



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 1 of 7</b>                   |

|               |  |
|---------------|--|
| <b>SCOPE:</b> |  |
|---------------|--|

PDS

|                 |  |
|-----------------|--|
| <b>PURPOSE:</b> |  |
|-----------------|--|

To define the process that will be used to determine whether any PHS patient, whether uninsured or underinsured, is eligible for full or partial charity care.

|                |  |
|----------------|--|
| <b>POLICY:</b> |  |
|----------------|--|

Presbyterian Healthcare Services (“PHS”) is committed to providing benefits to the community. PHS has defined four categories of community benefits (see Community Benefits Planning and Reporting policy, fin.pds.115). In summary, these are:

- Charity care for uninsured and underinsured patients.
- Un-reimbursed cost of government programs.
- No-charge services, donations, and sponsorships targeted to underserved populations.
- No-charge services, donations, and sponsorships for the broader community.

This policy addresses charity care for the uninsured and the underinsured, a component of our community benefit. This policy does not cover patients eligible for county indigent funds.

As a nonprofit, charitable, community-based healthcare provider, PHS will provide medically necessary services at no charge or at a reduced charge based on a sliding scale to patients who meet the specific criteria defined in this policy. These criteria shall be consistently applied.

The PHS Patient Financial Services Department will maintain an effective communication program between all areas of the delivery system to ensure the consistent application of this policy.

Third-party payment sources (for example, Medicaid, Indigent Funds, Indian Health, or Crime/Reparation Funds) must be reviewed and evaluated before an account may be considered for charity care to assure that PHS’ assets are prudently managed. PHS policies and procedures distinguish between individuals who choose not to pay (Bad Debt) and those who cannot afford to pay (Charity Care).

When a patient has indicated or demonstrated an “inability to pay,” or a need for financial assistance, a PHS Financial Counselor from the PHS Patient Financial Services Department, or another appropriate PHS representative, will provide the patient with a self-pay resource packet which contains a Financial Assistance Application (see Attachment A). The Counselor or other



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 2 of 7</b>                   |

PHS representative will assist the patient in completing the application and obtaining all required documentation.

A patient who is approved for charity care at any PHS facility will be eligible for medically necessary services throughout the system at the approved charity care level for a six-month period or for the same medical course of treatment unless other resources are located to satisfy the account. This six-month period may be extended or waived based on the individual circumstances of the patient. Patient accounts less than one year old that currently hold a "Bad Debt" status will be reviewed and considered when charity care is approved. Exceptions will be directed to the Charity Care Committee for approval.

PHS periodically reviews its charity care policies to ensure that PHS fulfills its responsibilities to provide medically necessary health care at no or reduced cost to eligible uninsured and underinsured patients. PHS reserves the right to revise, modify or change this policy at any time.

|                   |  |
|-------------------|--|
| <b>PROCEDURE:</b> |  |
|-------------------|--|

The Financial Assistance Application and the procedures used to evaluate and make a determination regarding charity care will be uniform throughout the organization.

1. Any patient presenting for emergency or urgent services will be evaluated and treated as appropriate regardless of ability to pay.
2. Subject to Emergency Medical Treatment and Active Labor Act (EMTALA) requirements, when a patient is scheduled for any services at PHS, he or she shall be notified that payment in full is expected at the time of service. If this is not possible, the patient shall be advised of PHS' policy regarding installment payments. (See Cash Collections Due At Time of Service (for non-emergency medical services) policy, CBO.PHS-H.110.) At this time, insurance or other payment sources will be identified and recorded by PFS. However, neither of these procedures will be followed in any situation that may violate EMTALA provisions. (See EMTALA Registration policy, LGL.PDS.117.) In that instance, the patient's insurance status will be recorded as soon after stabilization as possible. If a patient does not have insurance coverage or cannot provide evidence of such, he or she will be classified as "Self-Pay" within the patient financial system.
3. If a patient account cannot be settled through other means, a PHS Financial Counselor or another appropriate PHS representative will supply the patient with a Community Resource Packet which will contain a Financial Assistance Application (see Attachment A). Accompanying this application will be instructions for its completion, along with a statement that the patient will be required to provide the documents necessary to verify income and family size.



