Steward Health Care System	**Charity Care Financial Assistance** **Chapter: Finance** **Policy Number: FIN 27** **Origination Date: 12/15/2020** **Last Revised: 3/16/2021**

Policy

Steward Healthcare provides financial assistance to patients without financial means to pay for emergency and other medically necessary care at a discounted rate on hospital charges if a patient/family gross income does not exceed 200% the Federal Poverty Guidelines (FPG).

Financial Assistance will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent according to the hospital's eligibility criteria.

All individuals presenting on hospital property requesting emergency medical services, individuals presenting to a Dedicated Emergency Department requesting medical services, and patients arriving/presenting via ambulance requesting medical services shall receive an appropriate Medical Screening Examination and Stabilization services as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395 and all Federal regulations and interpretative guidelines promulgated thereunder.

Approval of charity care is based on need and requires CFO and Business Office Director signatures regardless of the dollar amount as shown on the financial assistance approval worksheet. Approved Charity Accounts should be written off once all appropriate documentation and signatures have been obtained according to this policy.

This policy is in effect for dates of service on or after 01/01/2021. Any charity care program in effect prior to this enterprise policy will be honored for the approved coverage period.

Purpose

In order to better serve the health care needs of our community, this policy establishes a framework pursuant to which Steward hospitals will properly identify patients that may qualify for Financial Assistance with their medical expenses under the guidelines and requirements set forth below.

Definitions

Federal Poverty Guidelines (FPG): A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits such as health insurance and/or financial assistance.

Family: Includes the patient, the patient's spouse or legal partner, and all the patient's children, natural or adopted, under the age of 18. If the patient is under the age of 18 (defined as a "minor"), the family shall include the patient, the patient's natural or adoptive parent(s) and the patient's children, natural or adopted under the age of 18. Under age 18 patient's living parents must be counted as part of the patient's "family" regardless of whether they live in that patient's home. Any patient 18 years or over is considered the basis for his/her own "family".

Financially Indigent: Person who is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

Members of Household: The number of family members living in their household used to calculate yearly income. Calculations will differ between adults and minors. Adults: Include the patient, the patient's spouse, and any dependents. Minors: Include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father. Emancipated minors will be considered adults for purposes of defining members of household.

In cases where members of household are not clearly defined, refer to prior year income tax filing.

Emancipated Minor: A minor with the functional ability to make informed health care decisions in accordance with relevant state law. Refer to state guidance for more detail.

Proof of Income: Total salaries, wages, and cash receipts before taxes. If the patient/applicant reports zero income, the patient/applicant will be required to report on the application how the patient/applicant and his/her family are surviving.

Procedure

A. Program Qualifications

1. Individual or family has gross income at or below 200% of current Federal Poverty Guidelines (FPG).
2. Not be a Medicaid recipient

B. Program Exclusions

1. Elective services
2. Physician services
3. Transplant services
4. Ambulance services
5. Patient convenience items (parking, telephone, television, etc)

C. Eligibility

1. All applicants applying for financial assistance must first be screened for Medicaid coverage and must cooperate in supplying information regarding other available medical benefits, potential sources of third- party coverage such as automobile insurance, government aid programs and financial assistance available under any contracts.

D. Eligibility Qualifications

1. Financially Indigent: Total household income at or below 200% of the current Federal Poverty Guidelines (FPG).

2. Presumptive:
    a. Patients covered by Out of State Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider (Medicaid coverage verification required). No other documents will be required in order to approve the financial assistance application. The patient will not be required to make a formal financial assistance/charity application. The hospital may submit the application and verification of Medicaid coverage as proof of qualification.
    b. Medicaid patients who exhaust their benefits.
    c. Deceased patients with no known estate.
    d. Homelessness or receipt of care from a homeless clinic
3. Undocumented: Patient residing in the United States without legal immigration status.
4. Special Circumstances:
    a. Patient who has become totally disabled due to medical condition and will no longer have their past level of income OR
    b. Patient who is above income limits but has large medical bills due to catastrophic illness.
    c. In rare cases where the patient is unable to comply with the eligibility requirements, the hospital CFO will have the authority to review special circumstances and make determinations on eligibility.
    d. Other State and County Programs:
        - Steward Health Care recognizes that states and counties may have indigent care programs, and that these programs may or may not provide sufficient funding for health care services. Patients that have exhausted their benefits with active state and county programs will be considered as qualifying for Steward's charity care policy, subject to a review every six months to determine appropriateness of continued coverage under the FAP. A list of these programs can be found at: http://mysteward/C3/CCRPatientAccess/Charity Care.

