ProHealth Care

Title:	FINANCIAL ASSISTANCE		
Policy Type:	Administrative	Effective Date:	8/19/2015
Entities Affected:	All ProHealth Care Entities	Last Review Date:	11/6/2018

Purpose Statement:

This policy outlines the eligibility criteria for financial assistance, the basis for calculating amounts charged to patients, the method of applying for financial assistance, billing and collection procedures and practices and publicizing of the financial assistance policy.

Definitions:

Guarantor: The person responsible for the bill.

PHC Provider: All ProHealth Care entities and/or physicians operating in service locations listed in Appendix A of this policy. These providers will be considered as "covered" by the PHC Financial Assistance policy.

Third Party Payers: Any Federal or State Program, commercial insurance, self-insured funds, HMO or PPO.

Self-Pay Payers: Patients that are uninsured.

Self- Pay Residual Balances: Balances due from patients that hold insurance coverage (deductibles, co-insurance, copayments, non-covered services).

Reasonable Collection Efforts: At least three (3) statements over a period of on average 120 days, including a final notice sent to the guarantor's home address. Reasonable collection efforts may also be supplemented by phone contacts to the guarantor's phone. Reasonable collection efforts must also include notification of the financial assistance policy (FAP).

Permitted Collection Agency Collection Efforts: Could include any/all of the following: collection calls and letters, credit bureau reporting, property liens, garnishment of wages, collection based on sale of residence in accordance with State law.

Prohibited Collection Agency Collection Actions: foreclosure on an individual's real property, attach or seize an individual's bank accounts or other personal property, cause an individual's arrest, cause an individual to be subject to a writ of body attachment.

Notification Period: The period during which the PHC Provider must notify the patient of the Financial Assistance Policy. This begins on the day that care is rendered and ends 120 days after the PHC provider provides the first statement for such care.

Application Period: The period of time in which a PHC Provider must accept and process FAP applications. This begins on the day that care is rendered and ends 240 days after the PHC provider provides the first statement for such care.

Household: Any adult of a common residence, including spouse or domestic partner (domestic partner is defined as either one of an unmarried heterosexual or homosexual cohabiting couple especially when considered as to eligibility for spousal benefits)

1) Parent's income and assets are included as household members for applicants less than 27 years of age if the applicant is claimed as a dependent on the parent's income tax returns.

2) Siblings' income or assets are not included as household income and assets on applicants return.
3) Children's income and assets are not included as household income and assets on an application for parents.

Medically Necessary Care: A health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice (Segen's Medical Dictionary).

Policy:

All ProHealth Care entities will provide emergency or other medically necessary care to persons residing in the ProHealth Care service area regardless of their ability to pay for services. No patient shall be denied medically necessary care on the basis of race, creed, color, sex, national origin, sexual orientation, handicap, age or source of payment. However, in order to provide uncompensated care to those members of the community who are truly in need, it is essential that payment be made by those who are able to pay for their care. Those who are eligible for governmental programs, such as Medicare and Medicaid, or the health insurance exchange, must apply for such benefits. If there is any funding available through research grants, insurance exchanges, special programs or coverage through any liability source, those dollars must be applied prior to applying Financial Assistance discounts for which the guarantor is otherwise eligible.

Procedure:

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA

Financial Assistance will be provided only to those persons residing in the ProHealth Care service area (Appendix A) at the time of service and who have done so for a period of at least six of the prior eight months immediately prior to the date of service. Those persons receiving services who are not residents of the ProHealth Care service area are responsible for payment for those services.

Based on (a) patient's financial status, (b) his/her eligibility for benefits under insurance or any federal, state or local assistance programs, and (c) other methods under which care might be provided, the Central Business Office will make the determination as to the patient's eligibility for Financial Assistance. Financial Assistance may be granted on a full or partial basis, depending on the financial status of the recipient. This benefit will be applied to any self-pay or self-pay residual balance for ProHealth Care entities included in this policy.

The financial assistance determination will be valid for a period of three months from the date of service. If services continue for a period greater than three months, the patient may reapply for financial assistance by re-affirming that the supplied information is still valid. If the financial circumstances of the patient change in that time period, new supporting documentation must be provided by the patient.

Eligibility for financial assistance will be based on household income and size and assets. Income and assets will be assessed as of the date of application for financial assistance.

