsequent medically necessary care based on non-payment by a family eligible for financial assistance; or (4) any action that requires legal or judicial process, such as placement of a lien, foreclosure, attachment, seizure, arrest, lawsuit, claim, writ, or garnishment.

2.5 **Financial Assistance Application or Application (FAA)** – the document used by CCHMC financial counselors to determine a patient's/family's eligibility for a federal or state health care program or for CCHMC Financial Assistance Program.

2.6 **Gross income** - total family gross income from all sources as defined under the IRS Code.

2.7 **Medically necessary services** – Inpatient, outpatient, home health, and emergency services, as well as professional services by CCHMC-employed providers, covered by the Ohio Department of Medicaid.

2.8 **Primary Service Area (PSA)** – Butler, Clermont, Hamilton, and Warren Counties in Ohio; Boone, Campbell, and Kenton Counties in Kentucky; and Dearborn County in Indiana.

3.0 IMPLEMENTATION

3.1 Under no circumstances will the amount owed by a patient/family residing in the PSA or State of Ohio exceed AGB. For the period beginning July 1, 2016, the AGB Percentage is 52%.

3.2 Patients/families who seek financial assistance under this Policy at the 100% discount level must complete a Financial Assistance Application (attached as Appendix A) and provide proof of

income, residency, and family size through documentation listed on the Application.

3.2.1 CCHMC will provide a patient/family with a free Application upon request or identification of uninsured status. A free copy of the Application, in English or other languages, may be requested by calling a financial counselor at 513-636-4427, e-mailing PFC@cchmc.org, or writing to CCHMC Patient Financial Services, 3333 Burnet Avenue, MLC 5011, Cincinnati, Ohio 45229. Applications are also available online at http://www.cincinnatichildrens.org/patients/resources/financial-assistance/.

3.2.2 Applications will be processed by the Financial Customer Service Department within 30 business days of receipt of all required documents.

3.2.3 Family Financial Advocates are available to assist patients and families and are located at 3333 Burnet Avenue, Cincinnati, OH 45229, in the main hospital.

3.3 Without charge, CCHMC will make this Policy, the accompanying Application, and a plain-language summary available in paper during the initial intake process for new patients and upon request for established patients, and by posting notice of the availability of financial assistance prominently at outpatient, emergency, and inpatient admissions areas and on CCHMC's website. Copies will be available in multiple languages, in a manner representative of the community that CCHMC serves. CCHMC will also include a conspicuous written notice on billing statements to notify and inform recipients of this Policy with contact information for the Financial Assistance Program and the website address of applicable materials.

3.4 After making reasonable efforts to determine eligibility for financial assistance and applying any available financial assistance, and after the passage of sixty days from billing, CCHMC may take the following actions in the event of non-payment of amounts due after all available financial assistance has been applied:

3.4.1 CCHMC will send four monthly statements notifying the guarantor of any partial payments received, any remaining balance due, and any other circumstances for non-payment. If a payment plan has not been established, these accounts may be transferred to an outside collection agency. Neither CCHMC nor collection agents working on its behalf will take extraordinary collection efforts to obtain payment.

4.0 OVERSIGHT

4.1 All revisions of this Policy must be approved by the Executive Committee of the CCHMC Board of Trustees. Authority for those amendments and operational authority for the execution of this Policy resides with the Chief Financial Officer.

5.0 REFERENCES

26 U.S.C. §501(r), 42 U.S.C. §1395dd (2016); 26 C.F.R. §1.501(r)-1 – 1.501(r)-7 (2016); Ohio Revised Code Chapter 5168 (2016).

REVISION HISTORY
Original
11/12/2004
Revision Date
12/10/2007, 12/10/2010, 4/1/2014, 7/1/2016

POLICY

The Children's Hospital of Philadelphia (CHOP) is committed to the advancement of healthcare for all children and to the care of children in the community it serves. As one of the many ways it seeks to fulfill those commitments and its charitable purpose, CHOP offers financial assistance for Medically Necessary Care to patients/families who meet the eligibility requirements in accordance with this policy.

PURPOSE

This Policy defines who may be eligible for financial assistance, the financial assistance (discount) available, the collection actions that may be taken, and the process to be followed to obtain a financial assistance determination. It is designed to establish a fair and consistent method of review.

SCOPE

This is a system-wide Policy and applies to all CHOP facilities, divisions, and practice plans that are listed in Attachment A and their employees. The term "CHOP" as used in this Policy refers to all of them. This Policy applies to Medically Necessary Care including emergency care, inpatient, outpatient, surgical, and home care. Financial assistance under this Policy is available only after all available public medical assistance and insurances (including workers compensation, automobile insurance, and liability claims payments) have been exhausted. CHOP may offer payment plans or other discounts under other CHOP policies.

Certain individuals or companies who provide healthcare services at CHOP do not follow this Policy. A list of these providers can be obtained from CHOP's Family Health Coverage Program and on CHOP's website.

RELATED DOCUMENTS

Administrative Policy Manual	Job Aid	Compliance With 501(r) Regulations
	A-2-04	Prompt Payment
	A-2-05	Discounts and Reductions of Patient/Family Financial Obligations
	A-2-08	Billing and Collections

DEFINITIONS

Federal Poverty Guidelines (FPG): Income thresholds issued annually by the U.S. Department of Health and Human Services. CHOP will use the FPG in effect on the date of the application for financial assistance.

Household/Household Members: Include:

1. The patient,
2. Any adults who live with the patient and who have primary responsibility for the care and control of the patient (e.g., parents, stepparents, legal guardians, kinship caregivers), and
3. The patient's siblings (including stepsiblings) who live with the patient.

Household Income: All income received by the patient and/or adult Household Members, other than siblings (unless a sibling has primary responsibility for the care and control of the patient), and includes but is not limited to:

1. Wages (as evidenced by pay stubs, W-2 forms, tax returns, and/or letters from employers)
2. Unemployment benefits
3. Temporary Assistance for Needy Families (TANF) benefits
4. Social Security benefits (including SSI/SSD/RSDI)
5. Retirement pensions
6. Alimony payments
7. Child support payments
8. Government stipends related to foster care or adoption
9. Inheritance
10. Trust fund payments

Income from the Supplemental Nutrition Assistance Program (SNAP) will not be considered in determining Household Income.

Medically Necessary Care: Healthcare services, including emergency care, which, in the opinion of a CHOP treating physician, is a service, item, procedure or level of care that is:

1. Necessary for the proper treatment or management of the patient's illness, injury or disability; or
2. Reasonably expected to, prevent the onset of an illness, condition, injury or disability, or is routine, generally accepted preventive care; or
3. Reasonably expected to reduce or ameliorate the physical, mental or developmental effects of the patient's illness, condition, injury or disability; or
4. Will assist the patient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the patient and those functional capacities that are appropriate for the patient's age.

Primary Service Area: The Pennsylvania counties of Berks, Bucks, Delaware, Chester, Lancaster, Lehigh, Montgomery, Northampton, and Philadelphia; the New Jersey counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Salem, and Somerset; and the Delaware county of New Castle.

IMPLEMENTATION

I. Discounts. If a patient is determined eligible for financial assistance under this Policy, 100% of the patient's financial responsibility for medically necessary and emergency care, after all applicable insurances, liability claims payments and other government assistance, is waived. Billing the patient/family for these services will be discontinued.[1] Financial assistance is not available for expenses associated with transportation, or for devices, pharmaceuticals or any other supplies or services that are not provided by CHOP, or for personal expenses such as meals and lodging.

II. Eligibility Criteria. Eligibility is determined by the Family Health Coverage Program (FHCP) staff on the basis of patient/family circumstances, including unique considerations that may be brought to their attention. Generally, to be eligible for Financial Assistance under this Policy:

A. The patient must reside within the Primary Service Area of CHOP. The residency requirement may be waived, however, when emergency care has been provided in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) or when specialized care that is available at CHOP is approved to be provided by a CHOP treating physician.

B. The patient and his/her Household must have a total Household Income of not more than 400% of the Federal Poverty Guidelines (FPG) for the Household size.

C. The patient/family must have an initial consultation, either in person or by telephone, with a counselor in CHOP's FHCP.

D. The patient/family must complete and sign a CHOP Financial Assistance Application and provide the Required Documentation (Section IV has the list of required documents).

E. Patients/families determined by CHOP to be potentially eligible for assistance from publicly supported programs must cooperate in applying and qualifying for any assistance from the applicable state's Medical Assistance (Medicaid) Program, Children's Health Insurance Program (CHIP), and/or other available public programs. Unless CHOP determines that the patient/family is not potentially eligible for public assistance, the patient/family will be required to submit verification of an application for Medicaid, CHIP, and/or other available public assistance (e.g., an E-File or E-Form number from an online CHIP application or a receipt received from a county assistance office). Patients/families who refuse to cooperate in a timely manner in pursuing such coverage may be deemed not eligible for financial assistance.

[1] NOTE: Because CHOP waives all patient responsibilities and does not pursue collection actions against eligible patients/families for emergency or Medically Necessary Care, patients eligible for financial assistance under this Policy will never be individually charged more than the amount generally billed. Therefore, CHOP does not calculate amounts generally billed (AGB).

F. The patient must be uninsured or insured by a health plan in which CHOP is a participating provider or has a case agreement. Financial assistance is generally not available for services when CHOP is considered out-of-network by the patient's health plan.

III. Applying for Financial Assistance. An application for financial assistance may be made at any time before, during, or after services are provided.

A. Patients/families who wish to apply for financial assistance, should:

i. Contact the Family Health Coverage Program via phone (1-800-974-2125) or email (fhcp@email.chop.edu) for an initial consultation.

1. It is best to do this before submitting an Application and Required Documentation (Section IV) because FHCP staff will assess preliminary information and help with applications to the applicable state's Medical Assistance (Medicaid) Program, Children's Health Insurance Program (CHIP), and with CHOP's Application for financial assistance.

ii. Submit the completed and signed Application and the Required Documentation (Section IV) to the FHCP:

1. In person at the FHCP's office at the Hospital (see address below),

2. By email to fhcp@email.chop.edu, or

3. By mail to:
Family Health Coverage Program
The Children's Hospital of Philadelphia
3401 Civic Center Boulevard
Philadelphia, PA 19104

B. Patients/families are required to update all information provided to CHOP as circumstances change (e.g., if health insurance or a new job is obtained, CHOP must be notified).

IV. Required Information and Documentation. The following information and documentation may be required:

A. Completed and signed Financial Assistance Application.

B. Completed public insurance applications, if applicable.

C. Driver's license or other valid picture identification with current residence address for all adult Household Members (other than siblings).

D. Evidence of citizenship or residency status for all Household Members, which may include birth certificates, passports, voter registration cards, visas, I-94 cards, permanent residency cards, employment authorization cards.

E. If the patient is school age, school registration papers or letter of registration from a school

administrator.

F. Authorization for release of information to/from state Medicaid and/or CHIP agencies.

G. Documentation related to Household Income (as specified in the definition of "Household Income").

H. Signed Certification of inability to pay.

Other Documents. CHOP may request additional information and may waive any of the Required Documents depending on the patient/family circumstances. Additional documents may include documents about other sources of income, residence, utility bills for the past 30 days or landlord letter, lease or mortgage documents and payment stubs for the past 30 days or landlord letter, credit card and insurance bills for the past 30 days, assets and debts. For example, CHOP may request information about the Household's accounts in banks and other financial institutions, investments, retirement plans and other assets that can be liquidated and are not needed for daily living. CHOP considers a Household's primary residence and vehicles needed for regular transportation as needed for daily living.

V. Determinations of Eligibility

A. Review and Final Authority. All Applications for financial assistance under this Policy are reviewed by the Family Health Coverage Program and determinations are made by FHCP staff or the Director of Ambulatory Services. In extraordinary circumstances the Director may refer the determination to the Vice President of Revenue Cycle and Reimbursement Strategy**.**

B. Basis for Denial. CHOP may deny an Application for financial assistance if: (i) any Required Document or information specified in Section IV is not provided or not waived; (ii) the patient has sufficient available insurance, including automobile insurance, payments from liability claims, workers compensation or other sources; or (iii) any false, untrue or misleading statement or information is provided to CHOP in connection with the Application.

C. Election to Grant Financial Assistance. CHOP may elect to grant financial assistance on the basis of other information that may be presented to or requested by CHOP that is not described in this Policy.

D. Reliance on Eligibility Determinations. CHOP will rely upon final determinations for one year from the date of the eligibility determination. If the patient/family wants to request financial assistance after this one-year period ends, they will be asked to complete a new Financial Assistance Application and to submit the Required Documentation. CHOP does not use any other determinations by any other agency or facility to presume or determine eligibility.

E. Revocation. CHOP reserves the right to deny financial assistance, and to revoke any financial assistance determination, based on any false, untrue or misleading statements or information

provided by the patient/family or any person on their behalf in connection with an Financial Assistance Application, or if the patient/family circumstances change.

VI. Collection Actions

A. Upon submission of a Financial Assistance Application, CHOP suspends all billing to the patient/family. Billing may resume for services not covered by this Policy, and after a determination that a patient is not eligible for financial assistance. CHOP will not pursue any collection actions against any individual who is responsible for payment for anyone who is eligible for financial assistance under this Policy, and will not pursue Extraordinary Collection Actions (defined below) against any individual without first making reasonable efforts to determine if the patient is eligible for financial assistance.

B. Collection actions that may be taken when this Policy is not applicable include sending periodic statements from CHOP or through a contracted business office, and, after the account is 120 days past due, referral of the unpaid account to a collection agency.

C. Extraordinary Collection Actions are:

1. Selling a person's debt to another party.

2. Reporting adverse information to consumer credit reporting agencies or credit bureaus.

3. Deferring or denying, or requiring payment before providing Medically Necessary Care because of an individual's nonpayment of one or more bills for previously provided care covered under this Policy.

4. Actions that require a legal or judicial process, including but not limited to:

(i) Placing a lien on an individual's property.

(ii) Attaching or seizing an individual's bank account or any other personal property.

(iii) Commencing a civil action against an individual.

(iv) Causing an individual's arrest.

(v) Causing an individual to be subject to a writ of body attachment.

(vi) Garnishing an individual's wages.

VII. Seeking Information.

Patients who wish to learn more about financial assistance and other discount programs at CHOP, or who wish to obtain copies of this Policy, the Financial Assistance Application or a plain language Summary of this Policy (Attachment B), should contact CHOP's Family Health Coverage Program (FHCP) by calling 1-800-974-2125, or by email to fhcp@email.chop.edu , or may go to CHOP's website address at: http://www.chop.edu/services/financial-assistance .

