

DEPARTMENTAL POLICY AND PROCEDURES MANUAL

Policy Section: Patient Financial Counseling	Section: Patient Access Services Page: 1 of 14
Effective Date: 11/21/2011	Prepared By: Melanie Urbistondo
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TITLE: FUNDING ASSISTANCE POLICY	

**PURPOSE**

Holy Cross Hospital is a member of the Catholic Health East system and is sponsored by the Sisters of Mercy. Catholic Health East is a community of persons committed to being a transforming, healing presence in the communities we serve. Aligned with our core value of commitment to those who are poor, we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet, expenses incurred in receiving healthcare.

The purpose of this policy is to establish guidelines for Funding Assistance for patients who incur significant financial burden as a result of the amount they are expected to owe “out-of-pocket” for acute care health care services.

In addition, this policy provides administrative and accounting guidelines for the identification, classification and reporting of patients as Funding Assistance as distinguished from Bad Debts.

**Definition of Funding Assistance:**

Funding Assistance is provided to a patient with a demonstrated inability to pay and residing in Broward County. A patient is eligible for Funding Assistance consideration based upon meeting certain income eligibility criteria as established by the Federal Poverty Income Guideline Sliding Scale. Acceptance of a patient residing outside Broward County will be determined on an individual basis by the Vice President of Mission Effectiveness and/or Chief Financial Officer.

A patient whose family income is equal to or less than 200% of the most recent Federal Poverty Guidelines is eligible for a full discount of allowable charges.

A patient whose family income is greater than 200% of the most recent Federal Poverty Guidelines and less than 400% of the Federal Poverty Guidelines, qualifies for a Partial Funding Assistance discount off allowable charges. The payment that Holy Cross Hospital accepts from the patient for a service, shall closely approximate, with the intent of not exceeding, the payment that the hospital would have received from Medicaid.

Funding Assistance may include unpaid coinsurance, deductibles and non-covered services if the patient meets the Funding Assistance eligibility criteria.

Funding Assistance represents health care services that are provided but are never expected to result in payments. As a result, Funding Assistance does not qualify for recognition as receivable or net patient revenue in the financial statements.

Bad Debt is payment not received for service rendered for which payment was anticipated and credit extended. Bad Debt patients do not meet the criteria for Funding Assistance, that is, they are considered able to pay but unwilling to satisfy their outstanding obligations.

Funding Assistance data reporting for services provided is based on cost of patient care services, not charges, with costs being determined by application of the standard cost-to-charge ratio or the HCH's cost accounting system. Funding Assistance write-offs are accounted for in separate deduction from revenue general ledger accounts. HCH means Holy Cross Hospital, Inc., which in turn, is a Regional Health Corporation ("RHC") of Catholic Health East.

Definition of Family:

Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Definition of Uninsured:

The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Definition of Underinsured:

The patient has some level of insurance or third party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

**POLICY**

As members of the Catholic healthcare ministry who are deeply committed to caring for those who are poor, HCH has established respectful and effective procedures for addressing the needs of those persons who are unable to pay for all or most of their care. In order to preserve the dignity of these persons and to facilitate the process of securing necessary information, HCH strongly prefers to perform financial screening upon scheduling, admission or registration (discharge processing in the ED) as part of the overall Financial Counseling process as described in the Key Performance Indicator System Policies. Patients who are at increased financial risk as a result of the amount they are expected to owe "out-of-pocket" should be referred to a Financial Counselor for assistance in applying for alternative payment programs (e.g., Medical Assistance) determining Funding Assistance eligibility, establishing payment plans or other financing arrangements. Financial Counseling services are to be made available to all elective, urgent and emergent patients.

Patients with insurance other than that afforded low income individuals should not have their patient liability unpaid balance, coinsurance, deductible or non-covered service written-off to Funding Assistance unless financial hardship can be proven.

## PROCEDURES

It is imperative that the determination, reporting, and tracking of Funding Assistance are in concert with HCH's mission and values and reflective of the organization's community commitment. HCH provides medically necessary care to all regardless of ability to pay. Partial and/or full Funding Assistance is based on the individual's ability to pay. The need for Funding Assistance is a sensitive and personal issue for recipients and needs to be addressed with reverence for those who are in need. Confidentiality of information and individual dignity shall be maintained for all that seek charitable services. The mental, emotional or physical conditions and limitations of the patient should be considered when applying criteria.