E. Eligibility Exclusions

1. Third party coverage (auto/liability/work comp) for their medical bills.
2. Covered under governmental/state Medical Assistance programs (Medicare and Medicaid) that owes deductibles, coinsurance, and/or copayments or has a 'spend down' amount. *(Payment of deductibles, coinsurance, copayments and spend down amounts are a condition of coverage and should not be written off or discounted).*
3. Real estate ownership and overall assets valued in excess of the services could disqualify eligibility in some states.

F. Coverage

1. Discount determined based on patient's income and current Federal Poverty Guidelines (FPG). *(Published in the Federal Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication).*

Federal Poverty Level		Discount on Billed Charges
< 200%		100%
2021 Poverty Guidelines for the 48 Contiguous States and the District of Colombia		
# in Household	**Poverty Guideline**	**200% of Poverty Guideline**
1	$12,880	$25,769
2	$17,420	$34,840
3	$21,960	$43,920
4	$26,500	$53,000
5	$31,040	$62,080
6	$35,580	$71,160
7	$40,120	$80,240
8	$44,660	$89,320
For families/households with more than 8 persons, add $4,540 for each additional person.		

G. Application

1. See Financial Assistance Application Attachment

H. Documentation Requirements

Outlined below are all the documentation requirements needed to substantiate the decision to approve a patient for Charity Care.

1. Completed Financial Assistance application

   Message: An unsigned application can be deemed acceptable if the patient is physically unable to sign or does not live within the vicinity of the hospital or unable to return the application by mail. In these situation's only, the hospital representative should complete all questions on the application, sign it and document why the patient is unable to sign the application.

2. Proof of income:
    a. Prior year's income tax return OR
    b. Bank Statement for prior 3 months
    c. Last 4 check stubs
    d. IRS W-2 withholding forms
    e. Forms approving or denying social security, unemployment compensation or workers' compensation
    f. Written verification of wages from employer
3. Proof of expenses:
    a. Copy of mortgage payment or rental agreement
    b. Copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable, and cell phones)
    c. And all other medical bills
4. Other:
    a. A witnessed statement signed by the patient or responsible party
    b. A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.
5. Income will be calculated by:
    a. Multiplying by four the individual's or family's income, as applicable for the three months preceding the date hospital services were provided or
    b. Using the individual's or family's income, as applicable for the twelve months preceding the date hospital services were provided.

I. Determination

1. Time Frame: Determination of eligibility to be made by the designated Charity Care Enrollment resource within 10 working days after receipt of all necessary information.
2. Effective Dates:
    a. Outpatient: Will be made effective for the initial date of service applied and applicable for 90 days following that initial date of service.
    b. Inpatient: Will be made effective for admit date through discharge date however a new application is required for each admission thereafter unless readmitted within 45 days. IP application can be used to cover related OP services in the 90-day period immediately

following the 1st day of the covered IP admission. Retro eligibility will be provided for 90 days prior to the date of service for both Inpatient and Outpatient.

3. *Message: Hospital has option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to.*

J. Facility Actions

1. Medicaid Eligibility Team will screen for Medicaid.
    a. If patient is deemed not eligible, the Medicaid Eligibility Coordinator will provide the patient with the ***Financial Assistance Application*** to complete and pass to the Charity Care Enrollment Resource upon completion. *If Medicaid Eligibility is handled by a vendor, said vendor will not screen for charity.*
2. If the Financial Application is incomplete, it will be the responsibility of the Charity Care Enrollment Resource to make 2 attempts to contact the patient via mail or phone to obtain the required information.
    a. Applications that remain incomplete after 30 calendar days of 'request of information' will be closed/denied and only can be reopened/reconsidered at CFO discretion.
3. Charity Care Enrollment Resource will gather and scan all required documentation for the application into designated file location for review. Insurance mnemonic ***CHARITYPND-Charity Pending*** will be assigned until approval determination made.
4. Facility CFO will review and if approved designate that approval by signing and returning the completed application or noting their approval directly in Meditech.
5. Charity Care Enrollment Team will run report based off Insurance mnemonic ***CHARITYPND-Charity Pending*** and screen accounts for determination and populate ***Financial Assistance Determination Worksheet*** accordingly.