The following income criteria shall generally be applied to all patients applying for financial assistance:

1) Household income will include all income from any source including wages and salaries and other sources of income including, but not limited to, the following ;
   a. all pensions from state, federal or private sources
   b. income from annuities, IRAs, TSAs, 401(k)s

c. stocks, or bonds
d. veterans benefits
e. social security payments
f. regularly received insurance checks such as unemployment benefits and workman's compensation
g. alimony; child support
h. returns on investments; net rents and net profits from business.

2) Size of the patient's family will be determined by the number of dependents claimed on the applicant's tax returns or identified as part of the household.

3) The poverty income guidelines issued by the Federal Government will be used to determine the level of eligibility for financial assistance.

The following asset criteria shall generally be applied to all patients applying for Financial Assistance:

1) An individual or household, to be eligible, may have equity and liquid assets consisting of:
   a) Equity in a personal residence, combined with other financial assets, in total less than $100,000. Other financial assets include the following, but are not limited to:
   b) cash on hand
   c) savings
   d) Stocks, bonds, annuities
   e) IRAs, TSAs, 401(k)s, 403(b)s, health savings accounts, deferred compensation accounts
   f) cash value of life insurance
   g) the market value of non-homestead real estate (i.e.; second home; vacation home) and personal property
   h) Additional exempt resources may include personal property of reasonable value used in the production of income, such as farm equipment and livestock;

2) Household and personal possessions, other than reasonable routine household and personal possessions;

3) One automobile or one truck unless additional vehicles are necessary to produce income;

4) Individuals, who have transferred any other property (in addition to the above) within two years of the application date, unless they have received full market value for the property, may have transferred assets considered a financial asset.

If an applicant meets asset limitations and with household income equal to or less than 200% of poverty guidelines, said applicant will be eligible for a 100% discount on his/her bill. If an applicant's income and assets exceed these limits but is equal to or less than 400% of Federal poverty guidelines, the applicant may be eligible for a partial discount on his or her services based upon Appendix B. In the case of uninsured patients, the final discount will be the greater of the determined financial assistance allowance percentage or the uninsured discount (see section on uninsured discounts).

General administration procedures related to eligibility:

1) Applicants requesting eligibility determinations prior to receiving services will be informed of their eligibility within five working days after a complete application is submitted. A complete application includes providing requested supporting information regarding income and assets. Applicants requesting eligibility determinations after service has been rendered will be informed of their eligibility within ten working days after a complete application is submitted.

2) Where eligibility is readily determined at the time of admission, the recipient should not be routinely billed for services received.

3) All emergent or non-emergent care provided by a PHC provider will be eligible for financial assistance consideration. The following services are excluded from the financial assistance program: Cosmetic surgery, in vitro fertilization (IVF), any infertility programs, elective sterilization procedures or the reversal thereof, retail services, hearing aids, vision services, and services routinely denied as not medically necessary by insurance policies. Physician fees related to independent physicians providing care within PHC facilities may not be eligible for financial assistance. Medical treatment for a medical condition associated with alcohol or other drug abuse or mental illness may be covered upon review by the Behavioral Medicine Department Medical Director. Such requests will be routed to the VP – Revenue Cycle to bring forward for review.

4) The PHC Entity reserves the right to request documentation for income and assets listed on an application, including but not limited to pay stubs, bank statements, income tax returns, real estate assessments and mortgage statements.

5) The PHC Entity reserves the right to reverse a determination if it is found that accurate and complete information was not provided during the application process.

6) The total amount of the patient's hospital bill charges may be considered in determining eligibility for Financial Assistance. Patient's maximum out of pocket exposure on any one account shall be limited to 15% of gross income if they meet income and asset qualifications for financial assistance. (A series/recurring account is considered one account.)

7) Patients with balances due after insurance has processed claims may be eligible for financial assistance after completion of the financial assistance application.

8) Exceptions to the policy must gain approval from the Vice President – Revenue Cycle. PHC financial assistance exceptions may include the following scenarios:

   a) Patients who are not legal citizens of the U.S. and cannot apply for health coverage through the exchange system. These patients must qualify under the PHC Financial Assistance income and asset criteria as listed in this policy and are also not eligible for health care coverage under any other federal program.
   b) Patients who are legal citizens of the U.S. but did not apply for coverage under the ACA Exchange System, or whose Exchange payer coverage has lapsed due to non-payment. These patients are given a 1 time exception for Financial Assistance eligibility if they qualify under the Financial Assistance criteria as listed in this policy. These patients are tracked via a PHC exception tracker by the PHC Customer relations staff and, in addition, their accounts are noted accordingly.
   c) *Presumptive Determination:* In addition to point (4.) under "General Administration Procedures", in cases where a patient cannot provide documentation in order for PHC Patient Accounting to validate income or asset criteria, a written attestation furnished by the patient or patient's employer may be sufficient to qualify for financial assistance.