**I. Eligibility Criteria: Excluded from coverage are any third parties who may be liable for payment for services.**

**A. Funding Assistance Application: (See Exhibit A)**

1. Any individual who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for Funding Assistance.
2. The Statement of Financial Condition (Exhibit A) is used to document each patient's overall financial situation. This application should be available in the primary language(s) of the service area.
3. Credit reports and/or publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay, may be used, when appropriate, to verify an individual's financial circumstances.
4. A patient's employment status and earning capacity, as well as family size, is taken into consideration when evaluating a Funding Assistance request.
5. The data used in making a determination concerning eligibility for Funding Assistance should be verified to the extent practical in relation to the amount involved.
6. Once a determination has been made a notification form is provided to each applicant advising them of the decision.

**B. Full Funding Assistance : 100% Discount**

A patient whose family income (as calculated on the Statement of Financial Condition) is equal to or less than 200% of the most recent Federal Poverty Guidelines qualifies for a Full Funding Assistance discount. Income is defined as annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Proof of earnings may be determined by annualizing pay at current earning rates. Per the guidelines set forth in the CMS Provider Reimbursement Manual Publication 15-1 (9/8/2005), an analysis of assets will be completed with the definition of assets being only those that are convertible to cash and unnecessary for the patient's daily living.

**C. Partial Funding Assistance:**

A patient whose family income is greater than 200% and less than 400% of the most recent Federal Poverty Guidelines qualifies for a Partial Funding Assistance discount of 50% up to 85% off allowable charges. The payment that HCH accepts from the patient for a service shall not exceed the payment the hospital would have received from Medicaid.

Flexible, interest-free payment plans are available (e.g., extended payment terms), as appropriate. Refer to HCH's Payment Plan, Prompt Pay Discount and Collection Policies.

**D. Medicaid Denied Patient Days and Non-covered Services:**

Medicaid patients are eligible for Funding Assistance write-offs related to denied stays, denied days of care, and non-covered services. These KePro denials and any lack of payment for non-covered services provided to Medicaid patients are to be classified as Funding Assistance.

**E. Catastrophic Funding Assistance:**

In order to qualify for Catastrophic Funding Assistance Circumstances the patient's Allowable Medical Expenses must exceed 25% of Family Income as described below:

1. The Hospital multiplies the Family Income as defined in Section L by 25%
2. The Hospital determines the patient's Allowable Medical Expenses.
3. The Hospital compares 25% of the Family Income as defined in Section L to the total amount of the patient's Allowable Medical expenses. If the total of the Allowable Medical Expenses is greater than 25% of the Family Income, then the patient meets the Catastrophic Funding Assistance qualification. The Hospital subtracts 25% of the Family Income from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income; this amount is then eligible for a Funding Assistance write-off.

**F. Persons Who are Homeless or Illegal Aliens:**

Patients without a payment source are classified as Funding Assistance if it is determined that they do not have a job, mailing address, residence, or insurance. Consideration must also be given to classifying emergency department only patients who do not provide adequate information as to their financial status. In many instances, these patients are homeless and have few resources to cover the cost of their care. These cases are evaluated on an individual basis and will use the one-page charity application displayed in Exhibit A-1. In accordance with the Sisters of Mercy, Holy Cross Hospital provides service to all human beings regardless of their citizenship. To that end, patients who are unable to provide the required documentation based on the fact that they are illegal aliens will be reviewed and approved for Funding Assistance on a case by case basis, pending any applicable 1011 indigent funding, without all required documentation and will use the one-page charity application displayed in Exhibit A-1.

**G. Special Circumstances:**

1. Deceased patients without an estate or third party coverage are eligible for Funding Assistance.
2. Patients who are in liquidation or reorganization bankruptcy or recently completed bankruptcy may be eligible for Funding Assistance.
3. On rare occasions, a patient's individual circumstances may be such that while they do not meet the regular Funding Assistance criteria in this policy they do not have the ability to pay their hospital bill. In these situations, with the approval of management, as indicated in Exhibit B, part or all of their cost of care may be written off as Funding Assistance. There must be complete documentation of why the decision was made to do so and why the patient didn't meet the regular criteria.

**H. Governmental Assistance:**

1. In determining whether each individual qualifies for Funding Assistance, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medicaid, a Healthy Families Program, Victims of Crime, State Children Services, etc.
2. Holy Cross Hospital is committed to assist the individual in determining if they are eligible for any governmental assistance.
3. Persons eligible for programs such as Medicaid but whose eligibility status is not established for the period during which the medical services were rendered, should be granted Funding Assistance for those services. Patients are required to complete a government assistance application, unless the application of such assistance is contrary to the person's religious beliefs.

