Policy and Procedure: Financial Assistance / Billing and Collections Policy	Policy Number: BO122
Effective Date: 9/19/18	Review Date and Initials: **1/1/2023 SND, 7/9/2024 SND, 3/12/25 SND**
Department Approval: SND	Administrative Approval:

PURPOSE

To define Financial Assistance offered by WSMC and to establish procedures that ensure consistent identification and recording of how charity care and requests for financial assistance will be addressed. Also ensures WSMC follows and applies uniform billing practices.

Patients who are without health insurance, are underinsured, or otherwise show a demonstrated inability to pay for emergency or medical necessary healthcare services received may qualify for financial assistance. This determination should be made during the registration process or shortly thereafter. However, untoward events after the service date could change the patient's ability to pay, making retrospective determination a possibility.

POLICY

It is the policy of Warm Springs Medical Center to provide appropriate healthcare services to individuals regardless of race, creed, national origin, handicap or method of payment. Patient responsibility for payment is essential to the provision of health resources in the community. However, certain patients may not have the ability to pay or have the sponsorship of entitlement programs.

WSMC is committed to providing financial assistance to individuals receiving emergency and medically necessary healthcare services who are unable to pay their bill based on their individual's financial situation. This policy is specifically targeted at low-income, uninsured, and underinsured individuals who meet certain eligibility requirements.

Providers: See Schedule A for further information.

Emergency Medical Care Policy:

Patients presenting for emergency services will receive evaluation and stabilization for their condition regardless of their ability to pay. Services will be provided according to Federal, state, and EMTALA guidelines. Financial services will be available for patients to apply after stabilization, or upon receipt of first bill.

Elective/Non-Emergent Care:

Patients requesting non-emergency/elective services at Warm Springs Medical Center may undergo financial screening prior to receiving care for elective services by contacting the registration department.

Indigent Charity Trust Fund: (ICTF)

Extraordinary Collection Actions (ECAs): Warm Springs Medical Center will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under this Policy. WSMC considers placement at a collection agency an ECA. Once placed with a collection agency this may include reporting to credit bureaus; subsequently to judgement, the collection agency may choose to proceed with garnishment.

Financial Assistance Plan (FAP): Any patient can complete an application and apply for financial assistance. Financial assistance can include full or partial charity adjustments. This financial assistance program is designed to meet all Federal and State requirements.

Full or Partial assistance may be awarded to emergency and medical necessary services. One hundred percent eligibility is considered indigent, with charity considered a partial eligible adjustment.

PROCEDURE

A. Each patient who appears eligible for Indigent or Charity Care determination and who requests such determination must complete a "Georgia Indigent Care Trust Fund Application" and provide supporting documentation as requested and necessary to verify the patient's financial condition. The application and supporting documentation must be received by the Business Office within thirty (30) days from the date of request, unless extenuating circumstances exist. The prospective Indigent and/or Charity accounts must remain in a self-pay financial class and regular collection efforts will continue until the application and documentation is received. These accounts are not to be left on the active A/R indefinitely, but adjusted off to bad debt and referred to a collection agency if the appropriate information is not received in a timely fashion.

B. This application and all supporting documentation will be reviewed by the Business Office Manager or the designated Business Office Representative. A decision will be made based on the federal poverty level calculations within fifteen (15) working days of receipt. Once the determination has been made a letter will be mailed to the patient with the final decision. Financial Assistance decision may classify the service as:

a) *Indigent* – household income below Federal poverty guidelines: 100% adjustment of total charges.

b) *Charity* – household income above Federal poverty guidelines, 25%, 50% or 75% discount off total charges. The remaining balance will be due and payable by the patient and normal collection efforts will continue.

c) *Uninsured* – patients who do not qualify for an Indigent or Charity Care discount, but have difficulty paying – we will work closely with the patient to establish an appropriate payment plan, based on the amount due and the patient's ability to pay. Extenuating factors such as large medical bills or multiple medical bills will be taken into consideration.

d) *Patient balances after insurance payment* – prompt payment discounts to patients on their co-pays and deductibles may be offered in accordance with the Billing and Collections Policy.

e) Time of service discounts are available.

In the case of an ineligible outcome, a second Business office representative will review the application and supporting documentation for a reconsideration.

Once all reviews of the application have been determined a denial letter with the reason will be sent to the patient with contact information for the Department of Community Health at toll-free number 1-877-261-3117 or local 404-463-5827 if the applicant disagrees with the final determination.

Eligibility:
Eligibility criteria is established based on ICTF policy in accordance to the federal poverty guidelines, updated annually.

Additional Criteria information:

(a) Provide services for no charge to persons with income below 125 percent of the federal poverty level (Indigent Care).

