Ashley County Medical Center
Policy and Procedure

Subject:	**Financial Assistance Policy (FAP)**		
Effective:	**April 3, 2009**	**Revised:**	**June 1, 2017**
Policy Owner:	**Financial Counseling & Admissions**		**May 19, 2020**
			May 20, 2021
			January 13, 2022
			May 4, 2022
			November 2, 2022
			December 16, 2022
Type of Policy:	**Organizational**		
Policy Distribution:	**Financial Counseling & Admissions**		

Purpose: To provide organizational guidelines of eligibility criteria and determination of qualifying individuals for financial assistance for all emergency and other medically necessary care provided by Ashley County Medical Center.

Policy:

Ashley County Medical Center (ACMC) is a not-for-profit Critical Access Hospital (CAH) existing to promote good health and provide quality healthcare with a qualified staff in a caring and compassionate manner. This hospital is committed to providing emergency care and medically necessary services to patients regardless of their ability to pay. Through our financial assistance program, we offer discounted charges for services to eligible patients that may cover all or part of their bill. The program reduces the patient bill based on income and family size. The reduction is based on a sliding fee scale. For uninsured patients, we will apply an automatic discount to patient's total charges of 60%.

A. SERVICES COVERED UNDER POLICY

The following healthcare services are eligible for financial assistance, depending on program eligibility:

1. Emergency medical services provided in an emergency room setting
2. Medically necessary healthcare services
3. Ashley County Medical Center's Physician office visits and services
4. Physical Therapy, Occupational Therapy, and Speech Therapy

The following healthcare services are not eligible for financial assistance:

1. Sleep Study
2. Orthopedic Surgery
3. Ophthalmology Surgery
4. Home Health
5. All services that have entered into legal action for collection

The "NOTICE OF PARTICIPATING AND NON-PARTICIPATING PROVIDERS", other than ACMC, delivering emergency or other medically necessary care in the hospital, is included within this Policy.

B. EMERGENCY SERVICES

ACMC will provide, without discrimination, care for emergency medical conditions to individuals, regardless of their eligibility under this financial assistance policy.

C. ELIGIBLE PATIENTS

Eligibility for financial assistance will be considered for those individuals who are unable to pay for their care based upon a determination of financial need in accordance with this Policy. A person whose individual or family income is not more than 225% of the current Federal Poverty Guideline (FPG) of the United States Department of Health and Human Services may be eligible for financial assistance. An eligible patient may not be charged more than amounts generally billed ("AGB") for emergency care or medically necessary care to individuals who have insurance. In the case of all other care provided, an eligible patient may not be charged more than the gross charges.

D. INELIGIBLE PATIENTS

Anyone who does not meet the organization's financial assistance criteria or who refuses to provide the information necessary to determine eligibility will be determined as ineligible for financial assistance.

E. DEFINITIONS:

Emergency Medical Care – Care provided by a hospital facility for emergency medical conditions.

Emergency Medical Conditions – Means emergency medical conditions as defined in section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary Services –

1. Are consistent with the person's symptoms, diagnosis, condition, or injury;
2. Are recognized as the prevailing standard and are consistent with generally accepted professional medical standards of the provider's peer group;
3. Are provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition which would result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing standards for the diagnosis or condition;
4. Are not furnished primarily for the convenience of the person or the provider; and
5. There is no other equally effective course of treatment available or suitable for the person needing the services which is more conservative or substantially less costly.

Application Period – The period during which an application must be accepted and processed under this policy. The application begins on the date the care was provided and ends on the later of the 240th day after the date that the first post-discharge billing statement for the care is provided. Applications may be accepted outside of the application period.

Medically Indigent Person – A person whom the organization has determined is unable to pay some or all of his/her medical bills because the individual's income is equal to or less than 225% of FPG.

Family Unit – Consists of individuals living alone; and spouses, parents and their children under age 21 or disabled living in the same household. A family unit may include minor children living with a legal guardian.

Gross Income – Total family unit income before taxes for the most recent three (3) months. Family unit income may include earnings, unemployment compensation, workers' 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, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count. If an individual is a non-relative and living with a family, his/her income is not included in gross income.

Amounts Generally Billed (AGB) – The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

Extraordinary Collection Action (ECA) – Includes any of the following actions:

- Selling an individual's debt to another party;
- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
- Deferring or denying, or requiring a payment before providing medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under this policy;
- Actions that require a legal or judicial process, which may include liens, foreclosure, attachment, seizure, commending a civil action, causing an individual's arrest, causing an individual to be subject to a writ of body attachment and garnishment.

F. AMOUNT OF FINANCIAL ASSISTANCE

The hospital bill may be discounted up to 100% if the qualified patient income does not exceed 225% of the FPG (family unit adjusted). To qualify for this program, the patient must not qualify for public aid or payment from other third-party sources, including Medicare and/or Medicaid.

Patients who qualify for a reduction in their patient bill or do not financially qualify for a reduction can arrange for installment payments. After a financial assessment, the appropriate monthly payment will be assigned with a prescribed timeframe.

