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Approved: Debra Ridenour/Charles Wiley

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OVERVIEW

Harrison County Hospital has a tradition of serving the poor, the needy, and all who require health care services. In order to promote the health and well-being of the community served, individuals with limited financial resources shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon Federal Poverty guidelines. The need for financial assistance is based on income and may be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

Appropriate signage will be visible in the facility, specifically in patient intake areas, creating awareness for the financial assistance program and the assistance available. Information, such as brochures, will be included in patient services/information folders and/or in patient intake areas. The Financial Assistance Policy and Application is available on our website, www.hchin.org, under Important Information. Paper copies of the Financial Assistance Application are visually placed in the main registration areas, are handed out to all uninsured patients during registration, and publically advertised one time a year on the hospital's Facebook page. In addition each statement includes a contact phone number to request a copy of the Financial Assistance Application and/or Policy. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area.

The necessity for medical treatment for any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS / GUIDELINES / FORMS TO BE USED

Cover Letter for Application, Application, Authorization to Release Information	(Attachment # 1)
My Income was Below the Federal and State Filing Requirements Form	(Attachment # 2)
Request for Verification of Bank Accounts	(Attachment # 3)
Financial Assistance Worksheet For Hospital	(Attachment # 4)
Catastrophic Financial Assistance Worksheet – Hospital Only	(Attachment # 5)
Final Request for Documentation Letter	(Attachment # 6)
Denial Letter	(Attachment # 7)
Confirmation of Social Security Exemption	(Attachment # 8)
Final Determination of Eligibility Letter	(Attachment # 9)
Payment Plan Letter	(Attachment # 10)

I. DEFINITIONS

- A. **Available Financial Resources:** Include assets that are immediately available, cash and investments such as savings, checking as well as other investments.
- B. **Financial Assistance Committee:** A committee consisting of the Chief Financial Officer, Patient Accounts Manager, Business Office Coordinator, Financial Counselor and Patient Advocate, Designated Medicaid Eligibility Representative(s).

- C. Household: The patient, his/her spouse and his/her legal dependents according to the Internal Revenue Service rules. We reserve the right to require documentation but do not include income or assets of dependent age 18 or younger.**
- D. Presumptive Eligibility: When a patient is presumed to be eligible for financial assistance without being required to submit an application for financial assistance, based on factors such as being homeless, being eligible for federal, state or local assistance programs, (food stamps, federally subsidized school lunch program, low income or subsidized housing), or receiving free care from a community clinic.**

II. FINANCIAL ASSISTANCE GUIDELINES

- A. To be eligible for full financial assistance the household income must be at or below 200 percent of the current Federal Poverty Guidelines or be deemed to be presumptively eligible based on established criteria.**
- B. To be eligible for partial financial assistance (75 percent reduction of the patient portion of billed charges) a financially indigent patient's household income must be at or below 300 percent but more than 200 percent the Federal Poverty Guidelines.**
- C. Following the determination of eligibility for financial assistance you will not be charged more than the hospital's Amount Generally Billed (AGB) using the look back method. The hospital's AGB discount percentage is 66% and explanation of how it is calculated is available from the Finance department on request.**
- D. To be eligible for full or partial financial assistance an indigent patient must be a U. S. Citizen or in the country legally, and residing within either Harrison or Crawford County, Indiana or Meade County, Kentucky, or have an established relationship with a physician who is a member of the Harrison County Hospital medical staff. Patients' visits to Harrison County Hospital due to a medical emergency are eligible to apply for full or partial financial assistance, regardless of person's race, color, religion, sex, national origin, age, disability or genetic information.**
- E. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.**
- F. To be considered for financial assistance, the patient must cooperate with the designated hospital representatives to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as, Medicare, Medicaid, HIP, COBRA, QMB, etc. To be eligible for assistance, the patient must apply for available government coverage such as Medicare Part B. If the patient is denied financial assistance related to failure to cooperate with Harrison County Hospital or government/state guidelines, they must wait 90 days from date of denial letter to reapply and previous accounts will not be eligible. Accounts originally classified as bad debts may be subsequently eligible for financial assistance for up to three years if not in legal collection status. If the patient is approved for assistance, a refund for the patient amount paid may be requested up to 180 days from the date the payment was posted, less collection fees.**
- G. Financial Assistance approval will be effective for six months or until a change in patient financial status is determined or is revoked due to non-cooperation. Hospital reserves the right to request additional information from patient during this six month period. It is the patient's responsibility to notify hospital staff of accounts with balances that may be eligible for assistance.**

- H. Harrison County Hospital recognizes the fact that there may be instances in which a patient's income exceeds the previously mentioned guidelines, but the patient's medical expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burdens. Financial assistance may also be appropriate for these individuals.
- I. This policy will also apply to services provided by all hospital employed physicians, if the place of service is Harrison County Hospital.