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 3 of 7</b>                   |

These documents include:

- a. Current Bank Statements
  - b. Current Proof of Income (pay stubs or other)
  - c. Most Recent Tax Return(s)
  - d. Any statements or other information to be considered
  - e. Documents that reflect current investments or other sources of savings or income
  - f. Documents that reflect resources of other family members who are legally responsible for the patient's obligation
  - g. All assets, including automobiles, trucks, land, buildings, livestock, ranch and farm equipment and savings accounts, etc.
4. The Financial Assistance Application and all supporting documentation shall be returned to the Patient Financial Services Customer Service Department. The completed application shall include the applicant's signature. A final determination of eligibility for charity care will be made within fourteen working days of receipt of a complete application.
5. After the PHS Financial Counselor, or another appropriate PHS representative, has received a Financial Assistance Application, it must be reviewed for completeness. Incomplete applications will be documented in the patient record or scanned into the system and a PHS Financial Counselor, or another appropriate PHS representative, will contact the patient or other responsible party to attempt to gather any additional information needed. The patient must be informed that the normal billing procedures will continue during this process. When a complete application has been received, it will be documented in the patient record or scanned and the account will be noted after the final determination is made. Should additional time be necessary, the patient will be advised of the approximate length of time that it will take PHS to reach a final determination on the application. If this additional time is necessary, PHS Patient Financial Services Department, or another appropriate PHS representative, will put a temporary hold on all collection activity related to the accounts involved until the determination is made. PFS will formally notify each applicant in writing of its final determination. All approved charity care accounts will be written off as charity care using the appropriate adjustment codes and with appropriate review as documented in the write-off and approval limits policy. Patient Accounting will retain a copy of the application and supporting documentation for 4 years.
6. When reviewing the Financial Assistance Application, the PHS Financial Counselor or another appropriate PHS representative will use the income guidelines provided in the PHS Financial Assistance Determination Guidelines located on PresNet at <https://phs.patientcompass.com/hc/media/DeterminationGuidelines.pdf> as well as the net value of all assets that may be liquidated to satisfy the debt. The decision to grant or reject an application must be made on an objective basis with documentation to support each decision. There will be no bias in this decision based on any demographic information, such as race, gender, immigration status, or zip code. In situations where copies of the proper supporting documentation cannot be made, the PHS Financial Counselor or another appropriate PHS representative must fully document his or her review of these documents



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 4 of 7</b>                   |

and the financial criteria on which the charity care decision was made.

7. The following accounts may be eligible for charity care without a completed Financial Assistance Application:
  - Patients or guarantors determined to be homeless.
  - Accounts that have been included in the patient's and/or responsible party's personal bankruptcy.
  - Accounts returned by the collection agency as uncollectible due to either of the above reasons.
  - Account balances remaining after payment has been received and applied from a sole community provider fund.
  - Account balances that are the result of visits and/or services received at any of PHS special care clinics, for example, child abuse or domestic violence.
  - Applications taken in a patient's home by a licensed representative of PHS (Home Health Professionals, etc.) where copies of the proper supporting documentation cannot be made. The review of those documents and the financial criteria on which the charity care decision is made must be documented.
  - Documented aliens that do not qualify for any Federal programs specifically designated for *undocumented aliens*.
  - Patients or guarantors who are deceased with no estate in probate.
  - Patients approved for Healing the Children program.
  - Patients enrolled in Family Planning Services or Pregnancy Related Services through the Health and Human Services State Coverage Insurance or other State Medicaid insurance programs that use a defined family income at or below 200% of the Federal Poverty Guidelines.
  - Patients enrolled in State Assistance programs that use a defined family income at or below 200% of the Federal Poverty Guidelines.

While Financial Assistance Applications may not be required on these application exceptions, discretion shall be used to ensure that people classified as eligible for charity care do meet the criteria when reporting the services as charity care. The specific condition warranting charity write-off must be properly documented on each account.