Patients may inquire about financial assistance at any time. Inquiries, recommendations or referrals should be directed to CHOP's Family Health Coverage Program.

VIII. Emergency Care. In accordance with the federal Emergency Medical Treatment and Labor Act (EMTALA), neither a medical screening examination nor stabilizing treatment for an emergency medical condition will be delayed or denied to determine a patient's/family's ability to pay or insurance status.

VIII. Notify and Inform. CHOP will notify and inform patients of this Policy and take steps to widely publicize it in accordance with applicable regulations. At a minimum, CHOP will:

- **A.** Post this Policy, the Application, and the plain language Summary on CHOP's website in a manner that is conspicuous and easily accessible to patients/families;
- **B.** Provide copies of this Policy, the Application, and the plain language Summary to patients/families upon request and without charge. This will include sending copies by mail, if requested, advising patients who inquire how to obtain copies electronically, and having copies available in public locations at CHOP, including in the emergency department and admissions areas;
- **C.** Offer the plain language Summary at patient intake;
- **D.** Inform members of the community served by CHOP about this Policy in a manner reasonably calculated to reach those members of the community served by CHOP who are most likely to require financial assistance;
- **E.** Include on all billing statements a conspicuous written notice of the availability of financial assistance that includes the telephone number to FHCP and web address to obtain additional information.
- **F.** Post conspicuous displays in public areas in all of CHOP's facilities that are reasonably calculated to attract patients' attention and notify and inform them of this Policy. This will include displays in the emergency room and admissions areas.
- **G.** Translate this Policy, the plain language Summary, and the Application into various languages in accordance with applicable regulations.

RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY

SENIOR VICE PRESIDENT, OUTPATIENT AND CLINICAL SERVICES

ATTACHMENTS

Attachment A: Providers Who Comply with this Policy
Attachment B: Plain Language Summary of Policy

Supersedes	Approved by:
10/30/2013	_____ Douglas Hock – EVP and Chief Operating Officer

TEXAS CHILDREN'S HOSPITAL **POLICY & PROCEDURE**

MANUAL:	TCH	POLICY NO:	GA303-01
SECTION:	General and Administrative	PROC. NO:	GA303-01
TITLE:	FINANCIAL ASSISTANCE/ CHARITY CARE POLICY	ORIG. DATE:	01/05/89
RESP:	Administration	EFF. DATE:	05/14/10
REV. BY:		DISTRIBUTION:	All Departments

POLICY STATEMENT -01

Texas Children's Hospital ("TCH" or "Hospital") is committed to providing the highest quality care and recognizes that some of its patients and/or patient families are unable to pay for some or all of their care. It is the policy of TCH to provide financial assistance to patients who are financially or medically indigent in furtherance of the mission and values of the Hospital.

This policy sets forth the standards and processes by which TCH provides free or discounted care to patients who are financially or medically indigent. Financial assistance will be available to all patients who qualify. Charity Care is only applicable to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. Other services not deemed "medically necessary" must be pre-qualified by the Charity Care Committee.

Financial assistance from TCH is considered as a "last resort" and is based upon patients meeting eligibility requirements. The Hospital will identify eligible patients and determine the amount of financial assistance available in connection with the Hospital's available resources, need to maintain financial stability and desire to continue to provide the highest quality care to its patients.

No patient will be denied financial assistance because of his or her race, religion, or national origin or any other basis which is prohibited by law. In implementing this policy, Texas Children's will comply with all applicable federal, state and local laws, rules and regulations.

DEFINITIONS -01

1. **Bad Debt**: Hospital charges that a patient is able but unwilling to pay or refuses to pay.

2. **Charges**: For purposes of this policy only (per the Patient Protection and Accountability Act), hospital charges that are generally billed to individuals who have insurance coverage covering such care.

3. **Charity Care**: Includes the following: (1) the unreimbursed cost to the Hospital for services provided to a patient receiving inpatient and/or outpatient treatment who meets the Hospital's criteria of financially or medically indigent, and/or (2) the cost to the Hospital for services provided to an uninsured patient who does not have the ability to pay.

4. **Charity Care Committee:** A Hospital committee comprised of appropriate representatives from the Hospital and/or Medical Staff with responsibility for: 1) annual review and if appropriate update of Charity Care eligibility policies and 2) review of applications for Charity Care and approving or denying Charity Care assistance.

5. **Charity Care Deductible**: The portion of a charity patient's Hospital bill that is the patient's responsibility. This amount may be determined by a Financial Counselor, a Patient Account Representative or the Charity Care Committee, as set forth in this policy.

6. **Family Income or Gross Income:** Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, 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. Family Income is based on definitions used by U.S. Bureau of the Census.

7. **Federal Poverty Guidelines ("FPG")**: Guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.

8. **Financial Assistance**: Hospital care provided at a discounted rate. A patient who is uninsured for the relevant service and who is not eligible for coverage through a Government Healthcare Program or other insurance, and who has family income in excess of 200% but less than 400% of FPG, will be eligible to receive Financial Assistance in the form of a discount off charges.

9. **Financially Indigent**: A patient who the Hospital has determined is unable to pay some or all of the patient's Hospital bills due to the patient's and/or the patient's family's income being below specified thresholds based on the FPG and/or because their monetary assets are below specified thresholds.

10. **Government Healthcare Program**: Any healthcare program operated or financed at least in part by the federal, state or local government (includes but is not limited to Medicare, Medicaid, and CHIP).

11. **Medically Indigent**: A patient who the Hospital has determined to be unable to pay some or all of his or her Hospital bills because such bills exceed a certain percentage of the patient's or patient's family's income and/or assets (e.g. due to catastrophic cost or other conditions), even though the patient and/or family have income or assets that disqualify them from meeting the criteria for financially indigent.

12. **Service Area**: Includes the following counties: Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery, and Waller.

13. **Under-insured Patient:** A patient who has some insurance or third-party coverage but has out-of-pocket expenses (self-pay balances) that exceed the patient's ability to pay.

14. **Uninsured Self-Pay Patient**: A patient who has no insurance or third party coverage to assist with meeting the patient's payment obligations.

PROCEDURE -01

1.0 **OVERVIEW**

1.01 The Patient Financial Services Department will identify patients who may be eligible for Financial Assistance.

1.02 A patient requiring Financial Assistance or Charity Care or thought to require such assistance will be referred to a Financial Counselor or Financial Assistance Specialist.

1.03 A patient seeking Financial Assistance or Charity Care must complete an application with a Financial Counselor. An application will be made available to anyone requesting one.

1.04 A patient is only eligible for Charity Care after all other financial resources available to the patient have been exhausted and the patient and patient's family are without sufficient income to cover out of pocket expenses, as determined by TCH. Existing and potential financial resources for the patient, such as, but not limited to, private health insurance, CHIP, agency funding, Medicare and/or Medicaid, will be reviewed.

1.05 Charity Care is only applicable to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. In instances where medical necessity is unclear, the Charity Care Committee will follow up with the patient's physician.

2.0 ELIGIBILITY

2.01 Eligibility is based upon Citizenship (US Citizen) and Residency (Service Area). Patients who are U.S. citizens and live in the Service Area are eligible for Charity Care per this policy.

2.02 Charity Care discount percentages are calculated using FPG, and may be updated in conjunction with FPG updates published in the Federal Register.

2.03 If a patient's annual family income is 100% or below of the FPG, the patient will most likely qualify for Medicaid. If the income is 101-200% of the FPG, or the patient does not qualify for Medicaid, the patient may qualify for CHIP. If the patient does not qualify for Medicaid, CHIP or any other program and the family income is below 400% of the FPG, the guidelines in Exhibit A will be applied to calculate the percentage of Financial Assistance to which the patient is entitled, and what the Charity Care Deductible will be.

2.04 If a patient has Medicare but no secondary coverage and income is within the FPG contained in this policy, the patient is required to apply for Medicaid prior to being considered for Charity Care.

2.05 A patient who is not a legal U.S. resident or resides outside of TCH's Service Area may be considered Financially Indigent or Medically Indigent under appropriate circumstances. Any Financial Assistance must be approved by the Charity Care Committee, taking into account the nature of the child's illness, the likelihood that treatment will lead to a successful outcome, the disposition of similar cases involving children who are legal U.S. residents, and the budgetary constraints of the Hospital.

2.06 In addition to using the FPG to determine a patient's eligibility for Financial Assistance, the following factors will be considered:

1. Family Income. Gross income generally must fall within FPG with consideration to family size, geographic area, and other relevant factors.
2. Denials. A patient must have applied for and been denied medical coverage by all potential funding sources including, but not limited to: Medicaid, Special HealthCare Needs (CSHCN), CHIP, Medicare (if applicable), and/or any potential commercial program.
3. Employment Status
4. Current Financial Obligations
5. Good Faith. Patients are expected to cooperate with the application process. If the application is denied for reasons other than an incomplete application, the patient's application will be presented to Charity Care Committee for consideration.

3.0 ELIGIBILITY DETERMINATION

3.01 Financial Counselors and Patient Account Representatives may determine the appropriate amount of Financial Assistance available to patients, and the amount of any applicable Charity Care Deductible in relation to the amount due after applying all other resources. The manager of the Financial Counselor or Patient Account Representative may approve the request for Charity Care in accordance with the FPG. All other applications must be forwarded to the Charity Care Committee.

3.02 A patient who can afford to pay for a portion of the services provided by the Hospital is expected to do so, even if the patient is Medically Indigent. The patient's portion of the Hospital bill will be described as the patient's Charity Care Deductible. Patients who have a Charity Care Deductible will be required to pay the deductible.

3.03 A determination of eligibility for Charity Care is effective for six (6) months and is applicable toward all Hospital balances incurred prior to an approved Charity Care application.

3.04 If a Charity Care application is approved, Charity Care will apply to balances after all third party coverage has been collected. Whenever other funding is available, whether or not the patient has been approved for Charity Care, agency funding must be secured prior to the service being scheduled and covered by Charity Care.

3.05 The Charity Care Committee may change a previous decision regarding a patient's eligibility for Financial Assistance based on a case by case basis.

3.06 A patient's eligibility for Financial Assistance may be reevaluated when one or more of the following occur:

1. Subsequent rendering of services
2. Income change
3. Family size change
4. When any part of the patient's account is Bad Debt or is in collections
5. Six months has elapsed since the patient qualified for Financial Assistance

4 AMOUNTS CHARGED TO PATIENT

4.01 TCH uses a "sliding scale" to determine the percentage discount applicable to a patient who qualifies for Financial Assistance. See Exhibit A.

4.02 If a patient/family is not eligible to participate in a Government Healthcare Program, TCH offers the following financial assistance to Uninsured Self-Pay Patients:

1. With Gross Income between 0% and 200% of the FPG, there is a 100% discount off billed charges.
2. With Gross Income between 201% and 300% of the FPG, there is a 75% discount off billed charges.
3. With Gross Income between 301% and 400% of the FPG, there is a 50% discount off billed charges
4. With Gross Income greater than 400% + of the FPG or those families who refuse to complete a Financial Assistance Application (Charity Care Application), there is a self-pay or prompt-pay discount of 40% of Charges.

4.03 A Medically Indigent patient is expected to pay a portion of the patient's Hospital bill. This portion is referred to as the Charity Care Deductible. Any portion of a Hospital bill that is not paid by a third party that is in excess of the Charity Care Deductible may be considered Charity Care by the Hospital. There may be occasions when a patient/family has experienced a catastrophic illness and cannot afford to pay the entire Charity Care Deductible. A payment plan (not to exceed 6 months) may be approved by the Patient Financial Services Department.

4.04 A Medically Indigent patient must meet his/her Charity Care Deductible and be re-evaluated at least every six (6) months in order to continue receiving Financial Assistance.

4.05 If a patient/family has out-of-pocket expenses, separate and apart from the patient's Hospital bills, that total more than 25% of the patient's/family's annual gross income, TCH will work with the patient/family on a payment plan so they will not be required to pay more than 25% of their gross income in any one year.

5 Application for Charity Care

5.01 An application may be completed by anyone who requests it or is identified with a need. An sample application is attached as Exhibit B. Any TCH employee or physician may refer a patient to the Financial Counselor/Patient Account Representative or Patient Accounting to initiate a Charity Care application. Charity Care may be granted at any stage of the Hospital's revenue cycle.

5.02 If the payment falls within the FPG, the Manager of Patient Admissions may approve the request for Charity Care if the patient resides in the Service Area and the family meets all other requirements. All other applications must be forwarded to the Charity Care Committee.

5.03 Patient Accounting will provide a written decision regarding a patient's eligibility for Charity Care to the applicant within 30 days of receipt of a completed application. This notification will include the discount amount approved, the payment that is expected from the patient, and reasons for any denial (if the request is denied).

5.04 If a patient does not have Medicaid or other private agency funding, but may qualify, the patient must cooperate with the application process to be considered for Charity Care. If a patient does not cooperate with the application process, Charity Care will be denied or revoked if active approval is on file and the patient will be responsible for any balances. The patient is required to provide the following documentation, at a minimum: any evidence of third party coverage, employment status, verification of employment and income, proof of residency, and family size. Verification of Income may include one or more of the following:

1. Prior Year Tax Returns;
2. Current Pay Stubs (last 2 months) or written verification of wages from Employer;
3. Social Security Check;
4. Bank Statement;
5. Disability check

5.05 A patient who does not provide the requested information or does not cooperate with efforts to secure coverage from a Governmental Healthcare Program will not be eligible for Charity Care or Financial Assistance. Such cooperation is not a precondition to the receipt of medically necessary treatment or emergency care.

5.06 Denials may be appealed through the Patient Financial Services department. Appeals should include supporting documents that demonstrate inability to pay that were not available or included at the time of the initial consideration.

5.07 Patient Accounting will retain all records relating to Charity Care for seven years.

6 Non-payment

6.01 If a patient does not pay the Charity Care Deductible for and fails to renegotiate a payment plan (if applicable), the uncollected balance will be considered Bad Debt.

6.02 The Hospital may use any and all reasonable efforts to collect Bad Debt. These efforts may include but are not limited to 1) telephone calls 2) email correspondence and 3) written correspondence.

7 Publication

In accordance with law, TCH will post information regarding the availability of Financial Assistance and Charity Care, and the existence of this policy. Information and instructions for applying for Financial Assistance and Charity Care will be posted in key public areas throughout the Hospital where patients present for services. Information is also provided in patient welcome packets. This policy will be available in Spanish, a notice regarding this policy will be published annually in the local paper, and a link to this policy will be available on the Hospital's website.