METHOD OF APPLYING FOR FINANCIAL ASSISTANCE

Whenever possible, arrangements for financial assistance should be made in advance of service. The patient or his/her physician should contact the Central Business Office at 866-432-7855 to request a financial assistance application (Appendix C) or to receive assistance in completing the application for financial assistance. The financial assistance application is also available online at www.prohealthcare.org. Information provided will be used to assess the patient's eligibility. The Central Business Office and/or Department of Social Work may contact the patient as part of the determination process if additional

information is needed. If additional information is needed, a final determination of eligibility will not be completed until all information is received. Financial assistance eligibility is based upon the financial status of the applicant and members of the applicant's household as of the date of the financial assistance application.

MINIMUM CHARITY CARE DISCOUNT (AMOUNTS GENERALLY BILLED)

ProHealth Care uses the look-back method to calculate a minimum charity care discount (amounts generally billed) to self-pay patients who qualify for financial assistance. Amounts generally billed to self-pay patients who qualify for financial assistance consist of gross charges minus a discount (uninsured discount). This discount is equivalent to the sum of the amounts of all claims that have been allowed by health insurers during ProHealth Care's previous fiscal year, divided by the sum of the associated gross charges for those claims. This discount is calculated annually in conjunction with ProHealth Care's fiscal year (referred to as an "amounts generally billed"). Patients who are uninsured and apply for financial assistance may be eligible for amounts greater than the uninsured discount upon qualification for the financial assistance program. The foregoing uninsured discount is intended to comply with the limitation of charges section for IRS Section 501r.

BILLING AND COLLECTION PROCEDURES/PRACTICES

1) Time of Service and Insurance Billing
   a) If a patient provides insurance information at time of service, a bill will be submitted to the insurance for processing. Any secondary insurance will also be billed upon receipt of the primary payor explanation of benefits.
   b) Copayments, coinsurance, deductibles or other similar patient responsibility amounts may be collected at time of service if identified. For emergent services, these amounts will be collected after the patient's condition has been assessed by a medical professional.
   c) Patients without insurance will follow the statement process outlined in the following section.

2) Patient Statement Process
   a) For amounts that are deemed to be the responsibility of the patient, a cycle of statements will be established to allow the patient to contact ProHealth Care if payment in full cannot be made.
   b) The statement cycle will be completed, on average, 120 days from the date the account transfers to a self-pay status. Statements are generated on average every 30 days.
   c) Statements will contain the following:
      i. standard language that states that payment in full is expected
      ii. the guarantor's financial responsibility
      iii. date of service
      iv. payor billed, if applicable
      v. summary charge information
      vi. a summary of payments and adjustments
      vii. balance due
      viii. phone number for the Customer Relations area of the Central Business Office
      ix. verbiage of how to apply for ProHealth Care's Financial Assistance Program
      x. web-site information
   d) For any self-pay balances due, ProHealth Care may offer interest free payment arrangements for the patient to pay any balances. Payment plans may be established for up to two years, with a minimum payment installment of $50.00 per account. Statements are issued on average every 30 days.

3) Financial Assistance
   a) Information about ProHealth Care's financial assistance policy will be included on the statements and in phone calls made to the central business office if the patient expresses a financial hardship.
   b) Patients that apply for financial assistance during the notification and application period will receive communication in writing of any documentation omissions in the application. The standard billing process will continue until all required documentation is received.
   c) Once a completed application is received during the notification period, billing statements will cease until a final determination of eligibility is completed.
   d) Any patient who applies for financial assistance during the application period will have any permitted and/or prohibited collection agency collection efforts, as defined in this policy, ceased upon receipt of a complete application and until a determination of eligibility is completed.
   e) Final determination of eligibility will be communicated to the patient in writing.

4) Collection Agencies
   a) Reasonable collection efforts will be used by ProHealth Care prior to referring an account to a collection agency, or classifying the account as "bad debt".
   b) Any collection agency used by ProHealth Care will adhere to State and Federal debt collection laws as well as to this policy with regards to collection practices. Collection agencies will follow Permitted Collection Agency Collection Efforts as defined in this policy to collect debts placed.
   c) All legal actions must be approved by ProHealth Care before proceeding.
   d) Collection agencies will refrain from the Prohibited Collection Agency Collection Efforts, as defined in this policy.
   e) Bankruptcy accounts will be identified and standard collection efforts will cease while payment is sought through the bankruptcy process. Statements will be held until further direction is received through the bankruptcy process.

