Policy applies to:

- ☐ All Companies
- ☒ Carson Tahoe Health System
- ☒ Carson Tahoe Regional Healthcare
- ☒ Carson Tahoe Continuing Care (LTACH)
- ☒ Carson Tahoe Physician Clinics (CTPC)
- ☐ Carson Tahoe Cardiology (CTC)
- ☐ Physician Hospital Organization (PHO)
- ☐ Sierra Surgery

Title: **FINANCIAL ASSISTANCE PROGRAM**	
Author: Revenue Cycle Director	**Effective Date: January 1st, 2016**
Approval: A. Beck, VP/CFO	**Review Date: November 2015**
Contact: Patient Financial Services	**Cancels: Charity Care Program, Financial Assistance- Physician Clinics**
Policy Committee Review Date:	

POLICY:

Carson Tahoe Health is committed to treating all patients equitably, with dignity, respect and compassion regardless of their financial status or ability to pay. In support of this commitment Carson Tahoe Health has established a Financial Assistance Program which offers both free and discounted care, depending on individuals' family size and income.

Patients seeking assistance may first be asked to apply for other external programs as appropriate before eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being. Financial assistance is provided only when care is deemed medically necessary and after patients have been found to meet all financial criteria.

PURPOSE:

To provide discount guidelines for the consistent determination of uncompensated or partial pay care to patients who may not qualify for state, federal, county or other assistance and/or have no reasonable means to pay for services received.

DEFINITIONS:

1. Medically Necessary: Health care services or products that a prudent physician would provide to a patient to prevent, diagnose, or treat an illness, injury, or disease, or any symptoms thereof, that are necessary and are:
   - Provided in accordance with generally accepted standards of medical practice;
   - Clinically appropriate with regard to type, frequency, extent, location and duration;
   - Not primarily provided for the convenience of the patient, physician or other provider of health care;
   - Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
   - The most clinically appropriate level of health care that may be safely provided to the insured.
2. Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious

jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
3. Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.
4. Underinsured: Patient having some insurance coverage but not enough, or when a patient is insured yet unable to afford the out-of-pocket responsibilities not covered by patient insurer.
5. Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care (determined as described in section D of the policy below).
6. Presumptive Eligibility: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.
7. Financial Assistance Committee: A multi-disciplinary team formed internally to review all financial assistance applications for approval and denial determinations in accordance with this policy.
8. Catastrophic Financial Assistance: Financial assistance given to patients with a federal poverty level >400% and whose medical expenses are greater than one-fourth of their annual income.

PROCEDURE:

A. Referral Process:

1. The referral process will optimally occur prior to or at the time of service, but may occur any time during the collection process, including post-assignment to an outside collection agency.
2. Uninsured patients must first be screened by an eligibility vendor or financial screening software to determine eligibility for an alternate payer source, including but not limited to federal, state, or county assistance.
3. Referrals for the Financial Assistance program may be made by the following areas: Patient Access, Patient Financial Services, Collection Agency, Physician Practice, and other community organizations.
4. Financial Assistance referrals should be made prior to any planned procedure.

B. Screening Process:

1. All patients with the inability to pay will be screened for financial assistance by Patient Access or Patient Financial Services. If found not to be eligible for any outside assistance, the patient is referred to a Financial Counselor for Financial Assistance screening using the most current income guidelines released by the Department of Health and Human Services. At this time the Financial Assistance application process begins.
2. Patients must live within the Carson Tahoe Health primary service area to be considered for financial assistance.
3. Factors to be considered during the screening process include comparing the patient's gross income to the annually published Federal Poverty Guidelines, legal household determination, treatment received, quantity of accounts under review, patient account balances, and exhaustion of all other payment sources.
4. Uninsured patients are required to apply for government program assistance through the government program directly.

C. Eligibility Criteria:

1. The Financial Assistance Program may only be used for medically necessary care as defined in the definitions section of this policy.

2. All applicants will be assigned a Federal Poverty Level (FPL) using the matrix found in the most current FPL table as defined by the IRS (Attachment A).
3. Household number of legal dependants will be based on the latest filed tax return.
4. Patients with a household FPL ≤400% will be considered for the Financial Assistance program. Patients with an FPL >400% are not eligible and alternate payment arrangements will be pursued, unless medically necessary services are considered catastrophic.
5. Patients eligible for the following programs/services are deemed medically indigent and may not require a complete Financial Assistance application in order to be considered for the program:
    - State assistance programs (food stamps, pharmaceutical assistance programs, welfare, etc.) Patient will need to submit proof of enrollment for determination.
    - Patients currently covered for Medicaid, but not eligible on the date of service, or patients eligible for Medicaid emergency or pregnancy services only.
6. For underinsured patients, a payment, denial, or benefit summary from primary insurance must be secured prior to consideration for the Financial Assistance program.
7. Patient cost share amounts, if any, will be determined utilizing the matrix shown in Attachment A.
8. Assets exempt from financial consideration include the residence where a patient and/or patient's family resides, automobiles needed to transport all working parties to and from work, savings accounts with less than two months of income, and retirement accounts with less than $50,000.00 are exempted from consideration.