III. IDENTIFICATION OF POTENTIALLY ELIGIBLE PATIENTS

- A. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process for up to 24 months following the date of service. Patients who are assigned to a hospital contracted collection agency may also be screened by that agency for financial assistance, with qualified recipients being reported to the hospital at least every 30 days. If the account is in collections at time of approval, agency fees may be deducted from any refund due patient.
- B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- C. Patients applying for financial assistance where it is reasonably believed they would qualify for a government financial assistance program (such as Medicaid or HIP) but do not apply due to religious beliefs, will be financially responsible for 15% of total charges on outpatient encounters and DRG Medicaid reimbursement rate on inpatient encounters. The patient should complete a written Application for Financial Assistance and submit Attachment # 8 (Confirmation of Social Security Exemption).

IV. DETERMINATION OF ELIGIBILITY

- A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. Information on the availability of financial assistance is also included on every statement/bill sent to a self-pay patient.
- B. The person requesting financial assistance should complete a written Application. For Financial Assistance (Attachment # 1) a completed application and supporting data should be returned to the Financial Counselor for evaluation. If the patient is food stamp, TANF or Medicaid eligible and can provide proof of eligibility then the need for other supporting data will be waived.
- C. In the evaluation of an application for financial assistance, a patient's total household income and available financial resources will be taken into account. The amount of financial assistance to be provided will be reduced by any available resources in excess of \$6,000 for an individual and increased by \$2,000 for each individual household member.
- D. Presumptive Eligibility: At Harrison County Hospital's discretion, Financial Assistance may also be considered and granted without completion of a Financial Assistance Application. Harrison County Hospital may refer to or rely on the following external factors and/or other program enrollment resources to determine patient's eligibility:
- Patient is homeless
 - Patient is eligible for other funded federal state or local assistance programs
 - Patient is eligible for state or local assistance programs
 - Patient is eligible for food stamps or federally subsidized school lunch program
 - Patient is eligible for a state-funded prescription medication program
 - Patient's valid address is considered low-income subsidized housing
 - Patient receives free care from a community clinic and is referred to hospital for further treatment

- The patient expires and there is insufficient money in the estate or no estate to pay the patient's HCH bill.
- Patients who are deemed presumptively eligible for Financial Assistance may receive an adjustment to their account and may only be eligible on a specific date of service

- E. Harrison County Hospital will not look to force liquidation of a personal residence, but may file a lien to protect our interest through future sale of such property. A credit report may also be generated.
- F. Financial assistance approvals for amounts greater than \$10,000 should be approved by the Patient Accounts Manager. Those greater than \$25,000 should be approved by the CFO. The Financial Counselor shall notify the patient of the outcome.
- G. Accounts where patients are identified as medically indigent or accounts where the collector or Patient Accounts Manager has identified special circumstances that when taken into consideration may affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination.

V. NOTIFICATION OF ELIGIBILITY DETERMINATION

- A. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision to the patient, which provides a reason for denial, will be provided, generally within ten (10) days of the application process utilizing the Final Determination of Eligibility Letter (Attachment # 9). Applicants denied financial assistance may qualify for an extended interest free payment plan approved by the Patient Accounts Manager, not to exceed 18 months.

VI. POLICY COMPLIANCE BY SERVICE LINE

- A. Collection activity may be suspended during the consideration of a financial assistance application. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be set up based on billing and collection policy.
- B. A free copy of the Billing and Collection Policy can be obtained by calling 812-738-8755.

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR HOSPITAL

Based upon Federal Poverty Guidelines, Gross income levels, 2021 (AGB discount 66% July 2021)

Family Size	100%	75%
1	0-25,760	25,761-38,640
2	0-33,840	33,841-52,260
3	0-43,920	43,921-65,880
4	0-53,000	53,001-79,500
5	0-62,080	62,081-93,120
6	0-71,160	71,161-106,740
7	0-80,240	82,241-120,360
8	0-89,320	89,321-133,980
Each Additional	9,080	13,260

List of Providers **Covered** by Financial Assistance Policy
In Harrison County Hospital Services Only

ANESTHESISTS
EMERGENCY ROOM PROVIDERS
HOSPITALIST
ORTHOPEDIC SURGEON
PODIATRIST
PEDIATRICIANS
RADIOLOGIST

PROVIDER BASED OFFICES

Institutional Claims Only
CORYDON MEDICAL ASSOCIATES
DERMATOLOGY & SKIN CANCER CENTER
FIRST CAPITAL MEDICAL GROUP
GENERAL SURGERY ASSOCIATES
HARRISON CRAWFORD HEALTHCARE
HCH PAIN MANAGEMENT
HCH OB/GYN
ORTHOPEDIC SURGEONS
SOUTH HARRISON FAMILY MEDICINE

List of Providers **Not Covered** by Financial Assistance Policy
All Other Services; which includes
services in Harrison County Hospital's non provider based Physician Offices
and After Hours Care