Ashley County Medical Center's "NOTICE OF AVAILABILITY OF UNCOMPENSATED SERVICES" provides further details regarding the eligibility and amounts of financial assistance.

G. METHOD OF APPLYING FOR FINANCIAL ASSISTANCE AND DETERMINATION PROCEDURES

In order to determine if a patient is eligible for assistance, an application must be completed by the patient or guarantor. The hospital will then review the application and make a determination of eligibility. Approval is valid for a period of one year. Patients must apply (or reapply) for free or reduced charges with current financial information on an annual basis.

In order to qualify for assistance, the patient must:

- Complete an application form
- Provide documentation of gross income for the last three (3) months, including where applicable;
    - Federal tax form 1040
    - Last three pay stubs for all household members (or if unavailable, a letter from employer stating weekly wages)
    - Provide evidence that patient has pursued all other payment sources, including public aid
    - Provide bank statements for the last two months for all household members

Upon completion, the application and related material will be reviewed for a decision of eligibility by the Financial Counseling Supervisor. Until the hospital has made reasonable efforts to determine the patient's eligibility, we will refrain from initiating extraordinary collection activities.

An application will be considered in a "HOLD" status if a third-party coverage is discovered that will pay for the related services. The determination process will not continue until the receipt of those monies.

Upon final approval, the eligible amount will be adjusted off the patient balance and a determination letter will be mailed to the patient informing them of the results of their application. Unless the application is placed in "HOLD" status, the determination process will be completed within ten (10) business days of receipt of the completed application.

If the application is not approved, a determination letter will be mailed to the patient informing them of the results of their application. If the patient believes the initial decision regarding his or her eligibility is incorrect, he or she may appeal the determination directly to the Financial Counseling Supervisor. A decision regarding this appeal will be made within five (5) business days.

It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering the non-emergent medically necessary service. However, the determination may be done at any point in the collection cycle prior to legal action. The need for financial assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than one (1) year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

H. COLLECTION ACTIONS

For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, Ashley County Medical Center may offer extended payment plans. In these cases, the hospital will not send unpaid bills to outside collection agencies and will cease all collection efforts. Ashley County Medical Center will not impose extraordinary collection actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Verifying that the patient owes the unpaid bills;
2. Providing information to the patient regarding the availability of financial assistance;
3. Providing determination of eligibility on a timely basis;
4. Requesting that the patient identify all sources of third-party payments;
5. Determining that the hospital has pursued collections from the third-party payment sources identified by the patient;
6. Documenting that the hospital has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements; and
7. Documenting that the patient has been offered a payment plan but has not honored the terms of that plan.

I. MEASURES TO WIDELY PUBLICIZE FINANCIAL ASSITANCE POLICY

Ashley County Medical Center's Financial Assistance Policy is available to the public using various means, which may include, but is not limited to the posting of the policy:

- In patients' bills,
- In the emergency room, admitting and registration departments, and patient financial service offices which are located on hospital campus locations, and at other public places as Ashley County Medical Center may elect;
- On the hospital website;

- In brochures available in patient access sites; and
- At other places within the community served by the hospital as Ashley County Medical Center may elect.

Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Ashley County Medical Center. Referral of patients for financial assistance may be made by any member of the hospital staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to application privacy laws. All Financial Assistance Policy documents shall be available in a translated version for any language spoken by at least 1,000 individuals or 5% of the community.

NOTICE OF AVILABILITY OF UNCOMPENSATED SERVICES

At Ashley County Medical Center, free or discounted services are available for medically necessary, non-elective inpatient and outpatient services to qualifying individuals.

ELIGBILITY CRITERIA:

To be eligible to receive free or reduced-charge care, your family income must not be more than 225% of the U.S. Department of Health and Human Services Federal Poverty Guidelines based upon family size.

If you think you may be eligible for free or reduced-charge services, you may make this request at Ashley County Medical Center. A written conditional or final determination of your eligibility will be made within ten (10) business days of your request.

To qualify for some level of free or reduced-charge care, your family income must be no more than 225% of the following income scale:

Size of Family Unit	Federal Poverty Guidelines (FPG)	100% Financial Assistance (150% FPG)	75% Financial Assistance (175% FPG)	50% Financial Assistance (200% FPG)	25% Financial Assistance (225% FPG)
1	$13,590	$20,385	$23,783	$27,180	$30,578
2	$18,310	$27,465	$32,043	$36,620	$41,198
3	$23,030	$34,545	$40,303	$46,060	$51,818
4	$27,750	$41,625	$48,563	$55,500	$62,438
5	$32,470	$48,705	$56,823	$64,940	$73,058
6	$37,190	$55,785	$65,083	$74,380	$83,678
7	$41,910	$62,865	$73,343	$83,820	$94,298
8	$46,630	$69,945	$81,603	$93,260	$104,918
For families/households with more than 8 persons, add $4,720 for each additional person to the Federal Poverty Guidelines, $7,080 for 100% Financial Assistance, $8,260 for 75% Financial Assistance, $9,440 for 50% Financial Assistance, and $10,620 for 25% Financial Assistance.					

