Community Hospitals and Wellness Centers
CHWC Montpelier Hospital (CAH)
CHWC Bryan Hospital
CHWC Archbold Medical Center

PATIENT ACCOUNTS POLICY AND PROCEDURE MANUAL

DATE INITIATED: 12/94

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SUBJECT: FINANCIAL ASSISTANCE POLICY ('Charity HCAP' prior to 9/1/16)

PA00004

OBJECTIVE: In accordance with Community Hospitals and Wellness Centers core values of compassion, integrity, honesty, respect and accountability, CHWC has established a financial assistance policy to ensure that all patients receiving emergency and medically necessary care, will be provided the opportunity to apply for financial assistance. The financial assistance program will allow patients to meet their financial obligations, without undue financial hardship to the patient or the patient's family.

POLICY: It is the policy of Community Hospitals and Wellness Centers to provide emergency and medically necessary care (refer to Ohio Administrative code 5160-1-01), to all patients, without discrimination or regard to ability to pay (refer to hospital EMTALA policy ER000099). The hospital facility disallows actions that discourage individuals from seeking medical care.

It is also the intent of CHWC to provide financial assistance to all patients, insured and uninsured, meeting the financial guidelines established within the hospital Financial Assistance Program. CHWC will make every effort to assure that patients are aware of the financial assistance options. CHWC will make information available regarding the policy and requirements to apply for Financial Assistance, to all patients receiving emergency and medically necessary care. This policy is applicable to all 3 locations of Community Hospitals and Wellness Centers, including Bryan, Archbold and Montpelier.

PROCEDURE:

Definitions:

Amounts Generally Billed (AGB) – The amount generally billed to a CHWC patient who has insurance coverage as defined in IRS Section 501 (r)(5)

EMTALA - Federal emergency Medical Treatment and Active Labor Act

Financial Assistance – Discount or elimination of payment for health care services provided to eligible patients with documented and verified financial need.

Plain Language Summary – Summary of financial programs offered by CHWC and process for applying for financial assistance.

Application Process – A process by which a patient or their appropriate representative completes a for with information on the patient's income, family size and assets. All completed applications will be evaluated by a CHWC Patient Representative for eligibility for a financial discount.

Extraordinary Collections Actions – Actions which require a legal or judicial process, reporting adverse information to credit agencies or bureaus. CHWC will determine charity eligibility prior to taking any extraordinary collection actions. Written notice must be provided at least 30 days in advance of initiating specific ECAs.

Federal Poverty Guidelines (FPG) – Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services and in effect at the date(s) of service for which financial assistance may be available.

Gross Charges – The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Gross Income - An individual's income before tax and other deductions are applied.

Cash Assets – Includes savings and checking accounts, money markets, stocks/bonds, mutual funds, Certificates of Deposit, property values (excluding primary residence), and any other assets with available cash.

Health / Medical Savings accounts – Savings account specifically available to cover out of pocket medical costs.

Notification Process:

All patients registering for emergency or medically necessary care will be offered a financial application and "plain language summary" at the time of registration. CHWC will also follow up with uninsured patients within 3 to 4 weeks of service, if a financial application is not received or Medicaid application is not completed by that date. Follow up consists of a phone call to offer the patient assistance with the Medicaid application and discuss financial assistance options.

Patient billing statements include on the back side, information on the HCAP and hospital financial assistance programs, including current poverty levels, as required by HCAP policy. The options for requesting a financial application are also listed on the statement.

Reference to the financial assistance information will be clearly noted on the front side of the statement.

The plain language summary, financial application, Billing and Collections Policy, and this Financial Assistance policy are displayed on the hospital website.

In compliance with the 5-percent/1000 person threshold under the HHS guidance safe harbor and 501r regulations, the Spanish version of the FAP, financial application and Plain language summary is also available at all hospital locations and on the hospital website.

Signage is posted at all 3 hospital buildings in customer areas including Admissions Office, Billing Office, Cashier area and Emergency Department. The signage will provide information on the hospital financial program and the application process.

Copies of the financial application and Plain language summary are distributed to the Compassion Clinic in Williams County. This is a 'Free Clinic' and patients are encouraged to complete the application if they need follow up services at the hospital.

