Financial Assistance Policy

Category:	Patient Accounting	Reviewed / Revised:
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POLICY: Wilkes Regional Medical Center (WRMC) shall provide appropriate levels of care, commensurate with the facility's resources and the community needs. WRMC is committed to assisting patients obtain coverage from various programs as well as providing financial assistance (FA) to every person in need of medically necessary hospital treatment. WRMC will always provide emergency medically necessary care regardless of the patient's ability to pay. Similarly, patients who are able to pay have an obligation to pay and providers have a duty to seek payment from these individuals.

OBJECTIVES:

- To model WRMC core values of *"Caring for Our Community"*.
- To ensure the patient exhausts other appropriate coverage opportunities prior to qualifying for WRMC financial assistance.
- To provide financial assistance based on the patient's ability to pay.
- To ensure WRMC complies with any required Federal or State regulation related to financial assistance.
- To establish a process that minimizes the burden on the patient and is cost efficient to administer.

DEFINITIONS:

The terms used within this policy are to be interpreted as follows:

- Amount Generally Billed (AGB): The average amount billed to WRMC insurance companies and Medicare for billable services provided to patients
- Bad Debt: Accounts that have been categorized as uncollectible because the patient has been unable to resolve the outstanding medical debt.
- Elective: Those services that, in the opinion of a physician, are not needed or can be safely postponed.
- Emergency Care: Immediate care which is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.
- Household Financial Income: As measured against annual Federal Poverty Guidelines includes, but is not limited to the following:
    - Annual household pre-tax job earnings
    - Unemployment Compensation

    - Workers' Compensation
    - Social Security and Supplemental Security Income
    - Veteran's payments
    - Pension or Retirement income
    - Other applicable income to include, but not limited to: rent, alimony, child support, and any other miscellaneous source
- Medically Necessary: Hospital services provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
- Other Coverage Options: Options that would yield a third party payment on account(s) including, but not limited to: Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile and/or other accidents.

Financial Assistance Guidelines

Eligibility Scale
Charity care shall be provided to uninsured patients whose Household Financial Income is 200 percent or less of the Federal Poverty Guideline (FPG).

For financially needy patients whose Household Financial Income is between 125 percent and 200 percent of the FPG, discounts shall be provided to limit such patient's payment obligation to the amount of the patient account balance after subtracting the percentage discount applicable to the patient's FPG household income provided in the following table:

Discount	Current Year Federal Poverty Guidelines for Family Size
100%	Family income is less than or equal to **125%** of FPG
75%	Family income is **125%** to **150%** of FPG
50%	Family income is **151%** to **200%** of FPG

Documentation Requirements

Documentation of household size and income is required. Acceptable documents may include:
- Most Recent IRS form 1040
- Pay Check Stubs from all working individuals in the "household" for the most recent month
- Bank Statements

If the patient does not or cannot present the information outlined above, the facility may use other evidence to demonstrate eligibility.

If additional information is required from the patient to complete the application, the facility will notify the individual in writing of the information that is missing and provide a reasonable time period for it to be provided.

Presumptive Eligibility
Patients who qualify and are receiving benefits from the following programs may be presumed eligible for 100 percent financial assistance:

- **Food stamps.** The U.S. Department of Agriculture Food and Nutrition Service Food Stamp Program.
- **State Relief Programs.** Some State programs that do not cover medical needs are available to individuals deemed to be living in poverty. WRMC may qualify a participant in specific programs as qualification for financial assistance when medical insurance benefits are not available.
- **Local Programs. V**erified as meeting poverty guidelines Some counties offer a financial assistance program designed to provide emergency short-term assistance to persons lacking the resources to meet their basic needs for food, shelter, fuel, utilities, clothing, medical, dental, hospital care and burial. The facility's Financial Assistance program may provide assistance for hospital charges not covered by these programs.
- **Homelessness.** Homeless persons qualify for assistance.
- **Deceased Patients.** Unpaid balances of patients who are deceased with no estate or surviving responsible party qualify for assistance.

Patients who meet presumptive eligibility criteria may be granted financial assistance without completing the financial assistance application. Documentation supporting the patient's qualification for or participation in a program must be obtained and kept on file. Unless otherwise noted, an individual who is presumed eligible under these presumptive criteria will continue to remain eligible for the Eligibility period outlined below, unless facility personnel have reason to believe the patient no longer meets the presumptive criteria.

