	Policies & Procedures **Financial Assistance**	Function: Billing Number/Reference: Date of Prior Issue: 10/15 Effective Date: Reviewed:

PURPOSE:

The purpose of this policy is to further the charitable mission of Chadron Community Hospital (the "Hospital") by providing a fair and comprehensive system of distributing free or discounted medical care to financially disadvantaged and other qualified patients within the available resources of the Hospital, within the requirements of the Internal Revenue Code, and implementing regulations. The Policy addresses:

- The scope of services available for financial assistance
- Eligibility criteria for financial assistance
- The extent to which financial assistance includes free or discounted care
- The basis for calculating amounts charged to individuals who are eligible for assistance under this Policy
- The method for applying for assistance
- Measures to widely publicize the Policy

RESPONSIBILITY:

It is the responsibility of the Hospital Board of Directors to ensure this Policy is being administered and carried out in a consistent manner and within the guidelines set forth in controlling laws and regulations.

SCOPE:

This Policy applies to all emergency and medically necessary inpatient and outpatient hospital services including services at Hospital-owned Rural Health Clinic, Home Health and Hospice, Dialysis, and other departments of the Hospital. Individuals will be considered under this policy who are uninsured, underinsured, and individuals who qualify for assistance in accordance with the terms and conditions herein.

CATEGORIES OF CARE ELIGIBLE FOR FINANCIAL ASSISTANCE

The following categories of care are eligible for financial assistance under this policy:

Emergency medical care

Medically Necessary Care

It does not apply to any service deemed non-medically necessary or cosmetic in nature. The Hospital reserves the right to determine those procedures that qualify as eligible medically necessary elective procedures.

COVERED PROVIDERS

Care provided by the Hospital and Hospital-employed physicians and practitioners is covered under this Policy. Contracted providers that provide a service performed in the Emergency Room and billed through the Hospital is a covered service.

Care provided by independent community physicians and other independent service providers is not subject to this policy. Accordingly, this Policy does not apply to any services that are not Hospital-owned such as the Chadron Medical Clinic, Radiology Imaging, visiting Specialty Providers, or other providers that are not the Hospital or Hospital-owned.

Patients may obtain a current list of providers who are subject to this policy at no charge by visiting the Business Office, calling 308-432-5586 and ask for the Business Office, or visiting www.ChadronHospital.com.

The current list of covered providers is all encompassed under Chadron Community Hospital. This policy also covers any services provided at Hospital-owned Rural Health Clinic (Legend Buttes Health Services).

ELIGIBLITY CRITERIA

Patients may be eligible for financial assistance if they:

- Are uninsured or underinsured;
- Ineligible for any government health care benefit program;
- Are eligible for a State Medicaid program the Hospital is not contracted with and can prove eligibility;
- Demonstrate they have a financial need as determined through the application process;
- Cooperate with the Hospital's policies and procedures; and
- Supply all required information to process the application.

Patients who may be eligible for Medicaid or other benefits are encouraged to apply for these benefits as these benefits will cover medical costs not provided by the Hospital, including prescription drugs.

DETERMINATION OF INCOME AND POVERTY LEVEL

A sliding fee scale based on the current year's US Department of Health and Human Services Poverty Guidelines will be used to determine the allowed discount. Guidelines may be found online at https://aspe.hhs.gov/poverty-guidelines.

Table 1. Patient's liability will be no more than the greater of % of Income and as limited by Amounts Generally Billed if patient qualifies:

Federal Poverty Level	% of Income
< or = 100%	0%
101%-200%	2%
201%-300%	5%
301%-400%	7.5%
401%-500%	10%
501%+	20%

DETERMINATION OF HOUSEHOLD SIZE

"Household" : A household is considered all individuals living together at the same residence, provided they have a legal (or have voluntarily accepted) responsibility for providing the necessities of life for each other. Temporary absences from the residence, such as attending schooling, military deployment, etc do not disqualify an individual from being counted as a member of the household. Hospital does not look for legal marital status when defining a household.

Children in joint or shared custody situations will be considered a member of the household providing the majority of the support for the child. If it is unclear who is providing the majority of the support, the child will be considered a member of the household in which he or she spends the majority of his/her time.

Independent adults that have chosen to share a residence with one or more other independent adults will generally be considered a single household without counting either the presence, or income of the other adults (i.e. two independent adults who share a residence to reduce costs, but do not represent themselves as a household or as a single family unit). Hospital generally relies on how individuals classify their relationship to determine household and does not discriminate based on sexual orientation.

"Household Income": The total income of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

For minors obtaining confidential services, discounts will be based on the income of the adolescent only. If they are an emancipated minor, their financial information will be handled as if they were an adult and the Hospital will request a completed application and associated supporting documents. For any other services for a minor, parent income will be used to determine discounts.