CHWC will periodically include information on the hospital financial assistance programs, in the quarterly newsletter that is mailed to residents in the 4 county area.

Methods of Applying for Financial Assistance:

Financial applications may be requested by insured and uninsured patients, by calling the Patient Accounts office at 419-630-2149 or emailing a request to Patient Accounts at billing@chwchospital.org. Applications can also be picked up at the admissions office at all 3 locations at any time. Patients may also download the financial application from the hospital website at URL: https://www.chwchospital.org/patient-services/chwc-financial-assistance/ . Completed applications can be dropped off at the admissions office of all 3 locations, or mailed to the CHWC Patient Accounts office at the Bryan address listed on the financial application.

Eligibility Criteria:

Services must be considered as emergent and/or medically necessary care. CHWC follows Ohio Medicaid policy in determining services that meet medical necessity (reference Ohio Administrative Code 5160-1-01). Most cosmetic surgery is not considered to be medically necessary.

For insured patients, the balance following insurance processing, that is deemed 'patient responsibility', including coinsurance, deductible and other non-covered amounts are eligible to be considered for financial assistance. If a patient balance is not processed by insurance due to lack of patient follow up with insurance, the balance is not eligible to be considered for financial assistance.

A patient must complete a financial application to be considered for financial assistance, with exceptions noted below. For patients eligible for the Ohio HCAP program, financial

applications will be accepted and processed for up to 3 years after the date of service. For patients above the HCAP income levels, CHWC will accept financial applications for a minimum of 240 days after the initial patient statement date.

For the HCAP program, a new financial application must be completed every 90 days for out-patient services, based on the date of service of the eligible account. In-Patient visits require a new application 45 days after the initial in-patient date of service. For the hospital financial assistance program, a new financial application must be completed every 90 days for in-patient and out-patient services.

CHWC may accept verbal clarifications of income, family size or any information that may be unclear on an application. The Person receiving the information will note 'verbal from XXX' and initial the update.

Uninsured patients are strongly encouraged, but not required, to apply for Medicaid or insurance through the Health Insurance Marketplace, before consideration of a financial discount. If a patient has applied for Medicaid and has completed a financial application, financial discounts will not be applied until a final eligibility determination is received from Medicaid.

Basis for Calculating Amounts Charged to Patients:

A patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the AGB percentage. The AGB (amount generally billed) will be calculated by CHWC annually and will be incorporated into the hospital charity levels within 30 days of publication of the new poverty levels. The AGB will be based on the Look-back Method (as defined by the Treasury Regulations under section 501r of the Internal Revenue Code of 1986). The AGB as of February 2021, is 55% for Bryan and Archbold, and 69% for Montpelier Hospital. The hospital minimum charitable discount is 50%.

Discounts are generally determined by a sliding scale of gross income, based on the Federal Poverty Guidelines. Federal poverty levels are issued yearly in the Federal Register by the Department of Health and Human Services. Current and historical Federal Poverty Levels are available at http://aspe.hhs.gov/poverty/index.cfm.

Cash Assets may impact the charity discount, as noted under the Financial Assistance criteria below. .

Following are the CHWC charity discount levels based on the Federal Poverty Guidelines

101% - 200% of FPG	= 100% adjustment
201% - 250% of FPG	= 75% adjustment
251% - 300% of FPG	= 50% adjustment

The income and sliding discount levels by family size are included as an appendix to this Financial Assistance Policy. The discount levels for patients eligible for charity are

updated yearly, after the poverty levels are published and after CHWC completes calculation of the AGB (average generally billed).

Ohio residents with gross income at or below the Federal Poverty Level, are eligible for a 100% write off of medically necessary gross charges or patient balances following insurance payment, under the HCAP program.

Following is information on the criteria used to determine eligibility for the HCAP program and the Financial Assistance Program.