8 Exceptions

Extenuating circumstances may arise in determining eligibility for patients who do not meet established criteria. The Charity Care Committee is charged with reviewing and approving such cases.

ASSOCIATED DOCUMENTS

EXHIBIT A – 2010 Federal Poverty Guidelines
EXHIBIT B – Charity Care Application

ASSOCIATED LAWS AND REGULATIONS

TEXAS HEALTH AND SAFETY CODE ANN. §§ 311.031 - 311.048
TEXAS TAX CODE § 153.310, § 171.063
Medicaid Conditions of Participation

Mark A. Wallace
President
Chief Executive Officer
Texas Children's Hospital

Review Dates:		**Revision/Approval Dates:**	
Administrative Policy & Procedure Operations Committee	05/12/10	Senior Vice President, HR	05/13/10

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT ACCOUNTS – HOSPITAL BILLING
Policies and Procedures

Policy Title: **FINANCIAL ASSISTANCE**	Effective Date 01/01/2016
Section: Patient Financial Services	Revised Date: 4/17/2017, 12/4/2017

PURPOSE AND SCOPE:

The purpose of this policy is to establish standard procedures for the determination of financial assistance to patients of Nationwide Children's Hospital (Nationwide Children's) and its Affiliated Entities that are in financial need. This policy sets forth a process for Patient Accounts Department staff, other hospital personnel, and External Vendors' representatives to identify those patients and families who are eligible for free or discounted care. Nationwide Children's Patient Accounts Department has the final authority for determining whether an individual is eligible for financial assistance and for determining that reasonable actions have been taken prior to Nationwide Children's engaging in Extraordinary Collection Actions. Eligibility for financial assistance applies to all patients regardless of race, creed, sex, age, national origin, ethnicity, or disability.

The services covered by this policy include all emergency and other Medically Necessary Care provided by Nationwide Children's and its Affiliated Entities.

Nationwide Children's will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for financial assistance. Nationwide Children's shall comply with the Emergency Medical Treatment and Labor Act (EMTALA) by providing medical screening examinations and stabilizing treatment and referring or transferring an individual to another facility, when appropriate, and providing emergency services in accordance with 42 CFR 482.55 (or any successor regulation). Nationwide Children's prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care.

DEFINITIONS:

Affiliated Entities – Affiliated companies owned by Nationwide Children's Hospital that provide emergency and other Medically Necessary Care in the hospital including Children's Anesthesia Associates, Children's Radiological Institute, Children's Surgical Associates, Pediatric Academic Association, and Pediatric Pathology Associates of Columbus. Although Children's Community Practices does not provide patient care in the hospital, it is owned by Nationwide Children's Hospital and offers financial assistance in accordance with this policy.
Amounts Generally Billed (AGB) – Amounts generally billed by Nationwide Children's to patients with insurance.
External Vendors – Companies hired to act as agents with respect to billing and collection.
Extraordinary Collection Actions – Actions taken by Nationwide Children's against an individual related to obtaining payment of a bill for care covered under this Financial Assistance Policy set forth in 26 CFR 1.501(r)-6(b) (or any successor regulation).
Family Size - Shall include the patient, the patient's spouse, regardless of whether the spouse lives in the home, and all of the patient's children, natural or adopted, under the age of eighteen who live in the home. If the patient is under the age of eighteen, the "family" shall include the patient, the patient's natural or adopted parent(s) (regardless of whether they live in the home), and the parent(s)' children, natural or adopted under the age of eighteen who live in the home.
FAP – This Financial Assistance Policy.

Federal Poverty Level (FPL) – A measure defined by the United States government based on annual income and household size to indicate poverty threshold.
Gross Charges – Amounts charged for medical care.
Gross Income - Total income before any deductions are taken.
Medically Necessary Care – Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
Patient Responsibility – Amount that an individual is responsible for after all insurance (including commercial and governmental payors) payments, deductions, and discounts have been applied to a patient's bill.

INSTRUCTIONS:

Eligibility Criteria

Any patients receiving or seeking to receive emergency or other Medically Necessary Care at Nationwide Children's may apply for financial assistance; however, the criteria used to evaluate eligibility may differ based on where the patient resides in the event a patient is seeking non-emergent care.

Ohio residents requesting financial assistance must first apply for Ohio Medicaid (Healthy Start and Healthy Families) and the Ohio Hospital Care Assurance Program (HCAP). Ohio residents exempt from Social Security and Medicare taxes must supply a completed form 4029 "Application for Exemption From Social Security and Medicare Taxes and Waiver of Benefits" in order to waive this requirement. Patients who are an Ohio resident but do not qualify to receive benefits under these programs and patients who are not Ohio residents that receive emergency medical care at Nationwide Children's may be eligible for financial assistance based on total Gross Income and Family Size as follows:

- Income at 200% or less of the Federal Poverty Level (FPL) will be written off at 100% of the Patient Responsibility.
- Income between 201% and 250% of the FPL will be written off at 80% of the Patient Responsibility.
- Income between 251% and 300% of the FPL will be written off at 60% of the Patient Responsibility.
- Income between 301% and 400% of the FPL will be written off at 45% of the Patient Responsibility.

Ohio residents with family income greater than 200% of the FPL but less than 400% of the FPL whose bills from Nationwide Children's exceeds 20% of the family yearly household income will be considered medically indigent for purposes of this policy. Medically indigent families will be eligible for a higher discount in the Patient Responsibility in an amount such that the family's Patient Responsibility for all Nationwide Children's bills equals a percentage (%) of the family's yearly household income as stated below:

- Income at 200% or less of the Federal Poverty Level (FPL) will be written off at 100% of the Patient Responsibility.
- Income between 201% and 250% of the FPL will be written off to a balance equal to 5% of the family's yearly household income.
- Income between 251% and 300% of the FPL will be written off to a balance equal to 7% of the family's yearly household income.
- Income between 301% and 400% of the FPL will be written off to a balance equal to 10% of the family's yearly household income.

Non-Ohio U.S. residents requesting financial assistance for non-emergent medical care must be pre-approved for financial assistance prior to receiving such non-emergent care. The pre-approval process will require the individual to submit medical justification for the services to take place at Nationwide Children's versus a healthcare facility in the patient's state of residence. Such justification will be reviewed by Nationwide Children's and patients determined by Nationwide Children's to have submitted appropriate medical justification may be eligible for financial assistance based on total Gross Income and Family Size as follows:

- Income at 200% or less of the Federal Poverty Level (FPL) will be written off at 100% of the Patient Responsibility.
- Income between 201% and 250% of the FPL will be written off at 80% of the Patient Responsibility.
- Income between 251% and 300% of the FPL will be written off at 60% of the Patient Responsibility.
- Income between 301% and 400% of the FPL will be written off at 45% of the Patient Responsibility.

Non-US residents requesting financial assistance for non-emergent care must be pre-approved for financial assistance prior to receiving such non-emergent care in accordance with Nationwide Children's Policy and Procedures for International Charity Patients. Nationwide Children's Steering Committee for International Patients determines an international patient's eligibility for charity care based upon several criteria, including the medical intervention needed, the likelihood of the intervention successfully resolving the underlying medical condition and being properly managed post-intervention, whether Nationwide Children's is uniquely able to provide such intervention, the availability of such services within the patient's country of residence, budgetary restrictions, and such other criteria as the Steering Committee may determine are appropriate to ensure Nationwide Children's charity care resources for international cases are used most efficiently and effectively. Information about the availability of charity care for international patients is available by contacting the Nationwide Children's Welcome Center.

Medicaid recipients who receive Medically Necessary Care not covered by Medicaid will have 100% of the Patient Responsibility for such Medically Necessary Care automatically written off. An application for financial assistance will not be required in these circumstances.

Families who provide a completed IRS Form 4029 to Nationwide Children's Patient Accounts Department will be eligible for a discount of the Patient Responsibility equal to that provided under this FAP to those with income between 301% and 400% of the FPL. An application for financial assistance will not be required in these circumstances.

Families with the address of a "Homeless Shelter" will be eligible for a 100% discount of the Patient Responsibility. An application for financial assistance will not be required in these circumstances.

Nationwide Children's Patient Accounts Department shall have the final authority for determining eligibility for financial assistance under this policy.

Basis for Calculating Amounts Charged to Patients

The amounts charged to patients eligible for financial assistance under this FAP for emergency and Medically Necessary Care will not exceed AGB. Nationwide Children's calculates AGB using the "Look-Back" method, as defined in federal regulations, based on all claims allowed by Medicaid, Medicaid Managed Care, Medicare and private health insurers over a 12 month period, divided by Nationwide Children's Gross Charges for those claims. Nationwide Children's updates its AGB calculation on January 1 of each year using data from the 12 month period ending on the September 30 immediately preceding that January 1. For calendar year 2018, AGB equals 57.6%. Members of the public may readily obtain a description of the calculation in writing and free of charge by contacting the Nationwide Children's Customer Service department listed below.

An individual eligible for financial assistance is charged only the amount that he or she is personally responsible for paying, after all deductions and discounts (including discounts available under the FAP) have been applied and less any amounts reimbursed by insurers (including both commercial and governmental payors).

Method for Applying for Financial Assistance

To be considered for financial assistance, the individual must apply for financial assistance with the Nationwide Children's Patient Accounts Department. Individuals who seek financial assistance under this Policy at the 100% discount level (i.e. individuals whose family income is 200% or less of the FPL) must complete a Financial Assistance Application and provide the information and documentation listed in the Financial Assistance Application. All other applicants may provide the necessary information to the Patient Accounts Department over the telephone, a paper application will not be required. Nationwide Children's reserves the right to request copies of pay checks, W-2's, and income tax returns.

A Financial Assistance Application (whether in writing or telephonically, as set forth above) must be made as follows:

- Outpatient hospital services for patients at or below 100% of the FPL are covered by HCAP and, as such, require a new application every 90 days from the initial date of service. Outpatient hospital services for all other patients require a new application every 180 days from the initial date of service. Recipients of the Disability Assistance (DA) program or its successor program under HCAP must submit a new application on a monthly basis.
- Each inpatient admission, unless the patient is admitted within 45 days of discharge for the same underlying condition, must be on its own financial assistance application. Subsequent readmissions can be on the same

application, but only if within 45 days and for a related condition. Outpatient accounts can be added to an application that has an inpatient account, but an inpatient visit cannot be added to an application that has outpatient accounts.

- Behavioral Health outpatient patients must submit a new application on an annual basis.

Nationwide Children's does not use prior FAP eligibility determinations to determine whether an individual qualifies for financial assistance under this policy.

Presumptive Eligibility for Financial Assistance
Nationwide Children's Hospital may use a third party to conduct a review of patient information to assess FAP-eligibility for the most generous assistance available under the FAP. This review and analysis utilizes a health care industry recognized, predictive model. Such reviews will not be used to determine presumptive eligibility for less than the most generous assistance available under the FAP.

Actions That May Be Taken in the Event of Nonpayment

Nationwide Children's will make every attempt to collect on the debt and make reasonable efforts to determine if an individual is FAP eligible before engaging in Extraordinary Collection Actions. Such reasonable efforts will include sending out statements and making phone calls to the responsible party on the schedule set forth below during the first 120 days of discharge. Nationwide Children's may use the services of an External Vendor to assist in debt collection.

0 - 30 days	First billing statement sent, along with written notice that financial assistance is available, the FAP application form, and how the individual may obtain assistance with the FAP application process.
31- 60 days	Second billing statement sent, along with a plain language summary of the FAP and a notice that Nationwide Children's intends to report the unpaid account to a credit bureau if such amounts are not paid within 365 days from the first post-discharge billing statement. In addition, one phone call is made to verbally notify the individual about Nationwide Children's FAP and how the individual may obtain assistance with the FAP application process.
61 - 90 days	Third billing statement sent, along with a plain language summary of the FAP and a notice that Nationwide Children's intends to report the unpaid account to a credit bureau if such amounts are not paid within 365 days from the first post-discharge billing statement. In addition, one phone call is made to verbally notify the individual about Nationwide Children's FAP and how the individual may obtain assistance with the FAP application process.
91 - 120 days	Fourth billing statement sent, along with a plain language summary of the FAP and a notice that Nationwide Children's intends to report the unpaid account to a credit bureau if such amounts are not paid within 365 days from the first post-discharge billing statement. In addition, two phone calls are made to verbally notify the individual about Nationwide Children's FAP and how the individual may obtain assistance with the FAP application.

In addition to written notice that financial assistance is available, the FAP application form, and information about how the individual may obtain assistance with the FAP application process, all billing statements will include the direct website address where copies of the FAP, FAP application form, and plain language summary of the FAP may be obtained.

Nationwide Children's may report unpaid accounts to the credit bureau after 1 year from the initial billing statement date. If an individual's bills are aggregated to cover multiple episodes of care, an unpaid account will not be reported to a credit bureau until at least 120 days after the first post-discharge billing statement for the most recent episode of care included in the aggregation.

If an individual submits an incomplete FAP application during the application period (i.e. the 240 days following the first post-discharge billing statement), Nationwide Children's shall provide the individual with a written notice that describes the additional information and/or documentation required under the FAP or FAP application form that must be submitted to

complete the FAP application as well as contact information for the Nationwide Children's department that can provide information about the FAP and that can provide assistance with the application process. Nationwide Children's will suspend any Extraordinary Collection Action (and, if applicable, inform its External Vendors to suspend such efforts) until Nationwide Children's has determined whether the individual is eligible for financial assistance under the FAP or the individual fails to respond to requests for additional information and/or documentation within a reasonable period of time.

Upon receipt of a complete FAP application during the application period, Nationwide Children's will make a determination as to whether the individual is FAP-eligible for the care and notify the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination. If the individual is determined to be eligible for assistance other than free care, Nationwide Children's will:

- Provide the individual with a billing statement that indicates the amount the individual owes for the care as a FAP-eligible individual and how the amount was determined. Such billing statement will also describe how the individual can obtain information regarding the AGB for the care.
- Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual.
- Take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual to obtain such payment.

If an individual submits an FAP application and, prior to Nationwide Children's determining whether the individual is FAP-eligible, the individual applies for Medicaid eligibility, Nationwide Children's will postpone determining whether the individual is FAP-eligible, and will not engage in any Extraordinary Collection Actions against the individual, until after the individual's Medicaid application has been completed and submitted and a determination as to the individual's Medicaid eligibility has been made.

