POLICY STATEMENT:

In order to serve the health care needs of our community, Shands Starke Regional Medical Center will provide financial assistance to patients without financial means to pay for medically necessary hospital services.

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. Financial Assistance is limited to those services that meet Medicare medical necessity 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.

If there are state specific laws that conflict with any portion of this policy, those sections have been identified and edited to comply with said law. In addition, attached to this policy are copies of each law as verification of requirements.

PURPOSE:

To properly identify those patients who are financially and/or medically indigent, who do not qualify for state and/or government assistance with their medical bills, and to provide assistance with their medical expenses under the guidelines for Financial Assistance.

ELIGIBILITY FOR FINANCIAL ASSISTANCE

1. FINancially INDIGENT:

   A. A financially indigent patient is a 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.

   B. To be eligible for financial assistance as a financially indigent patient, the patient’s total household income shall be at or below 200% of the current Federal Poverty Income Guidelines. (see exhibit D)
C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance as a financially indigent patient. The Federal Poverty Income Guidelines are 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. (see exhibit E)

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for financial assistance lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 200% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the healthcare needs of the community.

E. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for financial assistance. Payment of copayments and spend-down amounts are a condition of coverage and should not be written off or discounted.

2. PRESUMPTIVE ELIGIBILITY:

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, will be eligible for financial assistance upon verification of Medicaid coverage for the service dates, since they will be considered uninsured. 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 coverage and benefits will also be eligible for financial assistance for medically necessary hospital services.

C. Deceased patients with no estate will automatically qualify for financial assistance.

3. MEDICALLY INDIGENT:

A. A medically indigent patient is a person who is uninsured or whose medical bills after payment by third party payers exceed a specified percentage of the person’s annual gross income and who is unable to pay the remaining bill.

B. To be eligible for financial assistance as a medically indigent patient, the patient’s total household income shall be at or below 400% of the current Federal Poverty Income Guidelines (see exhibit E) and their hospital medical expenses for the proceeding 12 month period exceeds 25% of the annual gross income.

C. The hospital may consider other financial assets and liabilities for the person when determining eligibility, but in no case will the hospital require a patient to 'spend down' more than 50% of their savings in order for the patient to qualify for financial assistance towards their remaining balance.

D. If a patient meets the medically indigent income and medical expense criteria, and have no savings or assets, they will be eligible for a full write-off of the hospital medical expenses.
PARTICIPATION IN THIS POLICY:

A. This policy covers all emergency and medically necessary care provided by the hospital and its employees.

B. Some third-party health care providers that provide emergency and medically necessary care within the hospital under contract to the hospital may not extend financial assistance in accordance with this policy, choosing instead to apply their own policies for financial assistance.

C. A list of all of the third-party health care providers that provide emergency and medically necessary care within the hospital under contract is available at (web site). This list indicates whether or not each third-party health care provider follows the criteria and procedures for extending financial assistance set forth in this policy.

FACTOR TO BE CONSIDERED FOR FINANCIAL ASSISTANCE DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for financial assistance:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for financial assistance are attached on Exhibit “D”. The current Federal Poverty Guidelines are attached as Exhibit “E” and they include the definition of the following:

1. Family
2. Income

FAILURE TO PROVIDE APPROPRIATE INFORMATION:

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.

B. The account may be reconsidered upon receipt of the required information, providing the information is received within 240 days from the first patient billing date.