HCAP

1. The guarantor/patient was a resident of Ohio on the date of service.
2. The guarantor/patient provides written documentation that the family income is at or below the federal poverty level. The federal poverty levels are usually updated each year. The new levels are updated on the hospital HCAP forms and are applicable to any accounts with dates of service as of the date the new poverty guidelines are published. Income includes total salaries, wages and cash receipts before taxes. CHWC will follow the guidelines in "OAC 5160-2-07-17" to determine amounts included as income.
3. For visits with date of service on and after 12/14/2000, the guarantor has 3 years from the date of service to apply. For visits with date of service prior to 12/14/2000, there is no time limit to apply for HCAP.
4. Only basic medically necessary hospital level charges can be adjusted off to HCAP. Professional fees and charges with revenue codes not listed in the Medicaid covered UB04 revenue code list are not eligible for HCAP adjustments. Reference "OAC 5160-2-07.17".
5. Any charges covered by either state plan Medicaid or managed care Medicaid plans are not eligible for HCAP.
6. The family size includes the parents, spouse and all children, natural or adoptive, under the age of 18 and living in the home. Step-parents and step-children, in relationship to the patient, are not included. Both person's of the same sex who are legally married in another state are counted when determining family size. For additional clarification on family size determination, refer to "OAC 5160-2-07.17".
7. When the patient is a child under the age of 18, both natural or adoptive parents income is included in determining total family income. If a parent does not live with, have any communication with or provide any type of support to the family, this information should be documented on the financial application, and the income for the parent with all rights and responsibility for the child is the only income counted. The family size will include the parent that is not providing any financial support to the family.
8. For patients over the age of 18 with a spouse that is not living in the household, and does not or will not contribute to the family's income, the patients income alone will be counted to determine income level. The patient is asked to provide written and signed notification that the separated spouse does not provide any financial income to the household. The separated spouse is included with the family size, regardless if he/she is providing any income.
9. Proof of income, if available, for either the 12 months or 3 months multiplied by 4 prior to the date of service, is included with the application. Income is figured based on gross income. If the patient fails to write the income on the HCAP application under the 3 month or 12 month column, but provides exact proof of income for the months, the Rep may note the

income on the application. If the patient fails to write the income on the application and does not provide exact proof of the required months, the Rep will either return the form to the patient to complete, or contact the patient by phone to get the income amount and note it on the application. One of the following verifications of income is necessary to determine a patient's eligibility for HCAP write off. An attempt should be made to obtain the information listed first and if unavailable, the 2nd listed support of income may be used. As a last resort, if no other proof is available, a signed statement is acceptable.

a. A copy of the pay check stubs or a letter from the employer giving the patient's income for the 3 month or 12 month period prior to the date of service. The hospital will use whichever figure makes the patient HCAP eligible.
b. Federal income tax returns or W2s from the most recent year, noting the current year income, but using the tax return/W2 as a back up for the income listed. Block 5 of the W2 and block 6 of the 1040 are used to determine yearly income. This will not provide exact proof of income but will support the income information listed by the patient on the application.
c. A signed, sworn statement or affidavit declaring the applicant's income for the 3 months or 12 months prior to the service date, and an explanation of how the patient is surviving financially when –0- income is reported.

Financial Assistance

1. Current gross income (based on the date the application is completed) is used to determine the level of discount, and income for the months prior to service, or expected income for the months following the date of service can be used to support any additional discounts that may be appropriate through the exceptions process. The Patient Accounts Director may also use cash asset balances and other written documentation about the family's financial situation including extraordinary expenses, to request a higher discount through the exceptions process.
2. Written proof of income and cash assets are required for determining the correct financial discount level. Any exceptions are to be approved by the President or CFO.
3. Block 5 of the W2 and block 6 of the 1040 are used to determine total yearly income.
4. The family size determination varies from the HCAP program. Step-children and step-parents, in relationship to the patient, are included if they reside in the same home. Also, children over 18 are included in family size, if the child is still supported by the parent (child is still a student).
5. If a patient is separated from his/her spouse and written proof is provided indicating that the separated spouse does not provide any financial assistance to the household, the income of the patient alone may be used to determine financial assistance.
6. Child support paid is subtracted from gross income to determine the appropriate income level, when the child is not included with the family size. Child support received is added to the gross income when the child is included with the family size. If a child is the patient and is in a family with split custody, with no child support paid by either parent, and the parent responsible for paying the medical bills applies for financial assistance, a discount level ½ way between the income level for the family size including the child, and the income level for the family size excluding the child, is figured and used to determine the charity level. Add the 2 discount levels together and divide by 2 to determine the amount that is ½ way

between the 2 figures. If there is an even number of children with split custody in the family, count ½ of the children to figure family size. When a child is the patient and is in a family with split custody with no child support paid, and both parents are responsible for paying the medical bill, both biological parents income should be obtained and the family size will include the child, both biological parents and any other biological or adopted siblings to the patient.