List of Providers Who Provide Emergency and Other Medically Necessary Care at Nationwide Children's

A list detailing providers who deliver emergency and other Medically Necessary Care at Nationwide Children's and whether their professional services are covered by Nationwide Children's FAP may be viewed at http://www.nationwidechildrens.org/financial-assistance, or a paper copy may be obtained by contacting the departments listed below under Contact Information.

Availability of the Financial Assistance Policy, Plain Language Summary of the Financial Assistance Policy and Financial Assistance Application

Web Site Access
http://www.nationwidechildrens.org/financial-assistance
Paper Copies

- Available upon request at no charge to the patient or responsible party.
- Paper copies are offered at intake in any admissions or registration areas on Nationwide Children's main campus (including the Emergency Room) and offsite locations.
- Letters and Financial Assistance Applications are mailed to the patients and/or parents upon request.
- All billing statements contain the Financial Assistance Application on the back of the statement as well as contact information for the department that can provide assistance with the application.

Notification and Information Provided to Hospital Facility Patients

- Signage located in any admissions or registration area on Nationwide Children's main campus (including the Emergency Room) and offsite locations to advise the patients or the responsible party of the availability of financial assistance.
- Automated telephone calls offering financial assistance that are made after the second billing statement is issued.
- Nationwide Children's Financial Counselors visit patients with need for financial assistance in their rooms or in the clinics.

Notifying and Informing the Broader Community

- The FAP, Plain Language Summary of the FAP and the Financial Assistance Application can all be found at www.NationwideChildrens.org.
- Nationwide Children's also periodically shares the Plain Language Summary of the FAP and the Financial Assistance Application with Federally Qualified Health Centers in Franklin County and also to community-based physicians who

are members of the Nationwide Children's medical staff so that the documents are readily available to patients of these providers.

Translated Documents

- The Financial Assistance Policy, Financial Assistance Application, and Plain Language Summary of the FAP will be available in the language spoken by each limited English proficiency (LEP) language group that constitutes the lesser of 1,000 or 5 percent of Franklin County or others reasonably likely to be affected by Nationwide Children's. The Director of Patient Accounts will be responsible for reviewing the language needs on an annual basis and making translated versions of the documents available as needed.

Contact Information

Counselors	Location	Phone
Nationwide Children's Financial Counselors	Admitting Office 700 Children's Drive or by appointment at any Nationwide Children's locations	**(614) 722-2070**
Nationwide Children's Customer Service	Patient Accounts Phone Calls Only	**(614) 722-2055**

Approved by:

_____ _____

Timothy C. Robinson
Executive Vice President & Chief Financial and Administrative Officer

Date

CHANGE HISTORY

Version	Approval date	Approved by	Change

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs (JHBMC) and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center (JHBCC).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and Medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted, so long as other requirements are met.

FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:
Attached as **EXHIBIT D** is a list of physicians that provide emergency and medically necessary care as defined in this policy at JHH, JHBMC and JHBCC. The lists indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physician's financial assistance policy provides.

Definitions

Medical Debt

Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the Hopkins hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay (opting out of insurance coverage, or insurance billing).

Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Elective Admission	A hospital admission that is for the treatment of a medical condition that is not considered an Emergency Medical Condition.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) Serious jeopardy to the health of a patient; (b) Serious impairment of any bodily functions; (c) Serious dysfunction of any bodily organ or part. (d) With respect to a pregnant woman: 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery. 2. That a transfer may pose a threat to the health and safety of the patient or fetus. 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the hospital.
Medically Necessary Care	Medical treatment that is necessary to treat an Emergency Medical Condition. Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.
Medically Necessary Admission	A hospital admission that is for the treatment of an Emergency Medical Condition.

Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified By the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximuim amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A patient with a hospital account referred to a collection agency notifies the collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

3. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
   b. Applications received will be sent to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.

4. To determine final eligibility, the following criteria must be met:

a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

b. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

c. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).

d. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

d. A Medical Assistance Notice of Determination (if applicable).

e. Proof of U.S. citizenship or lawful permanent residence status (green card) if applicable.

f. Proof of disability income (if applicable).

g. Reasonable proof of other declared expenses.

h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements for medical costs billed by a Hopkins hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based upon JHMI guidelines.

a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments to the Financial

Assistance Evaluation Committee for final evaluation and decision.

b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay patients do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e., Psychiatry) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patient's representative request an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance

Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

15. If a patient account has been assigned to a collection agency, and patient or guarantor request financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If the hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

18. JHHS Hospitals may extend Financial Assistance to residents with demonstrated financial need, regardless of citizenship, in the neighborhoods surrounding their respective hospitals, as determined by the hospital's Community Health Needs Assessment. The zip codes for JHH and JHBMC are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 and 21052. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. Financial Counselors will refer these patients to The Access Partnership program at Hopkins (see FIN057 for specific procedures).

REFERENCE[1]

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

1[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility. Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.

Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

Senior Director, Patient Finance (JHHS)
Director, PFS Operations (JHHS)

REVIEW CYCLE

Two (2) years

APPROVAL

_____ _____
Sr. VP of Finance/Treasurer & CFO for JHH and JHHS Date

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

4. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year)

5. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.

6. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets *in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

7. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.

8. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

9. Financial Assistance is only applicable to Medically Necessary Care as defined in this policy. Financial Assistance is not applicable to convenience items, private room accommodations or non-essential cosmetic surgery. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.

10. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted.

11. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

12. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

13. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exception

The Director of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 3/1/16

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,760**	$ 26,136	$ 28,512	$ 30,888	$ 33,264	$ 35,640
2	**$ 32,040**	$ 35,244	$ 38,448	$ 41,652	$ 44,856	$ 48,060
3	**$ 40,320**	$ 44,352	$ 48,384	$ 52,416	$ 56,448	$ 60,480
4	**$ 48,600**	$ 53,460	$ 58,320	$ 63,180	$ 68,040	$ 72,900
5	**$ 56,880**	$ 62,568	$ 68,256	$ 73,944	$ 79,632	$ 85,320
6	**$ 65,160**	$ 71,676	$ 78,192	$ 84,708	$ 91,224	$ 97,740
7	**$ 73,460**	$ 80,806	$ 88,152	$ 95,498	$ 102,844	$ 110,190
8*	**$ 81,780**	$ 89,958	$ 98,136	$ 106,314	$ 114,492	$ 122,670
**amt for each mbr	$8,320	$9,152	$9,984	$10,816	$11,648	$12,480
Allow ance to Give:	100%	80%	60%	40%	30%	20%

* 200% of Poverty Guidelines

** For family units with more than eight (8) members.

EXAMPLE:

Annual Family Income	$55,000
# of Persons in Family	4
Applicable Poverty Income Level	48,600
Upper Limits of Income for Allowance Range	$58,320 (60% range)

($55,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- Patient is deceased with no known estate
- The Access Partnership Program at Hopkins (see FIN057 for specific procedures)
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- The Pregnancy Care Program at JHBMC (see FIN053 for specific procedures)

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for medically necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures. However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost medically necessary care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets *in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.
5. Patient is not eligible for any of the following:
   - Medical Assistance

- Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the Hopkins treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exception

The Director or designee of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 3/1/16

# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,640**	$ 47,520	$ 59,400
2	**$ 48,060**	$ 64,080	$ 80,100
3	**$ 60,480**	$ 80,640	$ 100,800
4	**$ 72,900**	$ 97,200	$ 121,500
5	**$ 85,320**	$ 113,760	$ 142,200
6	**$ 97,740**	$ 130,320	$ 162,900
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allow ance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,480 for each additional person at 300% of FPL, $16,640 at 400% at FPL; and $20,800 at 500% of FPL.

UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-RE0722 *
INDEX TITLE: Revenue

SUBJECT: Financial Assistance Process
DATE: May 9, 2018

I. POLICY

UPMC is committed to providing financial assistance to people who have health care needs and are uninsured, underinsured, ineligible for a government program, do not qualify for governmental assistance (for example Medicare or Medicaid), or who are approved for Medicaid but the specific medically necessary service is considered non-covered by Medical Assistance, or otherwise unable to pay for medically necessary care. UPMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

In order for UPMC to responsibly manage its resources and provide the appropriate level of assistance to the greatest number of persons in need, patients are expected to contribute to their cost of care based on their individual ability to pay.

Patients applying for financial assistance are also expected to cooperate with UPMC's procedures for obtaining financial assistance or other forms of payment, those with the financial capacity to purchase health insurance will be encouraged to do so.

In accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, no patients shall be screened for financial assistance or payment information prior to the rendering of a medical screening examination and to the extent necessary, services needed to treat the patient or stabilize them for transfer as applicable. The granting of financial assistance will not take into account age, gender, race, social or immigration status, sexual orientation, gender identity or religious affiliation.

Links to policies referenced within this policy can be found in Section XIV.

II. PURPOSE

This policy addresses the various types and levels of financial assistance eligibility requirements, services that are included and excluded, and the process for securing financial assistance.

III. SCOPE

This policy applies to all fully integrated United States based UPMC hospitals and physician providers. (See attachments - Facility & Provider Listings).

IV. DEFINITIONS

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

Emergency Care or Emergency Treatment: The care or treatment for emergency medical conditions as defined by EMTALA (Emergency Medical Treatment and Active Labor Act.)

Financial Assistance**:** Financial assistance is the provision of healthcare services free of charge or at a discount to individuals who meet the established criteria.

Family**:** As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, adoption, marriage, same-sex marriage, unmarried or domestic partners.

Uninsured**:** The patient has no level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. to assist with meeting his/her payment obligations for health care services received from UPMC.

Underinsured**:** The patient has some level of insurance (either private or governmental) or other potential assistance options, such as Victims of Violent Crimes, Auto Insurance, 3rd Party Liability, etc. but still has out-of-pocket expenses that exceed his/her financial ability to pay for health care services at UPMC.

Income/Family Income: Income/Family Income is determined by calculating the following sources of income for all qualifying household members.

- Wages, salaries, tips
- Business income
- Social Security income
- Pension or Retirements Income
- Dividends and Interest
- Rent and Royalties
- Unemployment compensation
- Workers' compensation income
- Alimony and child support
- Legal Judgments
- Cash, bank accounts and money market accounts
- Matured certificates of deposit, mutual funds, bonds or other easily convertible investments that can be cashed without penalty
- Support Letters
- Other Income, such as income from trust funds, charitable foundations, etc.

Items that are not considered in determining income include:

- Primary Residence
- Retirement Funds
- Primary Vehicle

Indigence: Income falls below 250% of the Federal Poverty Guidelines.

Discounted Care: Uninsured and income falls between 251% and 400% of the federal poverty guidelines

Financial or Medical Hardship: Financial assistance that is provided as a discount to eligible patients with annualized family income in excess of 250% of the Federal Poverty Guidelines and the out of pocket expense or patient liability resulting from medical services provided by UPMC exceeds 15% of family income.

Federal Poverty Guidelines: Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current Federal Poverty Guidelines can be referenced at http://aspe.hhs.gov/poverty-guidelines.

Presumptive Charity Care: The use of external publicly available data sources that provide information on a patient's ability to pay.

V. ELIGIBILITY

A. **Services Eligible under this Policy**. Financial assistance is available for eligible individuals who seek or obtain emergency and other medically necessary care from UPMC Providers. This Financial Assistance Policy (FAP) covers medically necessary care as defined by the Commonwealth of Pennsylvania. The Commonwealth of Pennsylvania 55 Pa Code § 1101.21a defines medical necessity as:

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

(1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability; or
(2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability; or
(3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

B. Services not eligible for financial assistance under this Policy regardless of whether they constitute medically necessary care include:

a. Cosmetic surgery not considered medically necessary
b. All transplant and related services
c. Bariatrics and all related services
d. Reproduction-related procedures (such as in-vitro fertilization, vasectomies, etc.)
e. Acupuncture
f. Online virtual health care visits and related telemedicine services, including virtual specialty care and second opinion services
g. Services performed at any UPMC Urgent Care location
h. Package Pricing - services included in a package price are bundled and subject to an inclusive rate which is not subjected to any other forms of discounting.
i. Private duty nursing
j. Services provided and billed by a non UPMC entity which may include lab or diagnostic testing, dental, vision and speech, occupational or physical therapies
k. Patient accounts or services received by a patient who is involved in pending litigation that relates to or may result in a generation of recovery based on charges for services performed at UPMC
l. Other non-covered services such as laser eye surgery, hearing aids, etc.

VI. ELIGIBILITY AND ASSISTANCE CRITERIA

A. Financial assistance will be provided in accordance with UPMC's mission and values. Financial assistance eligibility will be considered for uninsured and underinsured patients, and those for whom it would be a financial hardship to pay in full the expected out of pocket expenses for services provided by UPMC. Financial assistance will be provided in accordance with federal, state and local laws. Applicants for financial assistance are required to apply to public programs for available coverage, if eligible, as well as for pursuing public or private health insurance payment options for care provided by UPMC. Patients who do not cooperate in applying for programs that may pay for their healthcare services may be denied financial assistance. UPMC shall make affirmative efforts to help patients apply for public and private programs.

Typically, financial assistance is not available for patient balances consisting only of co-pays or when a person fails to comply reasonably with insurance requirements (such as obtaining authorizations and/or referrals) or for persons who opt out of available insurance coverage, regardless of whether or not the patient meets eligibility requirements.

In addition, this policy will not apply to individuals who reside outside the service area and would be required to travel in order to seek treatment from a UPMC

Provider. The service area includes all counties contiguous to a UPMC facility. Non-resident international patients are excluded from financial assistance, unless the patient is treated for an emergency. UPMC, in its sole discretion, may waive these exclusions after considering all relevant facts and circumstances. Additionally, UPMC may approve financial assistance for patients utilizing presumptive charity care.

B. Patient Financial Assistance Eligibility Guidelines. Except as otherwise provided herein, services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Level guidelines published by the U.S. Department of Health and Human Services. [1]

1. Indigence:

   A. When a patient is *uninsured* and the patient's and/or responsible party's (ex. Parents, Spouse, etc.) income is at or below **250%** of the Federal Poverty Guidelines, the patient will be approved for a 100% reduction for the care provided by the Provider. This means that the fees for services are completely waived.

   B. When a patient is *underinsured* and the patient's and/or responsible party's (ex. Parents, Spouse, etc.) income is at or below **250%** of the Federal Poverty Guidelines; the patient is eligible for financial assistance. The patient's insurance will be billed, if approved the patient may not have any patient liability after insurance, unless it is a co-payment. If the underinsured patient's income is greater than 250% of the Federal Poverty Guidelines, the patient may be eligible for financial assistance in the form of financial or medical hardship.