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, Ashley County Medical Center could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless or received care from a homeless clinic;
- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
- Patient is deceased with no known estate
- Medicaid eligibility
- Medicaid Non-Covered Services

NOTICE OF PARTICIPATING AND NON-PARTICIPATING PROVIDERS

PROVIDERS	PARTICIPATING INDICATION
Arkansas Pathology	No
BCS, Inc. (Anesthesia Billing)	Yes
Emergency Staffing Solutions (ER Physicians)	No
Laboratory Corporation of America (Reference Lab)	No
Cheryl Rabalais, ANP – Family Practice	Yes
Pamela Winston, ANP – Family Practice	Yes
Jenny Murphy, ANP – Family Practice	Yes
Julie Bays, ANP – Family Practice	Yes
Tracey Longstreth, ANP – Family Practice	Yes
Dr. Adam Sandlin – Obstetrics/Gynecology	No
Dr. Appalanaidu Sasapu – Oncology/Hematology	No
Dr. Balil Malik – Oncology/Hematology	Yes
Dr. Barry Thompson – Family Practice	No
Dr. Benjamin Walsh – Family Practice	Yes
Dr. Brad Walsh – Family Practice	Yes
Dr. Bradley Fogel – Pathology	No
Dr. Charles Clogston – Cardiology	No
Dr. Curtis Lowery – Obstetrics/Gynecology	No
Dr. David Pope – Pathology	No
Dr. David Tamas – Radiology	No
Dr. David Wells – Radiology	No
Dr. Dawn Hughes – Obstetrics/Gynecology	No
Dr. Douglas Kerin – Radiology	No
Dr. Everett Magann – Obstetrics/Gynecology	No
Dr. Felicia Watkins-Brown – Family Practice	Yes
Dr. Henry Gomez – Pediatrics	Yes
Dr. Ian Birkett – Pathology	No
Dr. Ian Cawich – Cardiology	No
Dr. Ira Murphy – OB/GYN	Yes
Dr. James Atkins – Pediatrics	No
Dr. James Workman – Radiology	No
Dr. Johnnie Hinton – Nephrology	No
Dr. Kara Worley – Obstetrics/Gynecology	Yes
Dr. Katherine Steward – Pathology	No
Dr. Kathleen Sitarik – Radiology	No
Dr. Keith Schluterman – Neurology	No
Dr. Kenneth Richards – Pediatrics	Yes
Dr. Lon Bitzer – General Surgery	Yes
Dr. Mark Malloy – Internal Medicine	Yes
Dr. Michael Allen – Pathology	No
Dr. Michael Huber – Cardiology	No
Dr. Michael Schonefeld – Nephrology	No
Dr. Michael Weiner – Pathology	No
Dr. Nafisa Daiani – Obstetrics/Gynecology	No
Dr. Nicholas Willis – Cardiology	No
Dr. Nurreddin Almaddah – Cardiology	No
Dr. Paul Stout – Pathology	No
Dr. Paul Wendel – Obstetrics/Gynecology	No
Dr. Perkins Mukunyadzi – Pathology	No
Dr. Scott Claycomb – Ophthalmology	No
Dr. Stephen Sturdivant – Pathology	No
Dr. Stewart Rushton – Obstetrics/Gynecology	No
Dr. Warren MacDonald – Orthopedic Surgeon	Yes
Dr. William Lim – Radiology	No

ASHLEY COUNTY MEDICAL CENTER
APPLICATION FOR UNCOMPENSATED CARE

1. Patient's Name_____ SS#_____ DOB_____
   Address_____ City_____ State_____ Zip_____
   Home telephone number_____ Cell_____

2. Household Members: (including yourself and/or patient)

Name	Age	Employer/School	Birth date

3. Income: List gross income of total household for the categories below. Please attach a copy of a recent pay stub, tax return, social security or disability statement, or other documentation of income::

	Last 3 months	Present
Wages		
Farm or Self-employment		
State Assistance		
Social Security		
Unemployment		
Alimony		
Child Support		
Military Fam Allotments		
Pension		
Other		

(If there is NO income at all, please explain how you pay your monthly bills.)

4. Monthly Bills (Please attach documentation of such as a copy of a payment coupon or a monthly statement):
   a. Mortgage/Rent _____
   b. Car Payment _____
   c. Credit Cards _____
   d. Other _____

5. List all checking and savings accounts, stocks, bonds, cash on hand, etc., for all household members_____
   _____

6. Does anyone in your household own any real estate (house, land, buildings, etc.)? YES_____ NO_____
   If yes, please supply information about the value of the property, any amount owed, and how the property is used._____
   _____

7. Do you rent?_____ Landlord_____ Phone #_____

8. Have you applied for Medicaid?_____ If denied, why?_____

My signature below signifies that the information I have provided on this application is true and accurate. I understand that falsification of information will invalidate this application. I authorize ACMC to make all inquiries as it deems necessary to verify the accuracy of the statements made herein.

_____ _____

Signature Date

06/20/2017