8. PHS uses the Federal Poverty Guidelines to determine eligibility for charity care. The Federal poverty guidelines are published and updated annually in February by the U.S. Department of Health and Human Services. A patient's income, taking into account family size, must be at or below 200% of the Federal poverty guidelines to receive 100% charity care. Those patients above 200% of the Federal Poverty Guidelines may receive a discount based on a sliding scale as indicated on the graph below:

Gross Wages and Assets  
as a Percent of the Federal

Percentage of Patient  
Liability Allowable as



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 5 of 7</b>                   |

| <u>Poverty Guidelines</u> | <u>Charity Care</u> |
|---------------------------|---------------------|
| 200% or less              | 100%                |
| 201% to 220%              | 85%                 |
| 221% to 240%              | 70%                 |
| 241% to 260%              | 55%                 |
| 261% to 280%              | 40%                 |
| 281% to 300%              | 25%                 |

All self-pay patients not qualifying for charity care will receive a 15% self-pay discount from billed charges. (See Self-Pay Payment and Collection policy, PFS.PHS.115.) This discount does not apply to amounts owed after the application of insurance payments.

The balance due from the patient/guarantor, after application of the percentage discount, shall be payable within a maximum time period of twelve months. If the patient's available resources do not permit monthly payments to satisfy the amount due, an additional amount of charity may be provided so that the remaining balance may be paid within 12 months.

9. If the included assets equal \$10,000 (excluding primary residence) or more, in connection with the evaluation of each Charity Care Application, PHS will only consider 25% of the total "Unencumbered Value" of all "Included Assets" and add that amount to the patient/responsible party's annual income for purposes of determining eligibility for charity care ("Patient's Asset Contribution").
10. Should the patient's financial, medical or social situation be so complex or unusual that the decision on charity care warrants special consideration, the case will be referred to the PHS Charity Care Committee. The purpose of the committee is to review these extraordinary cases that are entitled to consideration even though they may not otherwise qualify for charity care. This committee will review the special circumstances and make decisions on the final disposition of the patient's account. The committee will meet on a regular basis to consider these special cases. Any person can make a request for special consideration. The Committee will review special cases to be considered/approved as determined by committee consensus.
11. For incarcerated patients who receive medical services while in custody, a claim will be submitted to the facility responsible. If the patient was not incarcerated at the time of service but is in custody while PHS is initiating collection procedures, the patient shall remain responsible for the balance. and normal collection procedures shall be followed.
12. The PFS Department shall communicate the decision on a patient's charity care application on a need-to-know basis to other departments. This notification will comply with the minimum necessary disclosure rules of HIPAA.
13. Patients must be notified in writing of the decision regarding their Financial Assistance Application **within 48 hours** of the date the final determination is made by PHS.



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 6 of 7</b>                   |

14. PHS will consider a Financial Assistance Application at any time prior to the patient's stay or visit up through and including any collection processes that may be taking place. Please note: Any patient can request an application at any time.
15. The Vice President of Revenue Cycle (or his/her designee) will review a sample of Financial Assistance Applications (approved and rejected) for each billing office and for the Home Health Department on at least an annual basis to insure that a fair and consistent process is followed with all applicants. The PHS internal auditor will audit a sample of Financial Assistance decisions on a periodic basis.
16. Performance Expectations: The thorough exploration of possible sources of payment and the proper and timely review of charity care applications are expected of all PHS representatives involved in this process. Failure to meet these expectations may negatively affect an employee's performance review.
17. PFS representatives shall not make charity care decisions on accounts of relatives or friends. Any such account must be transferred to another representative.

Exceptions to this policy can only be made with the approval of the PHS Chief Financial Officer.

|                     |  |
|---------------------|--|
| <b>DEFINITIONS:</b> |  |
|---------------------|--|

**PDS:** Presbyterian Delivery System, which includes CDS (formerly PDS-A) and RDS (formerly PDS-R)

**CDS (formerly PDS-A):** Central Delivery System, which includes:

- Presbyterian Hospital (PH) inpatient, outpatient, and home health care (PHH) services,
- ambulatory care clinics (PMG),
- Presbyterian Kaseman Hospital (PKH) inpatient, outpatient, behavioral, and skilled nursing services,
- Presbyterian Rio Rancho Emergency Center (PRREC), and
- Albuquerque Ambulance Services (AAS)