K. Approved

1. Charity Care Enrollment Resource will generate letter sent to the patient notifying them that they do qualify and verifying which balances/dates of services are being covered under the Charity Care Application. *Reference Financial Assistance Decision Determination Letter- Approved.*
2. Charity Care Enrollment Resource will update Insurance Mnemonic to ***CHARITY – Charity***.
3. Charity Care Enrollment Resource will notify any vendor who may be working the account to cease all collection efforts on the account.
4. Charity Care Enrollment Resource (prior to taking Charity Care adjustments), will review all patient's qualifying accounts with open balances remaining (up to 90 days prior to the approved service date) to ensure any previous uninsured/self-pay discounts have been reversed so charity care discount can be applied properly.

L. Denied

1. Charity Care Enrollment Resource will notify Financial Counselors of any patient that does not quality and letters will be sent to the patient notifying them that they do not qualify. *Reference Financial Assistance Decision Determination Letter- Denied.*
    a. Patients do have the ability to appeal the determination in writing by providing information on the reason for the appeal and any relevant information. Appeal letter must be received within 30 calendar days from the date of the determination letter. Disputes and appeals may be filed directly to the facility CFO who ultimately will make determination to overturn or not. *Reference Financial Assistance Appeal Dispute Form.*
2. Charity Care Enrollment Resource will update insurance mnemonic to SP- Self Pay thus reflecting the facility self-pay discount rate and signaling generation of patient statements.

Attachments

1. Financial Assistance Application
2. Financial Assistance Determination Worksheet
3. Financial Assistance Decision Determination Letters (Approved/Denied)
4. Financial Assistance Appeal/Dispute Form

References

Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395

Review and Approval

The following Steward Health Care System personnel originated and approved this policy:

Date	Contact	Approved By	Description
12/15/2020	Patient Access Director	Revenue Operations Directors, VP of Reimbursement and Divisional CFOs, Steward Clinical Excellence Committee	New policy **Effective Date 1/1/2021**
12/31/2020	Patient Access Director	Steward Chief Financial Officer, Steward VP of Reimbursement, Steward Clinical Excellence Committee	Added #D4c for Other State and Country Programs. Added State Appendix for Texas. **These changes are effective 1/1/2021.**

3/16/2021	Patient Access Director	Steward Chief Financial Officer, Steward VP of Reimbursement, Steward Clinical Excellence Committee	Removed patient residency requirement. Added definitions for Household Member and Emancipated Minor. Added that under special circumstances CFO can review and make determination if eligibility requirements not met. Updated 2021 poverty guideline amounts and added 200% poverty guidelines. Replaced CBO/PFS with designated Charity Care Enrollment resource. Updated Attachment 2 to include 2021 federal poverty guidelines. Removed Texas Appendix.

Please note, this policy will be reviewed annually and updated for revised Federal Poverty Guidelines.

Financial Assistance Application
(Hospital Name)

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION	**PARENT/GUARANTOR/SPOUSE** ***Complete if patient is under age of 18 or has designated legal guardian****
Name_____	Name_____
Address_____	Address_____
City_____	City_____
State/Zip_____	State/Zip_____
Best Contact # _____	Best Contact # _____
SS#_____	SS#_____
Employer_____	Employer_____
Employer Address_____	Employer Address_____
Employer City_____	Employer City_____
Employer State/Zip_____	Employer State/Zip_____
Work Phone_____	Work Phone_____
Length of Employment_____	Length of Employment_____
Supervisors Name _____	Supervisors Name _____

A. Income: Please provide the income for each of the following persons in your household.

Patient/Guarantor:	**Spouse/Second Parent:**
Wages $_____ Hr/ Wk/ Month/Year	Wages $_____ Hr/ Wk/ Month/Year
Other Income	Other Income
Child Support: $_____	Child Support: $_____
VA Benefits: $_____	VA Benefits: $_____
Workers' Comp: $_____	Workers' Comp: $_____
SSI: $_____	SSI: $_____
Other: $_____	Other: $_____

Total Yearly Family Income $_____

B. Living Arrangements: Please provide number of persons in the household. _____

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment $_____

C. Income Verification: Please provide the following documentation to verify your income:

IRS Form W-2	Written Employer Verification
Paycheck Remittance (Last 4)	Proof of Participation in or Denial from Governmental Assistance programs
Tax Return (Prior Year)	Bank Statements (Prior 3 months)
Social Security, Workers' Comp or Unemployment Compensation Determination Letter	