2. Discounted Care: Assistance may be in the form of a discounted or reduced patient obligation depending on the patient's and/or responsible party's income.

   If an uninsured patient's and/or responsible party's (ex. Parents, Spouse, etc.) income is greater than **250%** and less than or equal to **400%** of the Federal Poverty Guidelines, the patient is eligible for assistance in the form of a reduction in patient liability for all accounts to the amounts generally billed (AGB) as defined below.

[1] Federal Poverty Guidelines for the current year are available at http://aspe.hhs.gov/poverty-guidelines. The Provider's use of federal poverty guidelines will be updated annually in conjunction with the federal poverty guideline updates published by the United States Department of Health and Human Services.

3. Financial or Medical Hardship: If a patient's and/or responsible party's (ex. Parents, Spouse, etc.) income exceeds 250% of the Federal Poverty Level, they may be considered for a Financial or Medical Hardship. UPMC will consider assistance where a patient's out of pocket expense or patient liability exceeds 15% of family income or where a patient's medical bills are of such magnitude that payment threatens the patient's financial survival. Assistance will be provided in the form of an adjustment of charges to prevent patient liability from exceeding the lesser of 15% of family income or the AGB.

Notwithstanding anything contained in this policy, if an award of financial assistance that does not cover 100% of the charges for the service is granted, the amount due from patients who are eligible under this Policy for discounted care will not be more than amounts generally billed (AGB) as defined below. UPMC in its discretion may waive or modify eligibility requirements after considering all relevant facts and circumstances in order to achieve this Policy's essential purpose of providing medical care to patients who lack financial means.

VII. AMOUNTS GENERALLY BILLED

UPMC will not charge an eligible individual for emergency or other medically necessary services more than the amount generally billed (AGB) to individuals who have insurance covering such care. UPMC will use the Look-Back method to determine AGB. The AGB is calculated using all claims allowed by the Medicare- Fee–For–Service and Private health insurances (including the Medicaid Managed Payers). For this purpose, UPMC will select the lowest percentage of any hospital facility covered by the policy and apply this percentage to all emergency or other medically necessary care covered by the policy. The lowest amount currently calculated is 13% resulting in a discount of 87%.

VIII. APPLYING FOR FINANCIAL ASSISTANCE

Eligibility determinations will be made based on UPMC's policy and an assessment of a patient's financial need. Uninsured and underinsured patients will be informed of the Financial Assistance Policy and the process for submitting an application. Applicants for financial assistance are required to apply to public programs for available coverage, if eligible, as well as for pursuing public or private health insurance payment options for care provided by UPMC. UPMC will process the request for financial assistance within 30 days of receipt. If there is missing documentation, the patient will be given an additional 30 days to respond to the request.

UPMC will make reasonable efforts to explain the benefits of Medicaid and other available public and private programs to patients and provide information on those programs that may provide coverage for services.

Information on public or private coverage and UPMC's Financial Assistance Policy will be communicated to patients in easy-to-understand, culturally appropriate language, and in the most prevalent languages spoken in applicable hospital service area communities.

A. Application Process:

Typically, a patient is not eligible for financial assistance until he or she has applied for and is determined to be ineligible for applicable federal and Commonwealth governmental assistance programs. UPMC will make resources available to assist patients in enrolling in and/or applying for federal and Commonwealth government programs. UPMC may decide to process the financial assistance application without the documentation that the patient is ineligible for Medical Assistance or other governmental assistance programs.

All applicants are expected to complete the UPMC Financial Assistance application form (see attachment) and provide requested documents. If documentation is not included with the application, the financial information shared on the application may be used in order to make the financial assistance determination. The patient's signature will be used as attestation to the validity of the information provided. In addition, while completed applications and supporting documentation are more likely to result in a more efficient application process, financial assistance may be awarded in the absence of a completed application and supporting documentation as provided by this policy under presumptive financial assistance (described below) or otherwise in the discretion of UPMC.

Financial Assistance applications are to be submitted to the following office:

Patient Financial Services Center
UPMC
Quantum 1 Building
2 Hot Metal Street
Pittsburgh, PA 15203
1-800-371-8359 option 2

Requests for financial assistance will be processed promptly and UPMC will notify the patient or applicant in writing within 30 days of receipt of a completed application. If denied eligibility for any of the financial assistance offered, the patient may re-apply at any time. If the patient is denied financial assistance and a payment to satisfy the balance or a payment plan is not established the account may be transferred to a 3rd-party collection agency for follow-up. Please refer to UPMC's Billing and Collections Policy HS-RE0724.

If the patient is approved for financial assistance, the eligible patient balances will be adjusted accordingly for services up to one year prior to the approval of the application. The application will remain on file for 3-months and may be used to grant financial assistance within the 3-month time period without requesting additional financial

information. Cancer patient's applications will be approved for a 6month forward time period to ensure a continuation of care.

The approval time period for financial assistance eligibility will begin on the date that the patient is determined eligible for assistance and 1-year prior to the date of eligibility. Service dates outside the 1-year range may be considered on a case to case basis at UPMC's discretion.

If a patient is approved for financial assistance through the application process and has made a payment to the accounts which qualify for financial assistance; payments over $5.00 will be refunded to the extent consistent with the level of financial assistance awarded, with the exception of co-payment.

B. Presumptive Financial Assistance Eligibility:

Presumptive Indigence:

UPMC recognizes that not all patients are able to complete the financial assistance application or provide the required documentation. There may be instances when financial assistance is warranted and the patient qualifies for assistance, despite the lack of formal applications and income assessment described in this policy. In the normal course of assessment of a patient's ability to pay, UPMC, in its sole discretion, may declare the patient's account uncollectible and classify the account as meeting eligibility criteria. Presumptive eligibility may be granted to patients based on life circumstances such as:

1. homelessness or receipt of care from a homeless clinic;
2. participation in Women, Infants and Children programs (WIC);
3. receiving SNAP (Supplemental Nutritional Assistance Program) benefits;
4. eligible for other state or local assistance programs, such as Victims of Violent Crimes;
5. deceased patient with no known estate.

When presumptive financial assistance eligibility is established, typically a 100% discount will be available.

Other Presumptive Eligibility:

For patients who are non-responsive to UPMC's application process, other sources of information, such as estimated income and family size provided by a predictive model or information from a recent Medical Assistance application, may be used to make an individual assessment of financial need. This information will enable UPMC to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

For the purpose of helping financially needy patients, UPMC may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for UPMC. The predictive model enables UPMC to assess whether a patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process.

Information from the predictive model may be used by UPMC to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Where efforts to confirm coverage availability have been unsuccessful, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

In the event a patient does not qualify for the highest level of financial assistance under the presumptive rule set, the patient may still provide the requisite information and be considered under the traditional financial assistance application process. When a patient is denied financial assistance though the presumptive eligibility process, a letter will be sent to the patient along with a financial assistance application. The patient will have 30 days to complete the application prior to sending the account to a 3rd-party collection agency.

Presumptive screening provides benefit to the community by enabling UPMC to systematically identify financially needy patients, reduce administrative burdens, and provide financial assistance to patients who have not been responsive to the financial assistance application process.

IX. NOTIFICATION OF FINANCIAL ASSISTANCE AND RELATED INFORMATION

UPMC's Financial Assistance Policy (FAP), the FAP application form and the plain language summary of the FAP (the "FAP Documents") shall be available to all UPMC patients as follows:

A. The FAP, FAP application form and a plain language summary of the FAP are available on UPMC's website, (http://www.upmc.com/about/community-commitment/financial-assistance/Pages/default.aspx), searchable by the mechanism applicable to the site generally. The FAP Documents will be printable from the website.

B. The FAP, the FAP application form and plain language summary of the FAP are available upon request and without charge, both in public locations in UPMC hospitals and by mail.

C. Visitors to the facility are informed and notified about the FAP and availability of the FAP Documents by notices in patient bills and by posted notices in emergency rooms, urgent care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses and at other public places as UPMC may select. Information will also be included on public websites. Referral of patients for financial assistance may be made by any member of the UPMC staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains and others.

X. APPEALS AND DISPUTE RESOLUTION

Patients may seek a review from UPMC in the event of a dispute over the application of this financial assistance policy. Patients denied financial assistance may also appeal their eligibility determination.

Disputes and appeals may be filed by contacting the Director of UPMC Revenue Cycle, Patient Advocacy. The basis for the dispute or appeal should be in writing and submitted within 30 days of the patient's experience giving rise to the dispute or notification of the decision on financial assistance eligibility.

Disputes or appeals should be submitted to the following office:

Director, UPMC Revenue Cycle, Patient Advocacy
Quantum 1 Building
2 Hot Metal Street
Pittsburgh, PA 15203

XI. COLLECTIONS IN THE EVENT OF NON-PAYMENT

UPMC will not engage in Extraordinary Collection Actions, as defined by applicable federal laws. If the individual is already a Financial Assistance recipient and he/she is cooperating in good faith to pay his/her balance but nonetheless experiencing difficulty, UPMC will endeavor to offer an extended payment plan.

Refer to UPMC Billing and Collections Policy HS-RE0724 for the actions the hospital facility may take in the event of nonpayment. This policy may be obtained at no cost by contacting the Patient Financial Services Center at 1-800-371-8359.

XII. REGULATORY REQUIREMENTS

In implementing this Policy, UPMC management and facilities shall comply with all applicable federal, state, and local laws, rules, and regulations.

XIII. RECORD KEEPING

UPMC will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

XIV. POLICIES REFERENCED WITHIN THIS POLICY

HS-RE0724 Patient Billing and Collections

SIGNED: Jeffrey Porter
Vice President, Revenue Cycle
ORIGINAL: October 1, 1999
APPROVALS:
Policy Review Subcommittee: April 12, 2018
Executive Staff: April 27, 2018 (Effective May 9, 2018)
PRECEDE: November 9, 2017 (Effective November 14, 2017)
SPONSOR: Associate Director, Revenue Cycle

Attachments

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

FACILITY LIST

UPMC Presbyterian Shadyside, Oakland campus
UPMC Presbyterian Shadyside, Shadyside campus
Western Psychiatric Institute and Clinic
Children's Hospital of Pittsburgh of UPMC
Magee-Women's Hospital of UPMC
UPMC St. Margaret
UPMC Passavant, McCandless campus
UPMC Passavant, Cranberry campus
UPMC McKeesport
UPMC Mercy
UPMC Bedford
UPMC East
UPMC Hamot
UPMC Northwest
UPMC Altoona
UPMC Horizon, Shenango campus
UPMC Horizon, Farrell campus
UPMC Jameson
UPMC Kane
The Williamsport Hospital d/b/a Williamsport Regional Medical Center
Divine Providence Hospital of the Sisters of Christian Charity d/b/a
Divine Providence Hospital
Muncy Valley Hospital
Soldiers and Sailors Memorial Hospital
UPMC Susquehanna Lock Haven d/b/a Lock Haven Hospital
UPMC Susquehanna Sunbury d/b/a Sunbury Community Hospital
Mon Yough Community Services

PROVIDER LIST

Butler Cancer Associates, Inc.
Center for Emergency Medicine of Western Pennsylvania, Inc.
Donahue & Allen Cardiology-UPMC, Inc.
Erie Physicians Network-UPMC, Inc.
Fayette Oncology Associates
Fayette Physician Network, Inc.
Great Lakes Physician Practice, P.C.
Hematology Oncology Association
Heritage Valley/UPMC Multispecialty Group, Inc.
Jefferson/UPMC Cancer Associates
Lexington Anesthesia Associates, Inc.
Mountain View Cancer Associates, Inc.
Oncology-Hematology Association, Inc.
Passavant Professional Associates, Inc.
Regional Health Services, Inc.
Renaissance Family Practice-UPMC, Inc.
Tri-State Neurosurgical Associates-UPMC, Inc.
University of Pittsburgh Cancer Institute Cancer Services
University of Pittsburgh Physicians, Inc.
UPMC Altoona Partnership for a Health Community
UPMC Altoona Regional Health Services, Inc.
UPMC and the Washington Hospital Cancer enter
UPMC Community Medicine , Inc.
UPMC Complete Care, Inc.
UPMC Emergency Medicine, Inc.
UPMC Multispecialty Group, Inc.
UPMC/HVHS Cancer Center
UPMC/Jameson Cancer Center
UPMC/St. Clair Hospital Cancer Center
UPMC/Conemaugh Cancer Center
Susquehanna Physician Services d/b/a Susquehanna Health Medical Group-SHMG
Tioga Healthcare Providers-THCP

MANUAL/DEPARTMENT	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL
ORIGINATION DATE	DECEMBER 2015
LAST DATE OF REVIEW OR REVISION	REVIEW: MARCH 2016 REVISION: JULY 2017, DECEMBER 2017
APPROVED BY	

TITLE: FINANCIAL ASSISTANCE POLICY (FAP) PUBLIC POLICY

PURPOSE

Children's Hospital Colorado (CHCO) is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with our mission to improve the health of children through the provision of high-quality, coordinated programs of patient care, education, research and advocacy, CHCO strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. CHCO will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

This policy helps to:

1. Define how patients are determined to be eligible for charity funds and discounted care in accordance with CHCO's Non-Discrimination of Patients policy and IRS regulations.
2. Standardize the process to assess a patient/family's ability to pay for services and to collect appropriate reimbursement based on qualifications and the Federal/State poverty guidelines for CHCO.
3. Define the policy for billing and collecting money from patients/families that are paying for their medical care while making sure that CHCO has a reasonable way to collect payments owed.