EXCEPTION TO DOCUMENTATION REQUIREMENTS

The CFO may waive the documentation requirements and approve a case for financial assistance, at his/her sole discretion, based on their belief the patient does/should qualify for assistance. Waiver of the documentation requirements should be noted in the comments section on the patient’s account, as well as the percent or dollar amount approved for financial assistance. Staff should print-out and attach the patient notes to the Financial Assistance (FA) application form.
TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.
Exhibit A
Financial Assistance Form
Financial Assistance Program Application

Patient Account Number: ____________________________  Date of Application: __________

PATIENT INFORMATION

Name: __________________________
Address: _______________________
City: ___________________________
State/Zip: ______________________
SS#: __________________________
Employer: ______________________
Address: _______________________
City: ___________________________
State/Zip: ______________________
Work Phone: ____________________
Length of Employment: __________
Supervisor: ____________________

RESOURCES

Checking: yes ___ no ___  Vehicle 1: Yr_____ Make_______ Model_____
Savings: yes ___ no ___  Vehicle 2: Yr_____ Make_______ Model_____
Cash on hand: $_________________
Vehicle 3: Yr_____ Make_______ Model_____

PARENT/GUARANTOR/SPOUSE

Name: __________________________
Address: _______________________
City: ___________________________
State/Zip: ______________________
SS#: __________________________
Employer: ______________________
Address: _______________________
City: ___________________________
State/Zip: ______________________
Work Phone: ____________________
Length of Employment: __________
Supervisor: ____________________
Exhibit A (continued)
Financial Assistance Program Application

INCOME

Patient/Guarantor:  
Wages(monthly): ______________________
Other Income:   Child Support:  $__________
VA Benefits:  $__________
Workers’ Comp:  $________
SSI:  $_______________
Other:  $______________

Spouse/Second Parent:  
Wages(monthly): __________________
Other Income:   Child Support:  $_______
VA Benefits:  $__________
Workers’ Comp:  $_______
SSI:  $_______________
Other:  $______________

LIVING ARRANGEMENTS

Rent_________  Own_________  Other (explain)__________________________

Landlord/Mortgage Holder:  _______________________________________________________

Phone Number____________________________  Monthly payment $________________

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Financial Assistance:

Proof of Income:  Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of 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). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant______________________________________

Hospital Representative Completing Application: ______________________________

===================================================================
The below signatures is 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:

Amount Approved $______________

BOM________________________________  CEO___________________________

CFO___________________________
Exhibit B
Income Guidelines for Determining % of Financial Assistance Discount
(For Financially Indigent Patients)

Based on Current Year’s Federal Poverty Income Guidelines

<table>
<thead>
<tr>
<th>% of Poverty Income</th>
<th>Discount from charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal to or Below Poverty</td>
<td>100%</td>
</tr>
<tr>
<td>101%-200%</td>
<td>100%</td>
</tr>
</tbody>
</table>
## Exhibit C
### Federal Poverty Income Guidelines 2016

Reference: Federal Register: January 25, 2016, Volume 81, Number 15 pp. 4036-4037

#### The 2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,880</td>
</tr>
<tr>
<td>2</td>
<td>16,020</td>
</tr>
<tr>
<td>3</td>
<td>20,160</td>
</tr>
<tr>
<td>4</td>
<td>24,300</td>
</tr>
<tr>
<td>5</td>
<td>28,440</td>
</tr>
<tr>
<td>6</td>
<td>32,580</td>
</tr>
<tr>
<td>7</td>
<td>36,730</td>
</tr>
<tr>
<td>8</td>
<td>40,890</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $4,160 for each additional person.

#### 2016 Poverty Guidelines for Alaska

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$14,840</td>
</tr>
<tr>
<td>2</td>
<td>20,020</td>
</tr>
<tr>
<td>3</td>
<td>25,200</td>
</tr>
<tr>
<td>4</td>
<td>30,380</td>
</tr>
<tr>
<td>5</td>
<td>35,560</td>
</tr>
<tr>
<td>6</td>
<td>40,740</td>
</tr>
<tr>
<td>7</td>
<td>45,920</td>
</tr>
<tr>
<td>8</td>
<td>51,120</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $5,200 for each additional person.

Charity Care Policies to use the new income guidelines effective February 1st, as well as any other polices that use the Federal Poverty Income Guidelines (FPI). As noted in the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the Federal poverty income guidelines (FPI). The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program. To find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.