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

_____

_____

D. Other Resources: Please provide the total amount of other resources available to you.

Checking: _____	Vehicle 1: Yr_____ Make_____ Model_____
Savings: _____	Vehicle 2: Yr_____ Make_____ Model_____
Cash on hand: $_____	Vehicle 3: Yr_____ Make_____ Model_____

E. Expenses: Please provide the following types of documentation to prove your expenses:

Copy of mortgage payment or rental agreement

Copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones)

All other medical bills

F. Attestation:

I understand the hospital may verify the financial information contained in this Financial Assistance Application in connection with The Hospital's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize The Hospital to request reports from credit reporting agencies and the Social Security Administration. I am aware that falsification of information on this Application may result in denial of financial assistance.

_____ _____ Date

Signature of Patient or Responsible Party

_____ _____ Date

Hospital Employee Signature

Financial Assistance Determination Worksheet
(Office use only)

Steward Health Care System

Patient Name: _____

Account Number(s): _____

Total Yearly Income: _____ Total Combined Charges: _____

Number in Household: _____

Circle type of documentation or income verification provided:	
1	IRS Form W-2, Wage and Earnings Statement
2	Paycheck Remittance
3	Tax Return
4	Social Security, Work Comp or Unempl Comp Letter
5	Government Program
6	Written verification by employer
7	Bank Statements
8	Written Attestation (Patient signed Assistance Application verifying Total Yearly Income)
9	Verbal Attestation (Patient verbally verified Total Yearly Income)
10	Patient Deceased
11	Other

Circle appropriate answer in response to the following question:	
Is Total Yearly Income within the Federal Poverty Guidelines (FPG)? *Reference Schedule A*	
YES	Approved for 100% percent financial assistance as Financially Indigent
YES	Approved for 100% percent financial assistance as Presumptive
YES	Approved for 100% percent financial assistance as Undocumented
YES	Approved for 100% percent financial assistance as Special Circumstance
NO	Does not qualify for assistance

The below signatures are indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Financial Assistance Write-Off:

BOM_____ Date _____

CEO_____ Date _____

CFO_____ Date _____

Schedule A: Federal Poverty Guidelines		
(Published in the Federal Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication).		
Federal Poverty Level	**Discount on Billed Charges**	
< 200%	100%	
2021 Poverty Guidelines for the 48 Contiguous States and the District of Colombia		
# in Household	**Poverty Guideline**	**200 % of Poverty Guideline**
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6	$35,580	$71,160
7	$40,120	$80,240
8	$44,660	$89,320
For families/households with more than 8 persons, add $4,540 for each additional person.		

DATE

Patient Name:
Address:

Steward Health Care System

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and are pleased to inform you that you have been approved for **100%** financial assistance**,** for the below mentioned accounts:

Account #	Date of Service	Amount Approved

Should you have any questions or concerns regarding your financial application, please do not hesitate to contact me.

Sincerely,
Your Name
Vendor Management, CBO
2375 N Glenville Drive, Building B
Richardson, TX 75082
Phone: **Your Phone Number**

DATE

Patient Name:
Address:

Steward Health Care System

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and unfortunately at this time, assistance has been denied. The reason for denial is: **Insert specific brief explanation**.

You have the right to appeal this decision. Should you choose to appeal this decision, you must complete the attached Appeal/Dispute Form and address the written appeal within 30 calendar days from the date of this determination letter to:

Insert Name of Designated Person

If you have any questions or concerns regarding this notification or your financial application, please do not hesitate to contact me.

Sincerely,
Your Name
Vendor Management, CBO
2375 N Glenville Drive, Building B
Richardson, TX 75082
Phone: **Your Phone Number**

Steward
Steward Health Care System

Financial Assistance Appeal Dispute Form

Patient Name: _____

Account Number(s): _____

Select Reason for Appeal:

_____ Additional Documentation to Provide (Please provide copy of additional documentation with this form)

_____ Change in Financial Situation (Provide supporting documentation & detailed explanation below)

_____ Other

Detailed Explanation: _____
_____
_____
_____
_____
_____
_____
_____

Date Completed: _____

Patient or Designated Representative Signature:

_____