SCOPE/PERSONNEL

All CHCO staff at all CHCO locations and CHCO Patients and Families

DEFINITIONS

Accounts Receivables (A/R)	Money owed by customers to Children's Hospital Colorado in exchange for care and services that have been delivered or used, but not yet paid.
Bad Debt	An account receivable based on services provided to a patient that is regarded as uncollectable, following reasonable collection efforts and aged at least120 days from the date the hospital provided the first post-discharge billing statement for the care, consistent with IRS section 501(r) requirements.
Children's Charity Care	A CHCO discount program for indigent patients who are not eligible for any other coverage (e.g., Medicaid, CHP+ or CICP, commercial insurance).
Colorado residence qualification	Proof of residency requires applicants provide a utility or phone bill, lease agreement or mortgage statement, communication from the child's school, identification cards (i.e.,—Driver's license, state issued ID), bank statement, or a letter of support from a family member or friend.
Extraordinary Collection Actions (ECA)	ECAs are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process (except certain liens or bankruptcy claims), involve selling an individual's debt to another party unless certain contractual terms are in place, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, ''credit agencies'').
Financial Assistance Policy (FAP)	The hospital policy that describes the: ○ Eligibility rules for financial help and whether such help includes free or discounted care; ○ Financial assistance and discounts available to qualified individuals; ○ Basis for calculating the amounts charged to patients; ○ Method for asking for financial assistance; and

	○ List of any providers delivering care in the hospital and which, if any, are covered by the facility's FAP and which are not.
Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits. Federal Poverty Guidelines are published annually by the Federal Government.
Foreign National	Non- US citizens who are residing in or visiting the US and are in need of medical services.
Guarantor	The person who is responsible for paying the patient's bill.
Guarantor Statement	A bill for care given. It is a summary of billing and payment information about patient accounts linked to one guarantor.
Income	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. Non-cash benefits (such as food stamps and housing subsidies) do not count. Family income is calculated before taxes and excludes unrealized capital gains or losses. It can include other unearned income which is countable gross cash received from sources other than employment.
Liquid Assets	Assets that can be converted into cash in a relatively short period of time, generally within 30 days. This includes, but is not limited to, checking accounts, saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short-term Certificates of Deposit (CDs) and partnership earnings kept in reserve. Retirement accounts and Tax Sheltered Annuities are liquid resources, if the applicant can draw funds out of the account without a penalty.
Medical Emergency	An injury or illness that is acute and poses an immediate risk to a person's life or long term health.
Medical Necessity	A covered service will be deemed medically necessary if, in a manner consistent with accepted standards of medical practice, it is found to be an equally effective treatment among other less conservative or more costly options, and meets at least one of the following criteria: • The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability or secondary disability; • The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability; • The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability; • The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.
Non-covered charge	Incurred charges that are deemed not a covered benefit per the patient's/guarantor's insurer.
Self-Pay	Patient does not have, or chooses not to use, commercial insurance, government program coverage, or other financial assistance. At the time of billing, a 35% discount will be applied to all self-pay balances.

FINANCIAL ASSISTANCE POLICY

1. Medical emergency services are eligible to be considered for Financial Assistance to U.S. residents.
2. Charity Eligibility
   A. The applicant(s) income must be below 250% of federal poverty guidelines.
   B. Charity care funding for non-emergency care is available to U.S. residents:
      1) Age 14 and younger who are Colorado residents; or
      2) Age 15 years and older who are Colorado residents may be eligible but require administrative approval; and
      3) Undocumented Colorado residents (within age requirements).
   C. The applicant(s) must be ineligible for Medicaid, Child Health Plan+ (CHP+), Colorado Indigent Care Program (CICP), or other health insurance. However, if an individual has Emergency Medicaid for an inpatient life or limb threatening condition, the applicant may be eligible for Charity.
   D. Charity may act as a secondary payer if the patient has commercial coverage. The secondary coverage may provide for a reduction in the amount of co-payments, deductibles, and co-insurance. In addition, charity care may also be used in cases when insurance benefits have been exhausted and services are deemed medically necessary (i.e., PT/OT, EDU, Audiology, Speech and Learning services).

E. A complete application for charity care assistance is required prior to determining eligibility
   1) The information that may be required to determine charity care eligibility is listed in the application.
   2) If charity care will be used to cover past dates of service, the patient/family must indicate the request for assistance on the application.

F. Application Period
   1) The application must be completed within 365 days from the date that the first post-discharge billing statement for the care is provided. Any services prior to 365 days from the application date will not be eligible for charity care coverage.
   2) If an incomplete application is submitted within the application period, the individual will have 60 days to complete the application before ECAs will occur. If ECAs have already started, CHCO will stop ECAs during the 60 day period. At this time the individual will be informed about missing information and how to get assistance.
   3) If a complete application is received, ECAs will be suspended until a determination is made and, if the individual is found eligible, ECAs will be reversed, refunds made, and if amounts are still owed a statement will be provided showing how that amount was determined.

3. Expectations for patients eligible for charity care assistance. The applicant must:
   A. Notify CHCO if there is a change in financial and/or coverage status; failure to do so may result in termination from the program;
   B. Pay the charity co-payment(s) at the time of service; and
   C. Bring the Charity identification card to every visit.

4. Charity Care Ineligibility Criteria – Patients are not eligible for charity care when the following scenarios arise:
   A. CHCO determines or identifies that the patient/family provided false information.
   B. The patient is not a Colorado resident and/or foreign national and is receiving non-emergent care.
   C. The patient/family fails to comply with application requirements for other programs (e.g., Medicaid, CICP, exchange plans, etc.).
   D. The patient/family fails to provide the required information within one (1) year of the date of service.
   E. Certain specialty services and specialties are normally not covered, unless deemed medically necessary:
      1) Transplants, which require a clinical assessment for non-emergency care to ensure the patient can adhere to the post-transplant medical requirements.
      2) Procedures denied by a medical insurance provider as “Non-Covered” benefits. Including:
         a. Services incurred prior to obtaining authorization from the patient’s insurance;
         b. Experimental procedures;
         c. Services denied by payers for non-compliance by the member (e.g., coordination of benefits not submitted).
      3) Services under research.

5. The Financial Counseling Department is the final authority for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible.

Note: CHCO can make changes to the Financial Assistance Program at any time without notice.

BILLING AND COLLECTIONS POLICY

1. CHCO will seek payment on accounts with balances in self-pay (i.e., patient liability). CHCO does not take part in extraordinary collection actions (ECA) before making reasonable efforts to decide whether financial assistance is available and/or collection efforts have been pursued. Any itemized statement requested by a guarantor will be given within ten (10) days of such request, in compliance with Colorado Revised Statute § 25-3-112.

2. CHCO will make reasonable efforts to notify patients and families about the FAP through the following methods:
   A. Orally notify individuals about the FAP and how to obtain assistance with the application process.
   B. CHCO will refrain from initiating ECAs for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care.
   C. CHCO will send at least three (3) monthly billing notices, every thirty (30) days, to the guarantor of an account informing of a balance due.
      1) First Notice informs the guarantor that there is an unpaid balance due on an account;

2) Second Notice reminds the guarantor of continued unpaid balance;
3) Final Notice of the past due account notifies the guarantor that he/she has thirty (30) days to resolve the debt, or ECAs may be taken on the debt and will specify the ECAs that CHCO intends to take and include a copy of the copy of plain language summary.
Note: The account can either be paid in full, set up on a payment plan, referred to financial counseling, or more insurance information obtained during this timeline. A plain language notice of CHCO's FAP is provided in both English and Spanish on every billing statement.

D. After three (3) billing notices have been sent and no payment is received within sixty (60) days of the Final Notice, the account may be turned to Bad Debt and ECAs may be taken.
1) Accounts qualify for Bad Debt when patient balances (i.e., self-pay) have not been paid and the hospital has made reasonable efforts, that include but are not limited to phone calls, statements or letters, to decide whether the individual is eligible for Financial Assistance.
2) The bad debt agency will report to the credit bureau sixty (60) days after an account is placed with such bad debt agency if no action is taken by the guarantor to resolve the balance either by making a payment or by submitting additional dispute information.
3) If all other options to collect payment have been taken and an account in bad debt has aged more than sixty (60) days without contact from the guarantor or the guarantor refuses to resolve the balance, legal action may be taken.

E. Initiation of a Financial Assistance Application
1) The application period for financial assistance will end no earlier than 240 days from the first post-visit bill.

F. All parties engaged in collection actions for CHCO will follow to this policy.

GENERAL INFORMATION

1. In order to preserve CHCO's ability to serve the pediatric health care needs of the community, uninsured or underinsured persons seeking scheduled, medically necessary services will be financially evaluated prior to physician evaluation. If a patient presents for an emergent or urgent condition, determining financial assistance needs will occur after stabilization and treatment. See EMTALA (Emergency Medical Treatment and Labor Act) policy.
2. CICP and the CHCO Charity Program are not insurance programs, but rather discount programs for those who are uninsured, or under-insured and have demonstrated financial need.
3. CHCO will not participate in nor support any activities (including media access) related to fundraising efforts intended to pay for a specific patient's care.
4. CHCO's Charity Program is not responsible for housing, food, transportation, immigration status, or continuity of care.
5. CHCO is available to help identify community based resources, facilitate services, and provide appropriate referral assistance. A Financial Counselor may be contacted at 720-777-7001.
6. CHCO is not obligated to provide Charity Care for non-emergency medical services.
7. CHCO acts in accordance with Colorado Revised Statute § 25-3-112 and 26 CFR 1.501(r)-0 through 26 CFR 1.501(r)-7.
8. Copies are available in multiple languages, including English and Spanish.

AMOUNTS GENERALLY BILLED (AGB)

CHCO limits the amount charged for care it provides to any individual who is eligible for assistance under its Financial Assistance Policy (FAP). The amounts billed for emergency and medically necessary medical services to patients eligible for Financial Assistance are calculated based on the look-back method and will not be more than the AGB to individuals with insurance covering such care. CHCO is using the "look-back" method based on actual past claims paid to the hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals). CHCO calculates an AGB percentage for each facility and uses the lowest percentage for all facilities, which is 58.38%. The ABG percentage will be reviewed and updated by the 120th day after the 12 month period the hospital facility used in calculating the AGB percentage, which is April every year for CHCO.

PROVIDER INFORMATION

1. Completed financial assessments will apply to the professional charges, providers covered under CHCO FAP include:

A. University of Colorado Medicine
B. Kay McDivitt, M.D.

2. The following professional charges will not be covered by CHCO FAP. These organizations may have their own financial assistance policies and inquiries should be made directly by the patient.
   A. TCH Radiology Professionals
   B. Radiology & Imaging Consultants, P.C. (RIC)
   C. University of Colorado Medicine Path Lab

ASSISTANCE AND METHODS FOR APPLYING

1. Applications and assistance in completing applications are available for free:
   A. Online (http://www.childrenscolorado.org/about/your-bill);
   B. At the Anschutz Medical Campus located at 13123 East 16th Avenue, Aurora, CO 80045 or the Briargate Urgent and Outpatient Specialty Care at 4125 Briargate Parkway, Colorado Springs, CO 80920; or
   C. By calling the Financial Counseling Department at 720-777-7001.
2. Completed applications cannot be mailed in, they must be submitted in person.

POLICY AND PLAIN LANGUAGE SUMMARY ACCESS

1. A copy of this policy and the plain language summary are available for free:
   A. Online (http://www.childrenscolorado.org/about/your-bill);
   B. At our Anschutz Medical Campus located at 13123 East 16th Avenue, Aurora, CO 80045 or our Briargate Urgent and Outpatient Specialty Care at 4125 Briargate Parkway, Colorado Springs, CO 80920; or
   C. Financial Counseling Department at 720-777-7001 or Patient Financial Services at 720-777-6422.
   D. Emailing pfs@childrenscolorado.org

ELIGIBILITY INFORMATION

1. Ineligibility for Medicaid, Child Health Plan+, Colorado Indigent Care Program, and other health insurance.
2. Household size and income, with consideration to liquid assets, below 250% of the Federal Poverty Level.
3. Submission of required information within 365 days from the date that the first post-discharge billing statement for the care is provided.

Federal Poverty Level (FPL) income guidelines chart are used to determine CHCO Charity Program Annual Maximum Income Guidelines. Information provided here is updated in April of each year.

Family Size	Annual Income
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450
7	$91,800
8	$102,150

Charity Rating	Percent of Federal Poverty
N	40%
A	62%
B	81%
C	100%
D	117%
E	133%
F	159%
G	185%
H	200%
I	250%
Z*	40%

*Z ratings are for homeless clients.

RELATED DOCUMENTS/REFERENCE

1. 26 CFR 1.501(r)-0 through 26 CFR 1.501(r)-7
2. https://www.irs.gov/pub/irs-irbs/irb15-05.pdf

REVIEWED BY

Finance
Revenue Cycle
Administrative Policy and Procedure Committee
Executive Team

CHCO/CU MEDICINE CICP and Charity Copayment Schedule

Calendar Year 2017

Outpatient Clinic Visit (Primary and Preventative care, CHC, ADO MED, YM, CAMP)

Rating	Charity CHCO	Charity CU Med	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$7	$7	$14	$7	$0	$7
41-62%=A	$15	$15	$30	$15	$0	$15
63-81%=B	$15	$15	$30	$15	$0	$15
82-100%=C	$20	$20	$40	$20	$0	$20
101-117%=D	$20	$20	$40	$20	$0	$20
118-133%=E	$25	$25	$50	$25	$0	$25
134-159%=F	$25	$25	$50	$25	$0	$25
160-185%=G	$35	$35	$70	$35	$0	$35
186-200%=H	$35	$35	$70	$35	$0	$35
201-250%=I	$40	$40	$80	$40	$0	$40
0%-Z	$0	$0	$0	$0	$0	$0

Specialty Outpatient Clinic Visit (Distinctive med care Oncology,Ortho,CCBD, Cardio, etc.)