D. Determining Discount Amount

1. Once eligibility for financial assistance has been established, Carson Tahoe Health will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) to insured patients for emergency or medically necessary care.
2. To calculate the AGB, Carson Tahoe Health uses the "look-back" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. Carson Tahoe Health uses data based on claims processed by Medicare fee for-service and all private commercial insurers for all medical care over the past year to determine the percentage of gross charges that is typically allowed by these insurers.
3. The AGB percentage is then multiplied by gross charges for emergency and medically necessary care to determine the discount. Carson Tahoe Health re-calculates the percentage each year. In 2015, the AGB percentage for inpatient and outpatient services is 29.7% based on most recent twelve month period.
4. The discount will be applied to gross charges or balance after insurance once a complete Financial Assistance application has been received and a determination has been made by the Financial Assistance Committee. (Gross Charges X AGB percentage = Amount adjusted to Financial Assistance or Balance after insurance X AGB percentage = Amount adjusted to Financial Assistance)

E. Application Process

1. Financial Assistance applications (Attachment B) can be distributed by the Patient Access and Patient Financial Service departments. Patients can also retrieve a Financial Assistance application from the organization's website, or online at: [http://carsontahoe.com/financialservices]. Once a completed application is received, the account financial class is changed to pend the collection process until a determination of the application is made.
2. Supporting financial documentation must be submitted with a completed Financial Assistance application and will include:
    - Prior year filed tax forms
    - At least past 90 days of pay stubs or other sources of income (i.e. social security, unemployment, etc.)

- Last three months of bank statements (all accounts)
    - Last three months of mortgage/rent receipts
    - Statements from any other asset accounts (i.e. retirement funds, insurance policies, investments, etc.)
3. Completed applications must be returned along with all supporting documentation within 14 days of issuance. Follow-up will be made with the patient to ensure timely receipt of completed application. Non-cooperation from the patient to follow-up with Financial Counselor requests will result in a denial after 30 days of no response. If no information is received, the account is placed into regular collection process.
4. Patients will be notified of incomplete information for applications submitted missing any of the supporting documents. Patients will be given an additional 30 days to comply with required documentation requests. Failure to comply with additional requests will result in a denial of Financial Assistance application.
5. A denial issued due to patient non-cooperation for providing requested documentation will prohibit the patient from re-applying for Financial Assistance on the same account(s).

F. Application Review

1. Completed Financial Assistance applications with required supporting documentation will be forwarded to the Financial Counselor, who will be responsible for requesting a credit bureau report, and assembling the complete Financial Assistance application packet.
2. Patients may be contacted at any time during the application review process and asked to submit additional documentation necessary to make a determination. Non-cooperation of such requests can result in a denial.
3. The Patient Financial Services department will be the custodian of all Financial Assistance complete, incomplete, and denied applications. All Financial Assistance documentation will be scanned into the patient account and retained for a minimum of seven years.
4. Completed Financial Assistance application packets will be routed for approval (including applications for pre-approval) to the Financial Assistance Committee on a monthly or as needed basis. All accounts will be reviewed by the committee including appealed decisions.

G. Approval

1. Once Financial Assistance Committee has approved an application, the Financial Counselor will ensure discount adjustments are made within the month of approval by routing to Patient Financial Services for final adjustment.
2. Financial Assistance approvals for a continuing course of treatment will apply to related accounts up to three months following approval. Patient will need to re-apply for Financial Assistance with any updated information if financial assistance is needed beyond the approval period.
3. Approval notification is sent to the patient within 10 days of decision and financial arrangements are made for any patient balance remaining.
4. It is expected that physicians making Financial Assistance referrals will provide free or partial pay care in proportion to that provided by Carson Tahoe Health.

H: Denials

1. Denial notification is sent to the patient within 10 days of decision and efforts are made to collect on remaining account balances.
2. Accounts denied for Financial Assistance will be sent back through the collection process, including re-placement to collection agency.
3. Reconsiderations can be made for patients who submit new or revised information within 30 days of the denial decision notification.
4. Application denial disputes made by the patient/guarantor must be made in writing and forwarded to the Financial Counselor at Carson Tahoe Health for review and response.

I: Actions in the Event of Non-Payment

The collection actions Carson Tahoe Health may take if a financial assistance application and/or payment is not received are described in a separate policy.

In brief, Carson Tahoe Health will make certain efforts to provide patients with information about our financial assistance policy before we or our agency representatives take certain actions to collect your bill (these actions may include civil actions, debt sales, or reporting negative information to credit bureaus).

More information on the steps Carson Tahoe Health will take to inform uninsured patients of our financial assistance policy and the collection activities we may pursue are included in Carson Tahoe Health's Billing and Collections Policy.

A free copy of this policy can be requested in person from our Financial Counselor at our facility at 1600 Medical Parkway, Carson City, NV 89703, by calling us at 775-445-8609, or online at: [http://carsontahoe.com/financialservices].