**I. Hospital Collection Efforts:**

Self-pay balances are transferred to collection agencies when the accounts complete a patient statement cycle (e.g. 120 days) with no payment from the patient or proof of eligibility for Funding Assistance or other programs. Accounts with applications pending for Funding Assistance or other assistance programs are held until the outcome of the application. A “pending application” is defined as an application that has been fully completed by the patient, submitted and is in the process of being determined for eligibility.

It is acceptable (but not preferable) to take an account through the full collection cycle and later reclassify it as Funding Assistance, as long as a consistent process is followed and a legitimate basis exists that the patient is unable to pay. For example, self-pay accounts written-off and sent to Bad Debt, reclassifying the account to Funding Assistance may be considered on the basis of all of the following factors:

1. No third party coverage or inadequate coverage exists
2. No payments are recorded on the account
3. The patient/guarantor was billed a minimum of 4 times

**J. Collection Agency:**

In some cases, a patient eligible for Funding Assistance may not have been identified prior to initiating external collection action. Accordingly, each collection agency engaged should be made aware of the policy on Funding Assistance. This allows the agency to report amounts that they have determined to be uncollectible due to the inability to pay in accordance with the Funding Assistance eligibility guidelines.

Collection agencies shall not, in dealing with the uninsured patients at/or below the 400% Federal Poverty Level, use wage garnishments or as a means of collecting on unpaid hospital bills. This does not preclude agencies from pursuing reimbursement for third-party liability settlements.

If a collection agency identifies special circumstances demonstrating a particular patient as being unable (versus unwilling) to pay their bill, their liability may be considered Funding Assistance, even if they were originally classified as a Bad Debt. The patient should be reclassified to Funding Assistance.

**K. Eligibility Period:**

The eligibility period is one year from the date of the initial eligibility determination, unless over the course of that year the patient’s Family Income or insurance status changes to such an extent that the patient becomes ineligible.

*Holy Cross Hospital will require updated supporting documentation (i.e., updated bank statement, support letter, check stubs etc...) to establish that a patient’s financial situation has not changed quarterly over the course of the one year eligibility period.*

**L Time Requirements for Determination:**

While it is desirable to determine the amount of Funding Assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. Every effort should be made to determine a patient's eligibility for Funding Assistance (See Exhibit C).

**M Definition of Family Income:**

Annual earnings, including, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, assistance from outside the household and other miscellaneous sources before taxes, less payments made for alimony and child support.

Proof of earnings may be determined by annualizing pay at current earning rates.

**N Noncompliant Patients:**

It is important for patients to cooperate with us and provide us the documents necessary for determining charity status. The documents necessary for determining charity status are provided to patients as part of the application process (refer to Exhibit E for the "Financial Evaluation Form"). Patients will be given ample opportunity to comply with the requested information. The charity coordinator corresponds with the applicant to guide them through the charity process and discuss all necessary documentation required for determining charity status. In the event a patient refuses to provide the necessary information or fails to respond to the charity coordinator within 45 days, they will be sent a letter requesting that they contact us to resume the charity application process. In the event a patient does not comply within 90 days, a second and final letter will be sent to the patient. If the patient does not comply within 120 days, the patient accounts may be referred to a collection agency.

**O Payment Assistance Rank Ordering (PARO):**

In certain circumstances, the Payment Assistance Rank Ordering (PARO) score may be used to support a decision for qualifying a patient for full or partial funding assistance. PARO is an industry recognized scoring mechanism, which uses data from publicly available databases to estimate the patient's household income and family size. PARO may be used to validate financial and demographic information provided by the patient, or it may be used in lieu of an application if the patient was unable to complete an application or if the patient is non-responsive.

**II. Approval Matrix:**

Exhibit B depicts the approval matrix for Funding Assistance.

**III. Accounting for Funding Assistance:**

Funding Assistance write-offs are accounted for in separate Deduction from Revenue general ledger accounts. One account should be used to track Funding Assistance given under the Full and Partial Funding Assistance provision; the other account should be used to track Funding Assistance given under the catastrophic coverage component. This allows tracking and monitoring of the amount and type of Funding Assistance being granted. The transaction codes used for accounting for Funding Assistance and their mapping to the General Ledger must be reviewed annually to ensure accuracy.

#### **IV. Roles and Responsibilities:**

A collaborative review between the Vice President of Mission Effectiveness and the Chief Financial Officer shall be made of this policy annually. Approval and reporting to the HCH Board occurs to ensure oversight and accountability.

#### **V. Recordkeeping:**

Records relating to potential Funding Assistance patients must be readily obtainable. Consideration should be given to maintaining a central file of the Statement of Financial Condition and other Funding Assistance summary forms if they are otherwise not readily accessible.