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$15	$15	$30	$15	$0	$15
41-62%=A	$25	$25	$50	$25	$0	$25
63-81%=B	$25	$25	$50	$25	$0	$25
82-100%=C	$30	$30	$60	$30	$0	$30
101-117%=D	$30	$30	$60	$30	$0	$30
118-133%=E	$35	$35	$70	$35	$0	$35
134-159%=F	$35	$35	$70	$35	$0	$35
160-185%=G	$45	$45	$90	$45	$0	$45
186-200%=H	$45	$45	$90	$45	$0	$45
201-250%=I	$50	$50	$100	$50	$0	$50
0%-Z	$0	$0	$0	$0	$0	$0

Ancillary Services (XR, PFT, Ultrasound, Intervent Radiology,Stress Test, Genetic Testing)

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$15	$0	$15	$15	$0	$15
41-62%=A	$25	$0	$25	$25	$0	$25
63-81%=B	$25	$0	$25	$25	$0	$25
82-100%=C	$30	$0	$30	$30	$0	$30
101-117%=D	$30	$0	$30	$30	$0	$30
118-133%=E	$35	$0	$35	$35	$0	$35
134-159%=F	$35	$0	$35	$35	$0	$35
160-185%=G	$45	$0	$45	$45	$0	$45
186-200%=H	$45	$0	$45	$45	$0	$45
201-250%=I	$50	$0	$50	$50	$0	$50
0%-Z	$0	$0	$0	$0	$0	$0

Inpatient Admission, Observation, Bedded Outpatient and Sleep Studies

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$65	$35	$100	$65	$35	$100
63-81%=B	$105	$55	$160	$105	$55	$160
82-100%=C	$155	$80	$235	$155	$80	$235
101-117%=D	$220	$110	$330	$220	$110	$330
118-133%=E	$300	$150	$450	$300	$150	$450
134-159%=F	$390	$195	$585	$390	$195	$585
160-185%=G	$535	$270	$805	$535	$270	$805
186-200%=H	$600	$300	$900	$600	$300	$900
201-250%=I	$630	$315	$945	$630	$315	$945
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Surgery

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$65	$35	$100	$65	$35	$100
63-81%=B	$105	$55	$160	$105	$55	$160
82-100%=C	$155	$80	$235	$155	$80	$235
101-117%=D	$220	$110	$330	$220	$110	$330
118-133%=E	$300	$150	$450	$300	$150	$450
134-159%=F	$390	$195	$585	$390	$195	$585
160-185%=G	$535	$270	$805	$535	$270	$805
186-200%=H	$600	$300	$900	$600	$300	$900
201-250%=I	$630	$315	$945	$630	$315	$945
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Services (CT, MRI, PET, EMG, Cath Lab, Nuc Med)

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$30	$22	$52	$30	$22	$52
41-62%=A	$90	$50	$140	$90	$50	$140
63-81%=B	$130	$80	$210	$130	$80	$210
82-100%=C	$185	$110	$295	$185	$110	$295
101-117%=D	$250	$140	$390	$250	$140	$390
118-133%=E	$335	$185	$520	$335	$185	$520
134-159%=F	$425	$230	$655	$425	$230	$655
160-185%=G	$580	$315	$895	$580	$315	$895
186-200%=H	$645	$345	$990	$645	$345	$990
201-250%=I	$680	$365	$1,045	$680	$365	$1,045
0%-Z	$0	$0	$0	$0	$0	$0

ED & Urgent Care

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$25	$35	$60	$25	$35	$60
63-81%=B	$25	$55	$80	$25	$55	$80
82-100%=C	$30	$80	$110	$30	$80	$110
101-117%=D	$30	$110	$140	$30	$110	$140
118-133%=E	$35	$150	$185	$35	$150	$185
134-159%=F	$35	$195	$230	$35	$195	$230
160-185%=G	$45	$270	$315	$45	$270	$315
186-200%=H	$45	$300	$345	$45	$300	$345
201-250%=I	$50	$315	$365	$50	$315	$365
0%-Z	$0	$0	$0	$0	$0	$0

Prescription and Optical Shop

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$5	$0	$5	$5	$0	$5
41-62%=A	$10	$0	$10	$10	$0	$10
63-81%=B	$10	$0	$10	$10	$0	$10
82-100%=C	$15	$0	$15	$15	$0	$15
101-117%=D	$15	$0	$15	$15	$0	$15
118-133%=E	$20	$0	$20	$20	$0	$20
134-159%=F	$20	$0	$20	$20	$0	$20
160-185%=G	$30	$0	$30	$30	$0	$30
186-200%=H	$30	$0	$30	$30	$0	$30
201-250%=I	$35	$0	$35	$35	$0	$35
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Lab

Rating	Charity CHCO	Charity CU MED	Charity Total	CICP CHCO	CICP CU MED	CICP Total
0-40%=N	$5	$0	$5	$5	$0	$5
41-62%=A	$10	$0	$10	$10	$0	$10
63-81%=B	$10	$0	$10	$10	$0	$10
82-100%=C	$15	$0	$15	$15	$0	$15
101-117%=D	$15	$0	$15	$15	$0	$15
118-133%=E	$20	$0	$20	$20	$0	$20
134-159%=F	$20	$0	$20	$20	$0	$20
160-185%=G	$30	$0	$30	$30	$0	$30
186-200%=H	$30	$0	$30	$30	$0	$30
201-250%=I	$35	$0	$35	$35	$0	$35
0%-Z	$0	$0	$0	$0	$0	$0

The **Hospital Inpatient & Ambulatory Surgery** copayment is required for charges related to non-physician (facility) services incurred while receiving care in a hospital for a continuous stay of 24 hours or longer or Ambulatory Surgery for operative procedures received by a client who is admitted to and discharged form the hospital setting on the same day.

The **Inpatient and Emergency Room Physician** copayment is required for charges related to services provided directly by the physician in the hospital setting, including emergency room care.

The **Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the outpatient clinic setting. This includes charges for primary and preventive medical care. Does not include charges for outpatient services provided in a hospital (i.e., emergency room care, outpatient surgery, radiology).

The **Hospital Emergency Room** copayment is required for charges related to non-physician (facility) services incurred while receiving care in the hospital setting for a continuous stay of less than 24 hours, including in the Emergency Room.

The **Specialty Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the specialty outpatient clinic setting, but does not include charges for outpatient services provided in the hospital setting (i.e., emergency room physician, ambulatory surgery). Specialty outpatient charges include distinctive medical care (i.e, oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventative medical care.

The **Prescription** copayment is required for prescription drugs received at a qualified CICP health care provider's pharmacy.

The **Laboratory Services** copayment is required for charges related to laboratory tests received by the client that are not associated with an inpatient facility or hospital outpatient charge during the same period; radiology and imaging services in clinic setting.

Outpatient Services- ***Increased*** clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET), Sleep Studies, Catheterization laboratory (cath Lab), or other Nuclear Medicine services in an Outpatient Setting are responsible for the copayment which is reflected in the chart.

Ancillary Services are services that are performed at CHCO outside of a specific Primary Care of Specialty Clinic, Inpatient, Outpatient, Ambulatory Surgery, ED or Urgent Care visits (e.g., X-Rays (flat films), ultrasounds, stress tests, pulmonary functiontion test, ECG, etc)

Table of Contents

I. Purpose

This Financial Assistance Policy ("Policy") is intended to provide the framework under which Financial Assistance will be made available to patients of Lurie Children's Hospital of Chicago (the "Hospital"). The Policy identifies the specific eligibility criteria and application process under which the Hospital will provide care free of charge or at a reduced charge, the criteria used in calculating the amount of the discount, the actions the Hospital may take in the event of nonpayment after reasonable efforts are taken to determine whether an individual is eligible under this Policy, and the measures the Hospital will take to widely publicize this Policy within the community served by the Hospital.

This Policy applies only to charges for Hospital services and is not binding upon providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an inpatient or outpatient basis.

While this Policy refers to "patient," it is recognized that this term includes any parent, guardian or other family member who is or may be financially responsible for the cost of care provided to the patient by the Hospital.

II. Policy Statements

A. In keeping with its mission, Ann & Robert H. Lurie Children's Hospital of Chicago (the "Hospital") is dedicated to making health care services accessible to pediatric patients without discrimination based on race, religion, gender, national origin, sexual orientation, or ability to pay, including whether or not the patient is eligible for Financial Assistance, or is medically indigent. The Hospital recognizes and acknowledges the financial needs of its patients and their families who are unable to afford the charges associated with the patient's medical care. In that regard, the Hospital will provide financial assistance, in accordance with this Policy, to certain qualifying patients who receive emergency or other "medically necessary" healthcare services (as defined by Centers for Medicare and Medicaid).

B. Financial Assistance described within this Policy will be offered in a manner that complies with state and federal requirements, and preserves the overall resources of the Hospital so that the Hospital can continue to make health care services possible for those children residing in Illinois who are in need of highly specialized care. Patients and families must cooperate with the Hospital in the identification of, application for, and procurement of payment sources, including public assistance where available; such efforts must be exhausted before a patient is eligible for Financial Assistance. Patients and families are expected to notify the Hospital if there is a material change in the patient's or the patient's family's financial status. Appendix D to this Policy contains a list of providers other than the Hospital who deliver emergency or other medically necessary care at the Hospital and identifies whether such providers are covered by this policy.

C. To manage its resources and responsibilities, and to allow the Hospital to provide assistance to the greatest number of children in need, the Board of Trustees, through the Finance Committee, establishes these guidelines for the provision of Financial Assistance.

III. Definitions

A. *Amounts Generally Billed:* Charges for emergency or other medically necessary services provided to a patient who is eligible for Financial Assistance shall be limited to no more than amounts generally billed to individuals who have public or commercial health insurance covering such care ("AGB").

i. In calculating the AGB, the Hospital has selected the "look-back" method. This means that the AGB is determined based on actual past claims paid to the Hospital by Medicare Fee for Service claims together with all private health insurers paying claims to the Hospital.

ii. The AGB percentage will be calculated annually by dividing the sum of all claims that have been paid in full during the prior 12 month period by the sum of the gross charges for those claims. This resulting percentage is then applied to an individual's gross charges to reduce the bill.

iii. A revised percentage will be calculated and applied by the 120th day after the first day of the start of the calendar year used to determine the calculations. The AGB percentage is listed in Appendix C. For further information regarding this calculation, please contact:

Patient Financial Services
Ann & Robert H. Lurie Children's Hospital of Chicago
225 East Chicago Avenue, Box 44

Chicago, Illinois 60611
(877) 924-8200

B. *Application Period:* During the Application Period, the Hospital will accept and process an application for Financial Assistance, a copy of which is attached as Appendix B and can be found on the Hospital's web site at: https://www.luriechildrens.org/financial-assistance ("*Application*"). The Application Period begins on the date the care is provided and ends on the later of 240th day after the date that the Hospital provides the first post-discharge billing statement for the care.

C. *Completion Deadline:* The Completion Deadline is the date after which a Hospital may initiate or resume ECAs (as defined below) against an individual who has submitted an incomplete Application if that individual has not provided the Hospital with the missing information and/or documentation necessary to complete the Application. The Completion Deadline must be no earlier than the later of (i) 30 days after the Hospital provides the individual with this written notice, or (ii) the last day of the Application Period.

D. *Council*: The Financial Assistance Council, which is comprised of the Chief Medical Officer, the Chief Financial Officer, the Department Heads of Surgery and Pediatrics or their designees, a representative from the Faculty Practice Plan and others, as appropriate. The roles and responsibilities of the Council are discussed in this Policy further below.

E. *Extraordinary Collection Actions (ECAs):* ECAs are defined as those actions: (1) requiring a legal or judicial process against a patient or other individual responsible for payment for services provided to patient, (2) involving selling debt to another party, (3) deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care, or (4) reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include (a) placing a lien (unless such lien is against a third party who caused a patient's injury);

(b) foreclosing on real property; (c) attaching or seizing of bank accounts or other personal property; (d) commencing a civil action against an individual; (e) taking actions that cause an individual's arrest; (f) taking actions that cause an individual to be subject to body attachment; or (g) garnishing wages. An ECA does not include filing a claim in any bankruptcy proceeding or engaging in certain debt sales as specified by the Internal Revenue Service. **The Hospital will not engage in ECAs before it has made Reasonable Efforts to determine if the patient is eligible for Financial Assistance.** Further information on the Hospital's use of ECAs can be found in the Hospital's separate Collections Policy, available upon request or on the Hospital website at [www.luriechildrens.org/financial-assistance].

F. *Family Income:* Family Income is defined based on definitions used by the U.S. Bureau of the Census and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, 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. Non-cash benefits (such as food and housing subsidies provided through state assistance programs) are not considered income.

G. *Federal Poverty Guidelines ("FPG"):* Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

H. *Financial Assistance:* Financial Assistance applies to emergency and other medically necessary services rendered to patients who cannot afford to pay, who are not eligible for public programs, and for which the Hospital has received financial documentation that the patient cannot make payment for services rendered. Financial Assistance is available for care provided to low income patients who are either uninsured or who have partial coverage but who are unable to pay some or all of the remainder of their medical bills. Financial Assistance does not include contractual allowances with insurance companies and other third party payers.

I. *Financial Assistance Council:* See definition of Council.

J. *Notification Period:* The Notification Period is defined as the period during which the Hospital must make a Reasonable Effort to notify the patient of the Policy and during which no ECAs will be taken. The Notification Period begins when the

Hospital provides the first post-discharge billing statement and ends on the 121st day thereafter.

K. *Plain Language Summary:* A written statement that notifies an individual that the Hospital offers financial assistance under this Policy and provides additional information about Financial Assistance in language that is clear, concise, and easy to understand. The Plain Language Summary will include:

i. A brief description of the eligibility requirements and assistance offered;
ii. A listing of a website or location as to where the Application may be obtained;
iii. Instructions on how to obtain a free copy of the Policy and Application by mail;
iv. Contact information of someone to assist with the process (as well as any other organization that the Hospital has identified to assist with Applications, if the Hospital has chosen to do so);
v. Availability of certain language translations of the Policy; and
vi. A statement that no Financial Assistance eligible patient will be charged more than AGB for emergency or medically necessary services.

L. *Reasonable Efforts:* The Hospital will have been considered to have made a Reasonable Effort in providing notification to the patient about the Policy if, at least 30 days before taking any ECA, the Hospital (a) provides a Plain Language Summary of the Policy to the patient and offers an Application to the patient prior to discharge from the Hospital, (b) sends at least one billing statement that includes conspicuous written notice of the availability of financial assistance, a telephone number of the Hospital where information can be found about the Policy and Application process and the direct website address where copies of the Policy, Application and Plain Language Summary of the Policy may be downloaded, includes in a written notice the ECAs that the Hospital intends to initiate to obtain payment for the care and the deadline (for submitting an Application) after which such ECAs may be initiated, and makes a reasonable effort to notify the patient orally about the Policy and above how to get assistance with the application process. The Hospital may provide a copy of the Policy, the Application, and the Plain Language Summary electronically and will also make available paper copies of these documents upon request.

In the case of patients who have submitted an Application, the Hospital will be considered to have made a Reasonable Effort:

i. When the patient and/or family submits an incomplete Application, and the Hospital:
(a) suspends any ECAs against the patient;
(b) provides written notification that describes what additional information or documentation is needed to complete the application process and includes a Plain Language Summary; and
(c) if the Application is completed during the Application Period, the Hospital follows the Reasonable Efforts steps described below for a completed Application.

ii. When the patient and/or family submits a complete Application during the Application Period, and the Hospital:
(a) suspends any ECAs against the patient;
(b) timely makes and documents a determination as to whether the patient is eligible for Financial Assistance; and
(c) notifies the patient in writing of the eligibility determination (including, if applicable, the assistance for which the patient is eligible) and the basis for this determination.

iii. When a patient and/or family has been determined to be eligible for Financial Assistance, if the Hospital:
(a) in the case of a patient determined to be eligible for Financial Assistance other than free care, provides the patient with a billing statement that indicates (i) the amount owed after subtracting Financial Assistance, (ii) how that amount was determined, and (iii) how the patient can get information on the AGB for the care;
(b) refunds any excess payments made by the patient; and
(c) takes all reasonably available measures to reverse any ECAs (other than the sale of a debt or a decision to delay or defer care for non-payment) taken against the patient.