8. The guarantor's cash assets (or parents if the patient is a minor) are reviewed to determine if resources are available to pay on the outstanding balances. The following guidelines are used to determine a reduction in the discount level based on the guarantor's cash assets. Medical Savings/Health Savings are included with the cash assets total.
    a. For patients that qualify for <100% discount based on income - If 50% of the cash asset value is equal to or greater than the outstanding guarantor balance, the discount based on the income level will be reduced by one level, unless the Patient Accounts Director, President/CEO or CFO determine other circumstances allow the full discount with no reduction.
    b. For patients that qualify for 100% discount based on income - If cash assets are greater than 50% of the total outstanding guarantor balance, the discount level may be reduced by one level, unless the Patient Accounts Director, President/CEO or CFO determine other circumstances allow the full discount with no reduction.
9. Deceased patients who do not have a surviving spouse or parent (for patients under 18) may be eligible for full charity with a letter from an Attorney stating the patient's estate is insolvent. If the deceased has a surviving spouse or parent, a financial application should be completed to determine eligibility for a financial discount.

Financial Assistance for Catastrophic and other extenuating circumstances:

The hospital President/CEO or CFO may also determine a visit to be eligible for financial assistance, based on information they have received from the patient that may or may not include the financial application. The President/CEO or CFO will provide written notice to the Patient Accounts Director to apply the discount.

Presumptive Eligibility:

Visits determined to be charity eligible through the I-Solutions program, will receive charity discounts according to the "self pay/collection policy". I-Solutions is an electronic screening process that provides a score relating to the patient's ability to pay.

Presumptive eligibility is determined after an account has completed processing with the collection agencies, and is closed for non-collectible status.

Refunds:

If a patient completes a financial application within 240 days from the 1st statement date and is eligible for a discount, patient payments that exceed the patient amount due following eligible charity discounts, will be refunded to the patient, or moved to other accounts with outstanding balances.

Notification of eligibility status:

For patients completing a financial application, letters are sent informing the

patient/guarantor of financial assistance eligibility. Letters are also sent to patients/guarantors that do not qualify for financial assistance.

Appeal Rights:

Patients may contact the Patient Accounts Office with questions regarding the determination of eligibility for assistance. If the patient is not satisfied with the explanation from the Patient Accounts Office, a request for review may be sent to the Director of Patient Accounts or to the Administrative office of Community Hospitals and Wellness Centers. The Director or an Administrator will contact the applicant within 30 days of receipt of the request for review.

Patient Cooperation:

CHWC will contact applicants to obtain additional information needed for incomplete financial applications. Contact may include phone calls if we are able to reach the applicant by phone. An 'information request form' is mailed to all applicants that we are not able to obtain the information by phone. A standard 'information request form' is used and will note the additional documentation required to process the financial application. The form states "If we have not heard from you or received the requested information within 2 weeks, the application will be considered incomplete and will not be processed." The form also states "The financial application can be reopened for reconsideration if the information is provided within 240 days of your 1st statement."

If the applicant does not cooperate with providing the additional information, the financial application will be scanned and then moved to an 'incomplete' file and noted on the patient account. The incomplete application will be held, and the requested information will be accepted through day 240 from the initial patient statement date. CHWC will not apply financial discounts to accounts that are pending insurance. Patients are required to cooperate with insurance requests before their account can be considered for financial assistance.

Actions in the event of non-payment:

Actions taken in the event of non payment or lack of cooperation with the financial assistance process are listed in the 'Self-Pay Billing and Collection Policy". This policy is also available at the following URL: https://www.chwchospital.org/patient-services/chwc-financial-assistance/ , on the hospital website.