(b) Provide services at a reduced patient liability for persons with incomes between 125 and 250 percent of the federal poverty level (Charity Care). This liability is determined by a sliding fee schedule and it is available upon request.

(c) Income to be considered in determining eligibility for Indigent or Charity Care may include, but are not limited to the following:

1) The guarantor's gross income, using either the average monthly income for the previous three months or for the previous year, whichever is more favorable to the applicant.

2) Self-employed individuals, the amount of income to be counted is gross minus work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

3) For monies received that may be considered as a non-recurring lump sum, consider the gross amount received as income in the month received.

4) Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family member should be excluded.

5) DO NOT use income for any person who is not financially responsible for the patient. (i.e. do not count income from one sibling as available to another sibling for purposes of paying medical bills. Also, do not count income from any child (minor or adult) in considering eligibility under the ICTF for the child's parent.

6) The previous exhaustion of all other available resources.

7) Catastrophic illnesses (medical bills exceed the family's gross annual income).

(d) Family Unit

1) The family unit consists of individuals living alone; and spouses, parents and their children under age 21 living in the same household.

(2) A family unit may include minor children living with a legal guardian. The child, legal guardian, and the legal guardian's family unit living in the same household may comprise a family unit.

Income Requirements:

a) Verification Of Income:

i. Copies of your three (3) most recent check stubs or an Employer Statement of Wages earned.

ii. Copies of your most recent Federal Income Tax Return, along with copies of all W-2's for that year. If you have interest in any Business you must provide a copy of the Business' Federal Tax Return.

iii. If you do not work but receive income from child support, food stamps, Social Security, unemployment or pension you must provide proof of that income.

iv. If you do not have any income:
- You may obtain a letter for Social Security or your local DFACS office. OR
- You may also request a Wages and Income Statement from the Ga Department of Labor office.

v. Any other pertinent information that may help us to decide your case.

Account Information:

a) Discounts may be applied to open and bad debt patient liability accounts balances.
b) Applications are accepted up to 240 days from the date of the first post discharge statement.
c) All financial assistance approvals will continue to be valid for six (6) months from the date of approval.

Resident Requirements:

Patient must be a Georgia Resident.

Charges:

Any patient eligible for full or partial financial assistance under the ICTF policy will not be billed more than the AGB for emergency or non-emergent medically necessary care. The AGB rate will be established by the Look Back Method as outlined in the Section 501(r)(5).

Regulations1.501(r)-5: hospital facility may determine AGB for any emergency or other medically necessary care it provides to a FAP eligible individual by multiplying the hospital

facility's gross charges for the care by one or more percentages of gross charges (AGB percentage (5))

(B) Medicare fee-for-service and all private health insurers that pay claims to the hospital facility, described in paragraph (b)(3)(ii)(B) of this section.

For example: AGB is determined by multiplying the gross charges for any emergency or medically necessary care it provides by AGB percentages which are based on claims allowed under Medicare. Copies of the current percentages, together with an explanation of how these percentages were calculated may be obtained for free by writing to:

WSMC, PO Box 8, Warm Springs, GA 31830

C. Business Office Representative will post the appropriate accounting transactions to reflect these discounts and it must be posted in the month the determination is made to the patients account

D. Warm Springs Medical Center will maintain written documentation regarding each Indigent/Charity Care/Self Pay discount determination for the appropriate timeframe of five (5) years.

1. Warm Springs Medical Center will maintain a Log of Patient Accounts, with patient identifying information that has been adjusted from the patients hospital accounts based on the ICTF guidelines as laid out in this policy.

2. Methods of Applying for Financial Assistance include,

1. Downloading an application from Warm Springs Medical Centers website www.warmspringsmc.org, and mailing or delivering to:

Warm Springs Medical Center
Attn: Business Office
PO Box 8
Warm Springs, GA 31830

2. By obtaining an Application Form from the Registration Desk, Business Office, or by calling our office at (706) 655-9297 and requesting an application be mailed.

3. Financial Assistance application with supporting documentation should be returned back to WSMC for processing.

3. Billing and Collections Process

1. At the time of billing, individuals will be sent a statement that includes a copy of the Plain Language Summary for the financial assistance program.

2. Warm Springs Medical Center offers all patients financial assistance information for medical necessary services. WSMC also follows up with patients by phone call and letter regarding the financial assistance availability and requirements for applying for such service.

3. Warm Springs Medical Center will send each patient or guarantor a statement for unpaid hospital charges. WSMC will also follow-up with a second statement and 2 letters following discharge, and periodically thereafter.

4. Warm Springs Medial Center offers several payment arrangement options to individuals as another form of assistance if they are not able to satisfy the total balance due and are deemed ineligible for Financial Assistance. All payment arrangement plans are interest free.