For patients over 19 years of age, including college students, claimed on their parent's tax returns, then the parent's income will be used to determine the discount. Parent information including tax returns and bank statements will be required with the application. For college students not included on their parent's taxes and who file their own tax returns, parent income will not be considered as part of the application process. All other patients over the age of 19 years old and emancipated minors will be required to complete the application and supply required documentation.

If a patient qualifies for a discount based on the DHHS Poverty Guidelines and is unable to pay for services for reasons such as other medical emergencies, natural disaster, or other justified reason, the Hospital will assess the need to adjust initial determination.

Income information will be obtained in a confidential manner.

ASSESSING INCOME LEVELS

For minors obtaining confidential services, the Hospital will inquire about income (job, allowance, etc.) and base the sliding fee discount on their information. They will be asked to pay at the time of service to avoid billing to their home address. If they are unable to pay at the time of service and they do not file taxes, the discount will fall within the highest discount available and the account with be written off to charity care.

For all other patients, they will be required to complete the Financial Assistance application along with the required documentation which includes two years of tax filings, three months of bank statements, and three months of pay stubs if the patient is working. Information will also be required for all persons residing in the household if the patient is cohabitating with a spouse, partner, or other family member.

Definition of Income

Income is total annual income before taxes (gross) from all sources. Income includes:

Wages and salaries before any deductions, but does not include food or rent in lieu of wages. Net receipts from non-farm or farm self-employment (receipts from a person's own business or farm, after deductions for business or farm expenses.)

Regular payments from social security, railroad retirement, unemployment compensation, workers' compensation, strike benefits from union funds, veteran's benefits, and public assistance including Aid to Families with Dependent Children (ADC), Supplement Security Income (SSI), and general assistance, training stipends, alimony, child support and military family allotments or other regular support from an absent family member or someone not living in the household. Private pensions, regular insurance or annuity payments, and income from dividends, interest, rent, royalties or periodic receipts from estates or trusts.

Income does not include:

Capital gains, any assets drawn down as withdrawals from a bank, the sale of property, a house, a car, tax refunds, gifts, lump-sum inheritances, one-time insurance payments or compensation for injury.

Non-cash benefits such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits.

Food or rent received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied non-farm or farm housing, and such Federal programs as Medicaid, Supplemental Nutrition Assistance Program (SNAP) or public housing.

Presumptive Eligibility

If a patient fails to submit an application for financial assistance or fails to supply sufficient information to support eligibility, Chadron Community Hospital may refer to external sources to determine possible eligibility when:

- patient is homeless
- patient is eligible for supplemental nutrition or utility assistance
- patient is eligible for Medicaid coverage prospectively
- patient is eligible for Medicaid but some services are not covered
- patient is eligible for Medicaid in another state
- patient is deceased and estate search does not find any results
- patient has filed for bankruptcy
- other situations as evaluated by Hospital Staff

Hospital may also use previous financial assistance eligibility determinations and patient circumstances as a basis for determining eligibility in the event that the patient does not provide sufficient documentation to support an eligibility determination.

LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED

Patients who are deemed to be eligible for financial assistance under this policy will not be charged for care covered by this policy more than Amounts Generally Billed by the Hospital to individuals who have health insurance covering such care. Discounts granted to eligible patients under this policy will be taken from gross charges.

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. Please refer to Appendix A to see the current AGB percentage and the method by which it is calculated.

The Hospital calculates its AGB Percentage on an annual basis at the end of each fiscal year. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.

APPLICATION PROCESS AND DETERMINATION

Patients may obtain a copy of this policy, a plain language summary of this Policy, and a financial assistance application free of charge

- by mail by calling the Business Office at 308-432-5586
- by email (upon patient election) by emailing Billing@ChadronHospital.com
- by download from www.ChadronHospital.com or
- in person at
  - emergency room
  - any admission area
  - Business Office at 825 Centennial Dr., Chadron, NE
  - Legend Buttes Health Services at 11 Paddock St., Crawford, NE

Patients who believe they may qualify for financial assistance under this policy are required to submit a completed Hospital Financial Assistance application form. It is the applicant's responsibility to provide proof of Household Income (the total income of all members living in the individual household) and/or any other information provided on the application as requested by the Hospital.

Patients may apply for financial assistance at any time there is an open balance. If financial assistance is approved and a payment plan is established for any outstanding balances, a verification of information will be required on a semi-annual basis until the balance is paid in full.

Requests for financial assistance will be accepted from any source. If the Hospital becomes aware of factors which might qualify the patient for financial assistance under this Policy, it will advise the patient of this potential and make an initial determination.