PUBLICIZING THE FINANCIAL ASSISTANCE POLICY

Signage identifying the availability of Financial Assistance is posted in English and Spanish. Pamphlets in English and Spanish that briefly describe the Financial Assistance program are available at registration points. Initial billings to self-pay patients include a notification on the statement asking patients to contact the Central Business Office at 866-432-7855 if they wish to apply for financial assistance. Financial Assistance applications are also available via mail if requested.

The Financial Assistance Policy is posted on ProHealth Care's consumer website at ProHealthCare.org.

Copies of ProHealth Care's Financial Assistance application are provided to other non-profit entities in Waukesha County that provide services to uninsured and under-insured patients that are referred to ProHealth Care entities for services.

References: N/A

Owned By:
Curtis Glaunert VP Revenue Cycle

Committees:
Administrative Policy Committee 11/6/2018

Appendix (A)

ProHealth Care Service Area

Zip Code	City/Town/Village	Zip Code	City/Town/Village
53003	Ashippun	53118	Dousman
53005	Brookfield	53119	Eagle
53018	Delafield	53120	East Troy
53029	Hartland	53122	Elm Grove
53036	Ixonia	53127	Genesee Depot
53038	Johnson Creek	53137	Helenville
53045	Brookfield	53146	New Berlin
53056	Merton	53149	Mukwonago
53058	Chenequa	53150	Muskego
53059	Neosho	53151	New Berlin
53064	North Lake	53153	North Prairie
53066	Oconomowoc	53156	Palmyra
53069	Okauchee	53167	Rochester
53072	Pewaukee	53178	Sullivan
53089	Sussex	53183	Wales
53094	Watertown	53185	Waterford
53098	Watertown	53186, 53188, 53189	Waukesha
53103	Big Bend	53549	Jefferson

Appendix B-Financial Assistance January 1, 2018: 200-400% Federal Poverty Guidelines

Federal Poverty Guidelines 2018											
	200%	210%	220%	230%	240%	250%	260%	270%	280%	290%	300%
	100%	95%	90%	85%	80%	75%	70%	65%	60%	55%	50%
	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:	Income up to:
FAMILY SIZE											
1	$24,280	$25,494	$26,708	$27,922	$29,136	$30,350	$31,564	$32,778	$33,992	$35,206	$36,420
2	$32,920	$34,566	$36,212	$37,858	$39,504	$41,150	$42,796	$44,442	$46,088	$47,734	$49,380
3	$41,560	$43,638	$45,716	$47,794	$49,872	$51,950	$54,028	$56,106	$58,184	$60,262	$62,340
4	$50,200	$52,710	$55,220	$57,730	$60,240	$62,750	$65,260	$67,770	$70,280	$72,790	$75,300
5	$58,840	$61,782	$64,724	$67,666	$70,608	$73,550	$76,492	$79,434	$82,376	$85,318	$88,260
6	$67,480	$70,854	$74,228	$77,602	$80,976	$84,350	$87,724	$91,098	$94,472	$97,846	$101,220
7	$76,120	$79,926	$83,732	$87,538	$91,344	$95,150	$98,956	$102,762	$106,568	$110,374	$114,180
8	$84,760	$88,998	$93,236	$97,474	$101,712	$105,950	$110,188	$114,426	$118,664	$122,902	$127,140
EACH ADD PERSON	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640
	310%	320%	330%	340%	350%	360%	370%	380%	390%	400%	
	45%	40%	35%	30%	25%	20%	15%	10%	5%	0%	
1	$37,634	$38,848	$40,062	$41,276	$42,490	$43,704	$44,918	$46,132	$47,346	$48,560	
2	$51,026	$52,672	$54,318	$55,964	$57,610	$59,256	$60,902	$62,548	$64,194	$65,840	
3	$64,418	$66,496	$68,574	$70,652	$72,730	$74,808	$76,886	$78,964	$81,042	$83,120	
4	$77,810	$80,320	$82,830	$85,340	$87,850	$90,360	$92,870	$95,380	$97,890	$100,400	
5	$91,202	$94,144	$97,086	$100,028	$102,970	$105,912	$108,854	$111,796	$114,738	$117,680	
6	$104,594	$107,968	$111,342	$114,716	$118,090	$121,464	$124,838	$128,212	$131,586	$134,960	
7	$117,986	$121,792	$125,598	$129,404	$133,210	$137,016	$140,822	$144,628	$148,434	$152,240	
8	$131,378	$135,616	$139,854	$144,092	$148,330	$152,568	$156,806	$161,044	$165,282	$169,520	
EACH ADD PERSON	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	$8,640	