5. After 120 days of the first post-discharge statement, the account may be referred to a Collection Agency working on behalf of WSMC. Prior to the account being sent to a Collection Agency, the individual is notified by 2 written notices that the account may be sent to collections if not satisfied or payment arrangements have not been established. Written notice will be sent at least 30 days before initiating an ECA. Written notice will follow the guidelines below:

    1. Written notice indicating that financial assistance is available to eligible persons
    2. Identify the ECA that the hospital plan to initiate to obtain payment
    3. States a deadline after which the ECA will be initiated that is no earlier than 30 days after the date that the written notice was provided
    4. Provides the person with a plain language summary
    5. Make reasonable effort to orally notify the patient about FAP and how the patient may obtain assistance

6. WSMC financial assistance application period is 240 days from the first post discharge statement. After the application period closes WSMC may choose not to accept Financial Assistance applications any longer.

7. If an individual applies for Financial Assistance after which an account has been sent to Collections the account will be closed with the Collection Agency and returned back to WSMC ceasing all further ECA until an eligibility is determined. If individual is determined to be ineligible the account may be returned back to Collections to continue ECA.

PUBLICATION OF POLICY

A. All appropriate documentation will be posted in the areas for patient notification for FAP per the "Public Notification about the ICTF Program" section of Appendix Q. All publications will be updated and amended as necessary,

a. WSMC will provide a plain language summary notifying individuals of the FAP program and the eligibility requirements.

b. The direct website address and physical location where an individual may obtain a free copy of this policy, the application forms, and any contact information for hospital staff that is available to assist with the FAP.

c. Provide information regarding FAP on patient statements.

d. Publish notices in newspapers of general circulation in the area.

e. Place signs in the emergency room, business office, and registration area that include appropriate program information.

f. Provide notices in English, Spanish, and any other languages as appropriate.

g. Staff will communicate the content of the notices to people who are unable to read and will assist individuals that may have difficulty applying for program services.

ATTACHED DOCUMENTS

a. Schedule A

b. Financial Assistance Plain Language Summary

c. Financial Assistance Application

d. Financial Assistance Application Instructions

e. Financial Assistance Federal Poverty Guidelines, updated each year accordingly

Schedule A

This policy pertains to facility charges rendered by Warm Springs Medical Center. Independent physicians and providers are not subject to this policy.

Current providers consulting at WSMC **not** included in facility billing but does honor WSMC Financial assistance approval decision:

1. Meriwether ER Physicians – Schumacher Group

Current providers consulting at WSMC **not** included in facility billing and does **not** honor WSMC Financial assistance approval decision:

1. West Georgia Imaging
2. Anesthesiology Services

WARM SPRINGS medical center
5995 Spring Street, Warm Springs, GA 31830

Do you need help with your hospital bill?

If you do not have insurance to cover your hospital bill and you have low income, you may qualify for help under Georgia's Indigent Care Trust Fund.

This hospital participates in the Georgia Indigent Care Trust Fund. We receive special funding to assist qualified patients with their medical bills. This year we will provide a certain amount of services to patients free or at a reduced charge.

Apply at **Patient Registration, Warm Springs Medical Center, 5955 Spring St. Warm Springs, GA 31830. The phone number is 706-655-9297.** We will make a decision on whether you are eligible within 10 working days. We will give you a written notice of our decision.

Sample

Federal Poverty income guidelines for 2018 are as follows:

Free Services:

Family Size	Income/Mo.
1	$1,265
2	$1,715
3	$2,165
4	$2,615
5	$3,065
6	$3,515
7	$3,965
8	$4,415
For Each add'l person add	$450

Reduced-Charge Services:

Family Size	75% Discount	50% Discount	25% Discount
1	$1,770	$2,023	$2,529
2	$2,400	$2,743	$3,429
3	$3,030	$3,463	$4,329
4	$3,660	$4,183	$5,229
5	$4,290	$4,903	$6,129
6	$4,920	$5,623	$7,029
7	$5,550	$6,343	$7,929
8	$6,180	$7,063	$8,829
For Each add'l person add	$630	$720	$900

Application for Financial Assistance

(All fields must be completed before application can be processed)

Patient Name: _____ **Date of Birth (DOB):** _____ **Date:** _____

Name of Applicant: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____**State:** _____**Zip:**_____

How long have you lived at this address? _____ Years _____ Months **Phone:** _____

Are you employed: _____ **Employer Name:** _____ **Work Phone:** _____

Are you a resident of Georgia? _____ **Total household Size:** _____ **Total # of dependents:** _____

List each member of household, date of birth, age, relationship to patient, and gross income from each source; state whether income is per week, month, or year:

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	TOTAL GROSS INCOME (wk/mo/yr)

If income of any member is from self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

(Note to applicant: You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example, if you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income.)