IV. Eligibility Criteria

A. To be considered eligible for free care or care at a reduced rate, the patient or family must apply by completing the Application (*see* Appendix A) and providing supporting documentation.

B. Supporting documentation for the Application includes (as applicable): current pay stubs, bank statements, prior year's tax returns, a signed letter from employer, and Social Security or disability checks. Failure to provide any of these documents, if required by the Application, may result in a denial of Financial Assistance. Applicants will not be denied Financial Assistance based on their failure to provide information or documentation that this Policy or the Application does not explicitly require.

C. The decision to provide Financial Assistance will be based, at a minimum, on a review of the following specific criteria, which will be fully documented by the patient in the Application (subject to Section IV(E) below): income, assets and liabilities of the family at the date of service.

D. Hospital may, in its sole discretion, consider other extenuating criteria when determining the eligibility of a patient for Financial Assistance, including, but not limited to:

   i. size of patient's immediate family;
   ii. medical status of the patient's family's main provider(s);
   iii. employment status of patient or patient's guardians along with future earnings potential of the family's main provider(s);
   iv. the willingness of the family to work with the Hospital in accessing all possible sources of payment; and
   v. the amount and frequency of Hospital and other health care/medication related bills in relation to all other factors considered.

E. Due to a variety of circumstances, the supporting documentation necessary to demonstrate a patient's eligibility for Financial Assistance may not be available. The Hospital may, in its sole discretion, consider verbal and/or written attestations from the patient or the patient's family about the eligibility criteria.

F. To be eligible for Financial Assistance, the patient must be an Illinois resident. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy residency. Acceptable verification of Illinois residency may include valid state-issued ID card, utility bill, vehicle registration card, voter registration card or statement from a family member of uninsured patient who resides at the same address and presents verification of residency.

G. This Policy shall apply regardless of the patient's immigration status.

H. Children who reside in a foreign country are not eligible for Financial Assistance.

I. Applicants will not be denied Financial Assistance based on race, color, religion, sex, age, national origin, or marital status.

J. Any free or discounted care offered under this Policy is subject to review to ensure compliance with this Policy.

K. The necessity for medical treatment of any patient will be based on the clinical judgment of the healthcare provider without regard to the financial status of the patient and/or family. All patients will be treated for emergency medical conditions (within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd)) without discrimination and regardless of their ability to pay or eligibility for free or discounted care.

L. Applications for Financial Assistance and/or new information as to the factors used to evaluate applications for Financial Assistance (such as a change in family size or income), will be accepted and/or evaluated at any time during the Application Period. It is understood that financial hardship can arise after the date of service. Regardless of the timing of the onset of financial hardship, individual circumstances will be evaluated in any request for Financial Assistance that is properly submitted during the application period

M. Families with Family Incomes exceeding the eligibility criteria guidelines stated above can apply to and be screened by Hospital for payment plan consideration.

N. When a determination of eligibility for Financial Assistance has been made, all accounts of patients within the same family shall be handled in the same manner for care provided for six months following the date of such determination, without the need for completing a new Application. Discounts will be applied to all open self-pay balances. A new Application will be required for care provided more than six months after the initial (or other prior) determination or if indications are received that the financial status of the patient or family has significantly changed from the initial evaluation period.

O. Exceptions to the above criteria may be made only with the approval of the Council.

[_____]

V. Presumptive Eligibility

The list below is representative of circumstances under which a patient is deemed to be presumptively eligible for a 100 percent reduction (i.e., free care for emergency or other medically necessary services) upon providing Hospital with (1) an attestation by the patient or his/her legal guardian or representative of the patient's satisfaction of one or more of these criteria and/or (2) documentation of his/her participation in one or more of these programs and any other reasonable documentation requested by the Hospital (to the extent applicable):

i. Participation in state funded prescription programs;
ii. Participation in Women's Infants, and Children's Programs (WIC), Supplemental Nutrition Assistance Program (SNAP), Illinois Free Lunch and Breakfast Program, Low Income Home Energy Assistance Program (LIHEAP), or a recipient of grant assistance for medical services;
iii. Patient receiving medical care from an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership.
iv. Patient states that he/she is homeless;
v. Low income/subsidized housing is provided as a valid address;
vi. Mental incapacitation with no one to act on patient's behalf;
vii. Deceased with no estate; or
viii. Medicaid eligibility, but not on date of service or for non-covered service.

VI. Calculation of Free or Discounted Care

A. The Hospital will limit amounts charged to patients eligible under this Policy to not more than AGB or the amounts set forth in the chart found in Section VI.C. below (whichever is less). A billing statement issued by Hospital to the patient/family who is eligible for Financial Assistance may state the gross charges for the patient's care and apply contractual allowances, discounts, or deductions to the gross charges, provided that the actual amount that the individual is personally responsible for paying is the lessor of the AGB or the amount set forth in Section VI.C

B. The levels of Financial Assistance provided by the Hospital are based on Family Income and FPG. FPG updates are generally published annually and the Hospital updates its policies with the most recently released Federal poverty guidelines (see Appendix A).

[_____]

C. The discount amounts or free care are calculated as shown below:

Add

Family Income as % FPG	% Family Obligation	Lurie Children's Charity %
0-300	0%	100%
301-325	20.00%	80.00%
326-350	40.00%	60.00%
351-375	60.00%	40.00%
376-400	80.00%	20.00%
>400	100.00%	0.00%

The Hospital additionally calculates 135% of Cost as Calculated in Medicare Cost Report Worksheet C whenever Financial Assistance is considered. The Hospital will then adjust the Family's liability by the discount calculation that is most beneficial to the patient.

D. In situations whereby the patient is uninsured and the Family Income is between 400% and 600% of the FPG (and Financial Assistance is not otherwise provided under this Policy in the form of free or discounted care), the patient will be responsible for 135% of costs as calculated in the Medicare Cost Report – Worksheet C. In addition, the maximum amount that may be required (for health care services provided by the Hospital) from a patient determined by the Hospital to the eligible under this paragraph (D) is 25% of the patient's Family Income and is subject to patients' continued eligibility under this Policy.

E. A patient who qualifies for Financial Assistance under this Policy is considered to be "charged" only the amount that the patient is personally responsible for paying to Hospital for his/her medical services, taking into account all deductions and discounts applied and any amounts reimbursed by insurers.

F. The Hospital's Extended Non Payment Plan Program offers payment arrangements for qualifying patients who may be unable to pay the balance at one time.

VII. Guidelines for Hospital's Consideration of Specialty Services

A. Decisions to provide certain high-cost specialized services, such as organ transplants or behavioral health treatment, when patients and their families are in need of Financial Assistance, will be made upon the recommendation of the applicable specialty service administrator and approval by the Council. The applicable specialty service administrator and the Council will consult with physicians and management in evaluating all relevant clinical, ethical, and financial factors.

B. The Council may also consult with an ethicist. Financial Assistance for such specialized services will be provided only in rare circumstances and only if the Hospital's Financial Assistance budget permits. The Hospital recognizes and acknowledges its obligation to provide its share of these services to patients without the means to pay for them. The Hospital further recognizes that it must maintain sufficient funds to enable it to meet its overall responsibilities to serve the health care needs of the pediatric community.

C. To convene the Council, the clinician who is recommending a particular patient treatment that requires consideration under this Section VII should contact the specialty service administrator. The specialty service administrator will assist in preparing an information package and arranging a Council meeting to review an Application.

D. The patient and/or patient's family has the right to appeal the Hospital's denial of Financial Assistance. The appeal must be submitted in writing with 30 days of notification of the original denial. The Council will consider all patient and/or family appeals. The decision of the Council on any such appeal will be final and binding on all parties.

VIII. Applying For Financial Assistance

A. *How to Apply:* Patients and families wishing to apply for Financial Assistance may complete an Application and submit it, along with supporting documentation, to the Admitting/Business office.

For questions about this Policy, the Application and/or the application process, please contact the Admitting/Business office:

Admitting/Business Office
Ann & Robert H. Lurie Children's Hospital of Chicago
225 East Chicago Avenue
12th Floor
Chicago, Illinois 60611
(877) 924-8200

B. *Completed Applications:* A written decision regarding eligibility will be provided to the patient and/or family within 30 business days of receipt of a completed Application. This notification will also include the Financial Assistance percentage amount (for approved Applications) or reason(s) for denial, the basis for determination, and the estimated amount of payment expected from the patient and/or the patient's family.

The patient and/or patient's family will continue to receive billing statements during the evaluation of a completed Application or applications for other third party sources of payment (e.g., Medicare, Medicaid). However, Hospital will suspend all ECAs against the patient during the evaluation period. If the account has already been placed with a collection agency, the agency will be notified by the Hospital to suspend collection efforts until an eligibility determination is made.

C. *Incomplete Applications:* If the patient and/or family member submits an incomplete Application, the Hospital will (a) suspend any ECAs against the patient; (b) provide a written notification that describes what additional information or documentation is needed to complete the Application and includes the Plain Language Summary; and (c) provide at least one written notice informing the patient about the ECAs that might be taken (or resumed) if the Application is not completed nor payment made by a deadline specified in the written notice, which shall be no earlier than the later of 30 days from the date of the written notice or the last day of the Application Period.

[_____]

D. *Other Implications of Eligibility Determination*: If the patient is determined to be eligible for Financial Assistance, Hospital will: (1) refund to the patient any amount he or she has paid for the care covered under the application period that exceeds the amount he or she is determined to be personally responsible for paying as an individual eligible for Financial Assistance under this Policy, unless such excess amount is less than $5.00 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin), and, (2) to the extent applicable, take reasonable measures to vacate any judgment against the individual, lift any levy or lien on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau, and take any other reasonable measures to vacate or reverse an ECA taken by the Hospital against the patient.

IX. Notification

A. To make our patients, families and the broader community aware of the Hospital's Financial Assistance program, the Hospital shall take a number of steps to widely publicize this Policy to the Hospital's patients and to the community members who are served by the Hospital, including:

i. Posting of conspicuous signage (that notifies patients of the Policy) in heavily trafficked patient areas such as admitting, emergency department and ambulatory registration areas, and where appropriate, such signage (or other signage located near the aforementioned signage) will state in capital letters "IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE";
ii. Offering pamphlets and brochures (including the Plain Language Summary) to patient and/or their families during the admission and/or discharge process;
iii. Offering patient and family counseling sessions with registrars, patient accounting staff, or financial counselors either before, during or after the time of service, as appropriate;
iv. Providing information about this Policy on the Hospital's website, including a complete copy of the Policy, Application and a Plain Language Summary of the Policy in a widely available format (for example, as a PDF document);
v. Providing individuals who ask how to access a copy of the Policy online with the direct Web site address, or URL, of the Web page where the Policy is posted;

vi. Providing conspicuous written notice on billing statements of the availability of financial assistance under the Hospital's Policy, including a telephone number of the hospital office or department where information can be found about the Policy and Application process and the direct website address where copies of the Policy, Application form and Plain Language Summary of the Policy may be obtained;

vii. Offering a copy of the Application before the patient is discharged from the Hospital;

viii. Informing patients about the Hospital's Policy during appropriate oral communications regarding the patient's financial responsibility for an outstanding bill;

ix. Providing at least one written notice to the patient or the patient's family stating what ECAs the Hospital may take if no Application is received or no payments are made by a specified date (at least as long as Notification Period) and this notice is provided at least 30 days before the applicable deadline; and

x. Disseminating information about the Policy and how to apply for Financial Assistance (including copies of the Policy, Plain Language Summary and Application) to various community agencies who also serve individuals who may have need for medical services and who are most likely to require financial assistance.

As described above, these documents are also available electronically and paper copies are available upon request and without charge, both by mail and in public locations in the Hospital, including, at a minimum, in the emergency room and admissions areas.

B. All printed information and/or forms regarding the Financial Assistance program will be available in primary languages spoken by significant populations we serve in accordance with state and federal law. Currently, these languages are Spanish, Polish, Cantonese, Tagalog, and Arabic.

C. Printed copies of this Policy (including the Application), the Plain Language Summary, and the Hospital's Collections Policy may be obtained in person or by mail at no extra cost by visiting or calling the Hospital's Admitting/Business Office at:

Ann & Robert H. Lurie Children's Hospital of Chicago
225 East Chicago Avenue
12th Floor
Chicago, Illinois 60611
(877) 924-8200

X. Reporting Requirements

At the request of the Illinois Office of the Auditor General's office, the Hospital will annually report information regarding the number of Applications completed and approved, the number of Applications completed and not approved, and the number of Applications started but not completed.

XI. Cross-References/Related Policies

A. Administrative Policies: Collections
B. Administrative Policies: Uninsured Patient Act
C. Administrative Policies: EMTALA

XII. Authorizations

The decision to provide charity care and Financial Assistance, as outlined herein, requires the approval of the following individuals:

Accounts below $5,000: Patient Financial Services Liaison

Accounts $5,000 to $25,000:	Above, plus Manager or Lead
Accounts $25,000 to $50,000:	Above, plus Director of Patient Financial Services
All Accounts over $50,000: High Cost Specialized or	Above, plus Vice President of Revenue Cycle

[_____]

Elective Services or Exceptions: The Council

XI. Regulatory Requirements.

In implementing this Policy, the Hospital will comply with all other federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this Policy.

Date Written:	1/1/1992	
Date Reviewed/Revised:	11/9/2001, 10/6/2003, 11/15/2004, 4/13/2005, 8/30/2005, 2/8/2006, 1/29/2007, 11/5/2007, 2/4/2008, 8/15/2010, 02-24-2015	
Date of Approvals:	Administrative P&P Committee:	11/15/2004, 1/29/2007, 11/5/2007, 2/4/2008, 9/1/2010
	Hospital Operations Committee:	11/28/2001, 11/5/2003, 12/1/2004, 4/13/2005
	MAAC:	1/19/2005, 3/30/2005
	Quality Council:	12/3/2001
	Medical Board:	12/11/2001
	QMPS Committee of the Board:	12/20/2001
	Finance Committee of the Board:	8/19/2010
	Finance Committee of the Board:	8/14/2013