The applicant is required to submit all information required on the Financial Assistance application form including, but not limited to, the following information:

- W-2 forms for each member of the household
- Previous two years income tax returns for all members of the household
- Three months most current employment stubs for all members of the household
- Three months most current bank statements for all members of the household

Applicants must provide proof they are not covered/eligible for Nebraska Medicaid. If the patient has commercial insurance or Medicare, the hospital must make a claim against this insurance to determine balance on the account.

Completed Application

Upon receipt of a completed application, the Hospital will suspend any collection actions taken against the patient and process, review and make a determination on the completed financial assistance application. Initial review of a patient's application and recommendation for approval for financial assistance shall be the responsibility of appropriate Hospital personnel. It shall be this person's/people's responsibility to assure all information is complete, all hospital accounts are compiled and documented, and any possible insurer has been billed and processed.

Determination of eligibility for financial assistance will be made based on the information provided by the patient, this Hospital policy, and the sliding fee scale. The compiled information will be given to the Revenue Cycle Director for approval. Special cases will be taken before the Board of Directors and the Hospital CEO for review and approval.

Unless otherwise delayed as set forth herein, such determinations shall be made within 30 days of submission of a timely completed application. Patients will be notified of the Hospitals determination by mail. If a patient is approved for a partial discount, the patient will be notified of the amount of the discount and any remaining balance. The patient will be billed for the outstanding balance. If the patient is approved for a 100% discount, the patient will be notified and the account written-off to charity care status. No bill will be sent to the patient. If the patient was not approved for any discount, the patient will be notified as to this determination and the reasons why it was not approved.

If there is a remaining balance after determination and the patient has not made a payment, the account will be turned over for further collection actions according to the Hospital's Collection Actions policy.

The Hospital will not consider an application incomplete or deny Financial Assistance based upon the failure to provide any information that was not requested in the application or accompanying instructions. The Hospital may take into account in its determination (and in determining whether the patient's application is complete) information provided by the patient other than in the application.

No Application Submitted

If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and
2. Provides at least thirty (30) days' notice to the patient that:
    - Notifies the patient of the availability of financial assistance;
    - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and
    - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;
3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and

4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

Incomplete Application

Failure to provide this information will result in an incomplete application. Incomplete applications will not be processed by the Hospital. If a patient submits an incomplete application, the Hospital will suspend collection actions and provide the patient with written notice requesting the additional information or documentation required to complete the application. The written notice will include instructions on what information is missing, a deadline to produce the missing information of at least 30 days from the date of notice, and the Hospital contact information.

COLLECTION ACTIONS

Patients will be provided a plain language summary of the financial assistance policy upon admission to the Hospital. Furthermore, all billing statements will include a conspicuous written notice regarding the availability of assistance, including the contact information identifying where the patient may obtain further information and financial assistance-related documents and the website where such documents may be found.

The Hospital or its authorized representatives may refer a patient's bill to a third party collection agency or take any or all of the following extraordinary collection actions ("ECAs") in the event of non-payment of outstanding bills:

- Reporting to credit bureaus
- Legal suit
- Selling the account to a third party
- Garnishment of wages

The Hospital may refer a patient's bill to a collection agency 120 days from the date the first bill for care was provided to the patient. The Hospital will not take ECAs against a patient or any other individual who has accepted or is required to accept financial responsibility for a patient unless and until the Hospital has made "reasonable efforts" to determine whether the patient is eligible for financial assistance under this policy. Patient Financial Counseling is responsible to determine whether the Hospital has engaged in reasonable efforts to determine whether a patient is eligible for financial assistance.

For questions and/or assistance with filling out the Financial Assistance application, the patient may contact the Hospital Business Office by phone at 308-432-5586, by email at Billing@ChadronHospital.com, or in person at 825 Centennial Dr., Chadron, NE.

Appendix A

Calculation of Amounts Generally Billed

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Hospital determines its AGB utilizing the method detailed below.

Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is the Hospital's gross charges multiplied by the AGB Percentage. The AGB Percentage is calculated by dividing the total of all claims allowed by health insurers during the prior 12-month period by the total gross charges for those claims. Claims are considered to be "allowed" not based upon when the care was provided, but when the insurer determines the allowable amount of the claim. The amount "allowed" includes the amount the insurer will pay plus the amount for which the individual is personally responsible (including co-pays and deductibles). Allowed claims are included in the AGB Percentage calculation regardless of whether they have been paid or collected. "Health insurers" for purposes of this definition are Medicare fee-for-service and all private health insurers.

The Hospital's current AGB Percentage is 69.8%.

The Hospital calculates its AGB Percentage on an annual basis at the end of each fiscal year. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by the Hospital to calculate the AGB Percentage.