If you do not have any income for your household, please explain your situation in the space provided below:

This verification will be valid for six (6) months from the date of approval unless any changes occur.

Please provide ONE of the following (required)

- ☐ Applicant and/or Spouse's three (3) most recent check stubs OR a current pay stub with year-to-date total
- ☐ Applicant and/or Spouse, a current wage inquiry for each person from the Georgia Department of Labor
- ☐ SSI, disability, child support, retirement, pension, VA benefits, workers compensation, or alimony statements or bank statements showing direct deposits of the same for patient/application and spouse
- ☐ Copy of last year's federal income tax return (including Schedule C for self-employed) or a statement from the person paying the bills.

Sample

STATEMENT

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information I have submitted is subject to verification, including credit agency reporting agencies, and subject to review by Federal and/or State agencies and other as required. I AUTHORIZE by employer to release to WSMC provider by proof of income. I UNDERSTAND that if any information I have given proves to be untrue, WSMC will reevaluate by financial status and take whatever action becomes appropriate and I will be liable for payment of charged for all services rendered. I agree to pay any remaining balances after financial assistance adjustments are made. I understand that this request for financial assistance may not pertain to other health care providers.

Signature of Applicant _____ Date _____

Please send completed and signed application with supporting documentation to:

Warm Springs Medical Center
Attn: Business Office
P O Box 8
Warm Springs, GA 31830

If you need any assistance with this application, information or process, please call the Registration Supervisor at 706-655-9297 or Business Office at 706-655-9225 for further assistance.

Allow 15 business days for processing. A written notice will be mailed with the final decision.

Sample

For Hospital Staff Use

Number counted in household _____ Total Countable Income _____

(Average income for last year or past 3 months, whichever is more favorable)

Verification of income supplied (if requested)? ☐ Yes ☐ No

Determination:
☐ Eligible for free services ☐ Conditional? ☐ Pending
☐ Eligible for discount _____% ☐ Conditional? ☐ Pending
☐ Ineligible Reason _____

Date notice mailed _____ Staff Signature _____ Date _____

Reconsideration _____ Result _____ Date _____

WARM SPRINGS medical center
5995 Spring Street, Warm Springs, GA 31830

Plain Language Summary
Financial Assistance Plan

This Summary provides information about out financial assistance policies.

It is policy of Warm Springs Medical Center to provide financial assistance to qualifying patients with their outstanding bills for medically necessary and emergent care received at our Hospital. WSMC participates in the Georgia Indigent Care Trust Fund Program (ICTF) and as our patient you receive certain benefits under the Trust Fund Program.

Important things to know about the financial assistance program and eligibility

- **Assistance is based on income -** Warm Springs Medical Center offers Financials assistance based on the Federal Poverty Income Guidelines. These guidelines are published yearly.
- **Application and Financial Documentation Requirement -** Any patient wishing to apply for financial assistance must complete the FAP Application and provide the required proof of income.
- **Charges -** Patients who are eligible for financial assistance will not be charged more than an amount generally billed for emergency or other medically necessary care.
- **Emergency Medical Care –** All patients will be treated for emergency medical conditions regardless of ability to pay or to qualify for financial assistance, in accordance with federal and state law.
- **Medical Necessity Services –** The necessity for medical treatment of any patient will be based on the clinical judgement of the health care provider without regard to the financial status of the patient.
- **Covered Providers –** This policy pertains to facility charges rendered by Warm Springs Medical Center. Independent physicians and providers are not subject to this policy.

  Current providers consulting at WSMC **not** included in facility billing but does honor WSMC Financial assistance approval decision Meriwether ER Physicians – Schumacher Group

  1. Meriwether ER Physicians – Schumacher Group

  Current providers consulting at WSMC **not** included in facility billing but does honor WSMC Financial

  1. West Georgia Imaging
  2. Anesthesiology Services

If you do not qualify for the ICTF Program, you are responsible for paying your medical bills. If you do not pay within 120 days of the first post discharge statement. The account will continue to age by appropriate guidelines and be sent to a collections agency for further collection actions, which includes reporting to credit reporting bureaus.

How to apply for financial assistance

Copies of the Financial assistance policy, this plain language summary, and the Financial Assistance Application with instructions are available free of charge, please:

1. Please visit our website www.warmspringsmc.org
2. Call our Registration Supervisor at (706) 655-9297, M-F from 8am to 4:30pm or contact our Business office at (706) 655-9225
3. Request a copy by mail
3. Visit our registration desk 24 hours / 7 days a week.

Sample