J: Eligible Providers

1. In addition to care delivered by Carson Tahoe Health System, emergency and medically necessary care delivered by the entities listed below is also covered under this financial assistance policy.
   a. Carson Tahoe Regional Healthcare and all locations
   b. Carson Tahoe Continuing Care and all locations
   c. Carson Tahoe Physician Clinics and all locations

2. Care provided by any of the providers not listed under eligible provider section J, will NOT be covered under this policy.

Attachment "A"

2015 Federal Poverty Level Guidelines

	Annual Income Guidelines							
Family Size	**100%**	**133%**	**150%**	**185%**	**200%**	**250%**	**300%**	**400%**
1	$11,770.00	$15,654.10	$17,655.00	$21,774.50	$23,540.00	$ 29,425.00	$ 35,310.00	$ 47,080.00
2	$15,930.00	$21,186.90	$23,895.00	$29,470.50	$31,860.00	$ 39,825.00	$ 47,790.00	$ 63,720.00
3	$20,090.00	$26,719.70	$30,135.00	$37,166.50	$40,180.00	$ 50,225.00	$ 60,270.00	$ 80,360.00
4	$24,250.00	$32,252.50	$36,375.00	$44,862.50	$48,500.00	$ 60,625.00	$ 72,750.00	$ 97,000.00
5	$28,410.00	$37,785.30	$42,615.00	$52,558.50	$56,820.00	$ 71,025.00	$ 85,230.00	$113,640.00
6	$32,570.00	$43,318.10	$48,855.00	$60,254.50	$65,140.00	$ 81,425.00	$ 97,710.00	$130,280.00
7	$36,730.00	$48,850.90	$55,095.00	$67,950.50	$73,460.00	$ 91,825.00	$110,190.00	$146,920.00
8	$40,890.00	$54,383.70	$61,335.00	$75,646.50	$81,780.00	$102,225.00	$122,670.00	$163,560.00

Financial Assistance Program Discount based on Federal Poverty Guidelines:

FPL	Discount
0-250%	100%
251-300%	75%
301-350%	50%
351-400%	25%

Attachment "B"

MEDICAL FINANCIAL ASSISTANCE PROGRAM

Please complete the enclosed application to help us determine your eligibility in our financial assistance program. Please return this application to the Patient Accounting Department along with the following documents:

- χ Income Verification:
  - χ Last 3 months payroll check stubs
  - χ Your latest Federal tax return
  - χ Verification of Unemployment compensation
  - χ Social Security Benefit Verification
  - χ Other ____
- χ Latest bank Statement(s)
- χ Copies of medical bills
- χ Utility Bills
- χ Other ____

This application MUST BE RETURNED TO the Patient Accounts Department or Financial Counselor WITHIN 14 DAYS. If additional time is required due to your medical condition, or if assistance with this application is needed, please contact a Financial Counselor at (775) 445-8609.

The hospital will notify you of determination of eligibility within 14 days of receipt of completed application.

All information relating to this application will be kept completely confidential

FINANCIAL APPLICATION

This application will cover all **active** accounts for:

Guarantor (Responsible Person): ____

Head of Household
Spouses Name
Street Address
City, State, Zip Code
Telephone Number

Individuals Residing in Household (List First AND Last Name)

NAME	Relationship	Age

LIST ALL INCOME FOR YOUR HOUSEHOLD

Source of Income	Monthly Income	Hourly Rate	AVERAGE hours worked per week
Pension/Retirement			
Social Security			
Wages Earned (Head of household)			
Wages Earned (Spouse)			
Unemployment Compensation			
Alimony			
Child Support			
Public Assistance			
Other Income			
TOTAL			

MONTHLY EXPENSES

Rent	$	Gasoline	$
Food	$	Insurance	$
Electric	$	Pharmacy	$
Heating Fuel	$	Child Care	$
Phone	$	Child Support	$
Cable TV	$	Alimony	$
Water	$	Other	$

ASSETS

Description	Year / Make	Value	Balance	Monthly Pmt	Institution
Home					
Automobile					
Automobile					
RV / Boat					
Cash on Hand					
Stocks/Bonds/M Fnd					
Life Insurance					

OTHER EXPENSES

List Name	**Current Balance**	**Monthly Payment**
Bank / Credit Union (Credit or Loans)		
	$	$
	$	$
TOTAL Medical Bills **(attach statements)**	$	$
Collection Agency Debt	$	$
Other	$	$

AUTHORIZATION

I request that Carson Tahoe Regional Healthcare utilize the attached information to determine my eligibility for a charity care adjustment. I understand that the information submitted is subject to verification and approval will be based upon that verification. I authorize Carson Tahoe Regional Healthcare to obtain information from any source deemed necessary to determine an acceptable financial agreement and/or assist me in obtaining financial assistance. In so authorizing, I release any person(s) or business(s) from any/all liability connected with said release.

____________________________________ _________________________

Signature of Responsible Party Date