In addition, notes relating to the Funding Assistance application and approval or denial should be entered on the patient's account.

#### **VI. Public Notice and Posting:**

Public notice of the availability of assistance through this policy is made through each of the following means:

1. Notices are posted in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, such as emergency departments, billing offices, admitting offices, financial counseling offices and hospital outpatient service settings.
2. Language is included on patient liability statements sent to patients indicating:
  - If the patient meets certain income requirements that the patient may be eligible for a government sponsored program or for financial assistance from the hospital, and
  - A hospital contact name and phone number that the patients may call in order to gain information on the hospital's Funding Assistance, reduced payment, and other financial assistance policies.
3. Posting notice of the availability of assistance and contact names and phone numbers on HCH's web site and notices.
4. Providing uninsured patients information about the types of financial assistance available. Upon request, a full text copy of the Funding Assistance Policy is made available.
5. Posting annually on the website or otherwise make available to the public on a reasonable basis:
  - The costs of Funding Assistance provided

- The unreimbursed costs of care provided to beneficiaries of government programs that serve the poor (being defined as shortfalls between costs and off-setting reimbursement/revenue that HCH experiences in providing care under the Medicaid and local/county indigent programs for care provided to Medicare beneficiaries who are dually eligible for Medicaid).
6. Posted notices (as listed above) shall be in the primary language(s) of the service area and in a manner consistent with all applicable federal and state laws and regulations.

**STATEMENT OF FINANCIAL CONDITION**

<b>Last</b>	<b>First</b>	<b>MI</b>	<b>Social Security #</b>	<b>D.O.B</b>
<b>Home Telephone #</b>		<b>Emergency Contact Telephone #</b>		<b>Alternate Contact Telephone #</b>
<b>Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Employer: Company Name</b>			<b>Business Phone #</b>	
<b>Employment Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Spouse Employer: Company Name</b>			<b>Business Phone #</b>	
<b>Spouse Employment Address: Street</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>

<b>Income Information:</b>		<b>Last 12 Months Gross Income</b>	
	<b>Patient</b>	<b>Spouse</b>	
<b>Family Size:</b>			<b>Was your Medical condition a result of an accident or injury?</b>  Yes or No  _____  <b>Have you retained the services of an attorney? Yes or No</b>  _____  <b>Attorney Name:</b>  _____  <b>Attorney's Tel#:</b>  _____
Patient's Gross Income:	\$	\$	
Other Family Income:	\$	\$	
Interest and Dividends:	\$	\$	
Real Estate or Personal Property:	\$	\$	
Social Security:	\$	\$	
State Financial Assistance:	\$	\$	
Other Income: (please specify)	\$	\$	
Alimony or Child support payments made: (subtract)	\$	\$	
<b>Total Combined Income:</b>	\$	\$	

<b>Monthly Allowable Expense Information Payment</b>		
<input type="checkbox"/> Rent <input type="checkbox"/> Own	Mthly	\$
Utilities	Mthly	\$
Food Allowance	Mthly	\$
Other Allowable Expenses	Mthly	\$
<b>Total Monthly Expenses</b>		\$

<b>Other Considerations</b>		
<b>Child Care / Babysitter</b>	Yes	No
<b>Single Parent caring for elders</b>	Yes	No
<b>Cost to provide services exceeds third party reimbursement</b>	Yes	No
<b>Emergency Services?</b>	Yes	No
<b>If patient is deceased is there an estate?</b>	Yes	No

By signing this form I agree to allow Holy Cross Hospital and/or Holy Cross medical group to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I understand that I am to apply for any assistance via State county or federal funding, which may be available for payment of my hospital visit, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this charity application applies only to the dates of service and corresponding account numbers referenced on this application for Holy Cross Hospital and Holy Cross Medical Group and that I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists. Unless patient requires a course of treatment based on one diagnosis a new charity form must be submitted for every date of service. I understand that this charity application applies to only Holy Cross Hospital and Holy Cross Medical Group accounts and I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists.

**Date of Request:** \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

Reviewed by \_\_\_\_\_  
 Rev 3/28/2011

\_\_\_\_\_ Date  
 10

**EXHIBIT (A-1)**



4725 North Federal Highway  
Ft. Lauderdale, FL 33308  
(954)-771-8000 – Main Hospital Campus  
(954)-267-7771 – Financial Counseling  
(954)-596-8001 – Business Office Customer Service

**FUNDING ASSISTANCE/INCOME INDIGENCY ATTESTATION STATEMENT**

**Patient Name:** \_\_\_\_\_

**HCH Account Number:** \_\_\_\_\_

I, \_\_\_\_\_ certify, under the penalty of law that my family income for the past twelve (12) months has been \$ \_\_\_\_\_, and that there are \_\_\_\_\_ people in my household/immediate family. I certify that I reside in \_\_\_\_\_ County/Country.