**RDS (formerly PDS-R):** Regional Delivery System, which includes:

- Lincoln County Medical Center (LCMC)
- Plains Regional Medical Center (PRMC)
- Socorro General Hospital (SGH)
- Espanola Hospital (EH)
- Dan C. Trigg Memorial Hospital (DCT)
- South Central Colfax County Special Hospital District (CGH)



|  |                                      |
|--|--------------------------------------|
| <b>TITLE:</b> Charity Care Application and Approval Procedures | <b>REFERENCE NUMBER:</b> PFS.PDS.116 |
| <b>CURRENT EFFECTIVE DATE:</b><br>09/26/2008                   | <b>PAGE 7 of 7</b>                   |

|                    |
|--------------------|
| <b>REFERENCES:</b> |
|--------------------|

- Community Benefits Planning and Reporting policy, fin.pds.115
- Cash Collections Due At Time of Service (for non-emergency medical services) policy, CBO.PHS-H.110
- EMTALA Registration policy, LGL.PDS.117
- PHS Financial Assistance Determination Guidelines located on PresNet at <https://phs.patientcompass.com/hc/media/DeterminationGuidelines.pdf>
- Attachment A: Financial Assistance Application

| <b>POLICY APPROVAL AND TRACKING INFORMATION</b>  |  |
|--|--|
| <b>Approvals:</b><br>Sr. VP and CFO, Finance: <u>Paul Briggs</u><br>Sr. VP, Legal Services: <u>Diane Fisher</u><br>VP, Corporate Compliance: <u>Jackson R. Ellison</u> | <b>Date:</b><br><u>4/09/09</u><br><u>4/09/09</u><br><u>4/09/09</u> |
| <b>Original Signed Version On File in Corporate Compliance Office.</b>   |  |
| <b>Current Author(s):</b> Bridgette Garcia, Director, Patient Accounting   |  |
| <b>Next Review Date:</b> 09/26/2010  | <b>Replaces Policy(ies) Named and Dated:</b><br>03/12/2008         |



## Financial Assistance Application

*If you need help to complete this form, please ask to speak with one of our Financial Counselors or call Customer Service at 505-923-6600.*

Name of PHS Facility \_\_\_\_\_ Patient Name \_\_\_\_\_ Acct Number \_\_\_\_\_

**Instructions for completing this form:**

**This completed form should be attached to the required documentation and returned to PHS Patient Accounting to be processed.**

1. Copies of your current federal tax return with all schedules, including W2's
2. Gross monthly income verification (paycheck stubs) for the last two pay periods

Responsible Party Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Other Responsible Party Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Cell Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Gross monthly income \$ \_\_\_\_\_ (Please submit current Federal Tax return and proof of income in the form of your last two paycheck stubs.)

**Additional Household Members**

| Name | DOB | Relationship | Name | DOB | Relationship |
|------|-----|--------------|------|-----|--------------|
|      |     |              |      |     |              |
|      |     |              |      |     |              |
|      |     |              |      |     |              |

**Persons who apply for financial assistance are required to first explore other sources of funding. Please indicate which sources you have applied for and the reasons you are not eligible for this assistance.**

- Group health insurance \_\_\_\_\_  
Does your employer offer group health insurance? Yes / No
- Medicaid (If denied, please attach a copy of the Medicaid denial.)
- Other state or county assistance (Sole Community, Indigent)
- Other third-party programs (homeowners, auto, etc.)
- Cobra Coverage

## Signature Required on Back of Form



Describe inability to pay account balance: (Additional documentation may be required.)

---



---



---



---



---

Please include any assets available

| Description  | Fair Market Value | Mortgage | Net Value |
|--|-------------------|----------|-----------|
| Rental Property, Real Estate owned, land and buildings (excluding primary residence) |                   |          |           |
| Cash on hand, CDs, Savings, Lines of Credit  |                   |          |           |
| Automobiles, Trucks, Boats, etc.   |                   |          |           |
| Farm Equipment, Livestock, etc.  |                   |          |           |
| Investments, Stocks and Bonds  |                   |          |           |
| U.S. Gov't and Marketable Securities   |                   |          |           |
| Other  |                   |          |           |
| Total Assets   |                   |          |           |

We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. Patients who fail to follow through in the application process or who refuse to apply for outside programs and who potentially may have qualified may be denied financial assistance.

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau reports. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance does not pertain to other healthcare providers.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**For Internal Use Only:**

| Account Number | Facility | Amount | Account Number | Facility | Amount |
|----------------|----------|--------|----------------|----------|--------|
|                |          |        |                |          |        |
|                |          |        |                |          |        |
|                |          |        |                |          |        |

Approved \_\_\_\_\_ Date \_\_\_\_\_  
 Denied \_\_\_\_\_ Date \_\_\_\_\_

Reason for Approval or Denial

---



---



---