Providers Covered by the Financial Assistance Policy:

This policy is applicable to all hospital services billed for the 3 locations of Community Hospitals and Wellness Centers, including Bryan, Montpelier and Archbold.

The following professional services are eligible for a financial discount.

Dr. Steven Bumb
Dr. George Magill
Dr. Scott Frederick
Dr. Joan Lawrence
Vaishali Patel, CNP
Dr. D Matt Cooley
Dr. Jodi Tinkel
Dr. Hanan Bazzi
Dr. Michael Nosanov
Ashley Hawkins, CNP
Jennifer Rittenhouse, CNP
Dr. Wainwright Jaggernauth

Dr. Shannon Keil	Lisa Scanlon, CNP
Greg Durham, CNP	Nicole Pothast, CNM
Dr. Divya Vijendra	Dr. Khalid Minhas
Dr. Monzur Haque	Dr. Jeffrey Bessette
Dr. Jeffrey Birn	Dr. Melissa Bosma
Dr. Christopher Carrel	Dr. Kelly Ferrell
Dr. Jason Gillum	Dr. Michael Gioia
Dr. Adam Gregory	Dr. Shawn Johnson
Dr. Brad Johnston	Dr. Jay Jones
Dr. Mark Kelly	Dr. Michael Kinzer
Dr. Jeremy Macke	Dr. Peter Mehta
Dr. Benjamin Moreno	Dr. R. Evan Nichols
Dr. Andrew Norton	Dr. Kevin O'Connor
Dr. Darshan Patel	Dr. Andrew Potter
Dr. John Reed, Jr.	Dr. Jay Shah
Dr. Mitchell Travis	Dr. Christopher Wing
Dr. Sai Yarram	Dr. Jeffrey Yngstrom
Caitlin Armstrong, CRNA	Megan Fillman, CRNA
Scott Johns, CRNA	Larry Pickett CRNA
Steve Schultz, CRNA	Charles Tabbert, CRNA

Other Providers that have agreed to accept the Financial discount determined by CHWC:

- Schumacher Emergency Physicians

Providers not covered by the Financial discount determined by CHWC:

- Dr. Darin Scribner – Pain Clinic
- Dr. Andrius Giedraitis – Pain Clinic
- Parkview Physicians Group of Ohio
- University of Toledo Physicians

DOCUMENTATION:
Not applicable

REFERENCES:
Not applicable

APPROVALS:

Board of Directors:	07/11, 04/13, 06/13, 7/14, 11/15, 8/16, 03/17, 10/17, 5/18, 2/19, 4/19, 02/20, 7/20, 2/21

COMMUNITY HOSPITALS and WELLNESS CENTERS

ADDENDUM TO FINANCIAL ASSISTANCE POLICY

CHWC Financial Assistance Program Income Level Breakdown
Based on Federal Poverty Levels as of 2021 Plus 200% - 250% - 300%

Guarantor Pays 0%	100% Discount	
1	Under	$25,760
2	Under	34,840
3	Under	43,920
4	Under	53,000
5	Under	62,080
6	Under	71,160
7	Under	80,240
8	Under	89,320
Guarantor Pays 25%	75% Discount	
1	$25,761 to	$32,200
2	$34,841 to	43,550
3	$43,921 to	54,900
4	$53,001 to	66,250
5	$62,081 to	77,600
6	$71,161 to	88,950
7	$80,241 to	100,300
8	$89,321 to	111,650
Guarantor Pays 50%	50% Discount	
1	$32,201 to	$38,640
2	$43,551 to	52,260
3	$54,901 to	65,880
4	$66,251 to	79,500
5	$77,601 to	93,120
6	$88,951 to	106,740
7	$100,301 to	120,360
8	$111,651 to	133,980

- If 50% of cash assets exceed the total balance, or if cash assets are greater than 50% of the total balance, the financial discount may be reduced by 1 level
- If cash assets are greater than 50% of the outstanding patient balance and income is at the 100% level, the discount may be reduced to 75%
- Other circumstances affecting a guarantor's financial situation may be considered to increase the financial discount