This income information can be verified by calling the following employer(s):

\_\_\_\_\_  
Company Name Phone Number  
\*If not currently employed please indicate such on the above line by writing "not employed".

Additionally, I understand that in accordance with S.817.50, providing false information to defraud a hospital for the purposes of obtaining goods for services is a misdemeanor in the second degree.

\*By signing this form I agree to allow Holy Cross Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount.

\_\_\_\_\_  
Guarantor Name Date Guarantor Signature Date

\_\_\_\_\_  
Witness Date Relationship to Patient

State of Florida  
County of Broward

The foregoing instrument was acknowledged before me this \_\_\_\_\_  
by \_\_\_\_\_, who is personally known to me or who has proved  
\_\_\_\_\_ as identification and who did/did not take an oath.

\_\_\_\_\_  
Notary Public Date

**EXHIBIT B**

**Authorization for Funding Assistance**

CEO, CFO and/or Vice President of Mission Effectiveness: Above \$15,000

Business Services Director and/or Controller: Up to \$15000

Supervisors: Business Services, Patient Accounting, Admitting and/or Collections and Financial Counselors: Up to \$1,000

\_\_\_\_\_  
Approval Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval Signature

\_\_\_\_\_  
Date



## EXHIBIT D

**ELIGIBILITY GUIDE: Using household income and size as in Attachment A, identify eligibility for Funding Assistance**

### Indigent/Charity Guidelines for 2011

<b>Family Size</b>	<b>Period</b>	<b>Federal Poverty Guideline (FPG)</b>	<b>If income is below 200% (shown below) of FPG, eligible for <i>Full Write off</i></b>	<b>If income is above 200% but below 400% (shown below), eligible for <i>Partial Write off</i></b>
<b>1</b>	<b>Annual</b>	<b>\$10,890</b>	<b>\$0-\$21,780</b>	<b>\$43,560</b>
<b>2</b>	<b>Annual</b>	<b>\$14,710</b>	<b>\$0-\$29,420</b>	<b>\$58,840</b>
<b>3</b>	<b>Annual</b>	<b>\$18,530</b>	<b>\$0-\$37,060</b>	<b>\$74,120</b>
<b>4</b>	<b>Annual</b>	<b>\$22,350</b>	<b>\$0-\$44,700</b>	<b>\$89,400</b>
<b>5</b>	<b>Annual</b>	<b>\$26,170</b>	<b>\$0-\$52,340</b>	<b>\$104,680</b>
<b>6</b>	<b>Annual</b>	<b>\$29,990</b>	<b>\$0-\$59,980</b>	<b>\$119,960</b>
<b>7</b>	<b>Annual</b>	<b>\$33,810</b>	<b>\$0-\$67,620</b>	<b>\$135,240</b>
<b>8</b>	<b>Annual</b>	<b>\$37,630</b>	<b>\$0-\$75,260</b>	<b>\$150,520</b>
<b>Each additional person after 8 add</b>		<b>\$3,820</b>		

FSG.FT.COLL.606 Federal Charity Guidelines 2011

### **Catastrophic Coverage:**

If Patient Liability is greater than or equal to 25% of the annual family income, amounts greater than 25% of the income may be written off to Funding Assistance due to Catastrophic Circumstances.

## EXHIBIT E



4725 North Federal Highway  
Ft. Lauderdale, FL 33308  
(954)-771-8000 – Main Hospital Campus  
(954)-267-7771 – Financial Counseling  
(954)-596-8001 – Business Office Customer Service

## FINANCIAL EVALUATION

### **Information Necessary to Establish Eligibility:**

1. Tax Return with W-2/1099 Form for the prior year to include **ALL PAGES**.
2. Notarized Affidavit Affirming Income **ENCLOSED**.
3. Recent bank statements for the last (3) months to include **ALL PAGES**.
4. Recent pay stub or Other Proof of Income for the **LAST 12 MONTHS**.
5. You must apply for Medicaid if denied, a copy of your determination letter needed for file.
6. Copy of ID required.

**Holy Cross Hospital and Holy Cross Medical Group reserves the right to ask for additional information as necessary to process the Funding Assistance Application.**

**This application needs to be returned in 15 days.**

Upon receipt of all of the required information identified above, your application will be reviewed, and you will be made aware of the determination.

**Failure to submit requested information will result in automatic denial of extended payments or financial assistance benefits.**