ProHealth Care

Appendix C

Financial Assistance Application
ProHealth Care

_____

I hereby request that ProHealth Care make a written determination of my eligibility for financial assistance. I understand that the information which I submit concerning my annual income, assets and family size is subject to verification by ProHealth Care. I also understand that if the information which I submit is determined to be false, such determination will result in a denial for financial assistance and that I will be liable for charges for the services provided.

Patient Name:_____
Last First Middle Initial

Current Address:_____
Street (No. P.O. Box) City State Zip Code

How Long at Above Address:_____ **Telephone**:_____ **Waukesha County Resident**: **Yes:** ☐ **No:** ☐

If at Above Address Less Than Six Months, Indicate Previous Address Below and Length at that Address:

Street City State Zip Code Length at Address

HOUSEHOLD MEMBERS (INCLUDING PATIENT):

Name	Relationship	Date of Birth	Social Security Number (Mandatory)

EMPLOYMENT, INCOME AND ASSET INFORMATION (ALL AREAS MUST BE COMPLETED):

Are you presently employed? ☐ Yes ☐ No Are you self-employed? ☐ Yes ☐ No

Please list Gross Monthly Income for all household members. Return the following items for verification of income: Tax Return and W-2 for the previous year, copies of check stubs for the last 90 days and, if Home Owner, Property Tax Bill and Mortgage Statement. A determination cannot be made unless this is provided.

Patient or Parent Name:	**Spouse, Parent or Other Name:**
Present or Last Employer:	**Present or Last Employer:**
Employment Dates **From:** **To:**	**Employment Dates** **From:** **To:**
Gross Monthly Wages:	**Gross Monthly Wages:**

OTHER SOURCES OF INCOME (check type and list amount for yourself or other household members):

☐	**Alimony/Child Support**	_____	☐	**Interest Income**	_____
☐	**Social Security**	_____	☐	**Worker's Compensation**	_____
☐	**Pension Annuity**	_____	☐	**Unemployment Compensation**	_____
☐	**School Grants**	_____	☐	**Auto Liability Income**	_____
☐	**Public Assistance**	_____	☐	**Rental Income (Net Profits)**	_____
☐	**Other (Specify)**	_____	☐	**Net Profits from Business**	_____

HOME OWNER: **OTHER PROPERTY:**

Home Owner Location:	**Location:**
Assessed Taxable Value:	**Assessed Taxable Value:**
Mortgage Balance Due:	**Mortgage Balance Due:**

RENTER:

Location:	
Monthly Rent Paid:	

AUTOMOBILE(S):

Make/Year/Model	Lien Holder (if other than applicant)	Balance Owed	Monthly Payment

ASSET DETAILS (check type and list amount for yourself or other household members):
PLEASE PROVIDE ASSET INFORMATION FOR HOUSEHOLD MEMBERS. A DETERMINATION CANNOT BE MADE UNLESS THIS INFORMATION IS PROVIDED. ALL INFORMATION IS SUBJECT TO VERIFICATION.

☐	**Checking Account**	_____	☐	**Savings Accounts**	_____
☐	**CD (s)**	_____	☐	**Income Property**	_____
☐	**IRA (s)**	_____	☐	**Other Real Estate**	_____
☐	**TSA (s)**	_____	☐	**Stocks/Bonds/Annuities**	
☐	**401 (k)s**	_____	☐	**Recreation Vehicles (Boat, RV, etc.)**	_____

☐ **LIFE INSURANCE** **Policy Type:** ☐**Term** ☐**Whole** **Today's Cash Value $**_____

IF YOU ARE SEEKING AN ELIGIBILITY DETERMINATION FOR SERVICES ALREADY RENDERED BY PROHEALTH CARE, PLEASE LIST DATES OF SERVICES AND PATIENT NAME.

Name: _____ Service Date: _____

_____ _____

I affirm that the information given in this document is true and correct to the best of my knowledge. I authorize the release of information to ProHealth Care for verification of this financial statement. ProHealth Care reserves the right to reverse a determination if it is found that accurate and complete information was not provided during the application process.

Date: _____ Signature: _____
(Signature of Patient/Guarantor/Spouse)

ProHealth Care Personnel Only

Date Received: _____