Eligibility Evaluation Process
In order to determine the appropriate level of financial assistance to apply to a patient's account, the facility will perform one of the following:

- Utilize a scoring mechanism, with the assistance of a third-party vendor that provides a patient financial profile.
- Require the patient to complete a financial assistance application
    - Household income, as defined above, will be considered in determining whether a patient is eligible for financial assistance. Household income will be included from all members of the household as defined by federal tax guidelines.
- Document the patient's qualification under Presumptive Eligibility criteria outlined above on a Financial Assistance application

Eligibility Period

- An individual who is presumed eligible under these criteria will continue to remain eligible for six months following the date of the initial approval, unless information is identified that the patient status has changed and would deem the patient to be ineligible.
- Upon initial approval, the facility will also include accounts as eligible for financial assistance. If the first post discharge statement was mailed 240 days or less from the eligibility date.
- Patients will be refunded any amounts they paid that are in excess of the final liability determined to be appropriate after financial assistance adjustments are applied.

Eligible Population

This policy is applicable to uninsured patients who:.

- Are admitted for Emergency Medical Care and for any Medically Necessary care following an Emergency Admission regardless of the location of their household
- Patients with third party insurance coverage (including governmental payers) may be eligible for financial assistance for balances after insurance. Patients may also request consideration for discounts for larger balances through the Hardship Settlement Policy.

Eligibility Notification

After receiving the patient's request for financial assistance and any financial information or other documentation needed to determine eligibility for financial assistance, the patient will be notified of the patient's eligibility determination within a reasonable period of time.

Communication of Financial Assistance Policy

WRMC communicates the availability of financial assistance policy to all patients through means which include, but are not limited to:

- On our website: www.wilkesregional.com
- On all billing statements
- Information posted at conspicuous locations throughout the facility
- During Financial Counselor patient interviews
- During Patient Accounting Customer Service patient interaction
- Physical Address to obtain a copy of Financial Assistance Policy and/or application can be obtained at no cost to patient by submitting a request to:

  Wilkes Regional Medical Center
  Financial Counseling Department:
  P.O. Box 609
  1370 West D Street
  North Wilkesboro, NC 28659
  (336) 651-8100

Financial assistance policy and application are available in English, Spanish and any other language that is considered the primary language of any population with limited English

proficiency that constitute more than 5% of 1000 persons (whichever is less) of the population served by the facility)

Participation by Clinicians who work in WRMC

A listing of Clinicians who are included in this Financial Assistance Policy and those who are not included in this policy is available by contacting our Financial Counselors at 336-651-8100.

Patient Responsibilities Regarding Financial Assistance

If applicable, prior to being considered for financial assistance, the patient/family must cooperate with the WRMC to furnish information and documentation to apply for the Financial Assistance Program as well as other existing financial resources that may be available to pay for the patient's health care, such as Medicaid, Medicare, third-party liability, etc.

- A patient who qualifies for partial discounts must cooperate with the provider to establish a reasonable payment plan that takes into account available income, the amount of the discounted bill(s), and any prior payments.
- Patients who qualify for partial discounts must make a good faith effort to honor the payment plans for their discounted healthcare bills. They are responsible for communicating to the provider any change in their financial situation that may impact their ability to pay their discounted healthcare bills or to honor the provisions of their payment plans.

Amount Generally Billed

AGB is determined through the "Look-back method" which is calculated as follows:

1. The AGB for emergency or medically necessary care provided to a financial assistance-eligible individual is determined by dividing sum of payments made by Medicare and other private health insurers for emergency and other medically necessary by gross charges associated for those claims. The percentage is calculated at least annually by dividing the sum of certain claims paid to the hospital facility by the sum of the associated gross charges for those claims.

2. The percentage is applied by the 120th day after the end of the 12-month period WRMC used in calculating the AGB percentage.

3. Information on AGB is available and can be obtained at no additional cost by submitting a request to:

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Financial Counseling Department:
P.O. Box 609
1370 West D Street
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(336) 651-8100

Additional Information

- WRMC has established a separate Billing and Collection policy which outlines actions that may be taken on balances due from patients. A copy of can be obtained at no cost to patient by submitting a request to:

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Financial Counseling Department:
P.O. Box 609
1370 West D Street
North Wilkesboro, NC 28659
(336) 651-8100

APPROVALS

Policy Coordinator	Donna McClung, PFS Director
Vice President (or above)	Barry Wald, VP Finance and CFO