POLICY: Financial Aid Policy

POLICY STATEMENT:

In order to serve the health care needs of our community. **Moab Regional Hospital and Providers,** Exhibit "A", **("The Hospital")** will provide 'Charity Care' to patients or the 'Responsible Party' without financial means to pay for 'Appropriate hospital-based medical services' (see defined terms below).

As used herein, "Charity Care" means appropriate hospital-based medical services provided to Indigent Persons. Charity Care will be provided to all persons without regard to race, religion, color, sex, age, disability, sexual orientation, gender identity, or national origin who are classified as "Indigent Persons" according to The Hospital's eligibility criteria.

As used in this Policy, 'Indigent Persons' means those patients (or the 'Responsible Party,' as defined below) who have exhausted any third party sources, including Medicare and Medicaid, and whose income is equal to or below 400% of the federal poverty standards, adjusted for household size (determined based on IRS Definition – the tax filer, the tax filer's spouse (if married filing jointly), and any dependents) or is otherwise not sufficient to enable them to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payor. As used in this Policy, "Responsible Party" means the individual who is responsible for the payment of any Hospital charges, which are not covered by a third-party payor.

As used in this Policy "Appropriate hospital-based medical services" means those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly of treatment available or suitable for the person requesting the service. "Course of treatment" may include mere observation or, where appropriate, no treatment at all.

PURPOSE:

To properly identify those persons who are Indigent, who do not qualify for state and/or government assistance, and to provide assistance with their medical expenses under the guidelines for Charity Care.

ELIGIBILITY FOR CHARITY CARE:

Eligibility determinations regarding Charity Care and decisions regarding the collection of amounts owed to The Hospital by Responsible Parties shall be made in accordance with this Policy and the Procedures contained in this Policy. The Hospital will not impose unreasonably burdensome application procedures for Charity Care eligibility upon the Responsible Party and will take into account any physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the Responsible Party's capability of complying with the application procedures. The Hospital will make every reasonable effort to determine the existence or nonexistence of any available third-party coverage that might cover in full or in part the charges for services provided to each patient. The Hospital may deny Charity Care to any person who is uncooperative with The Hospital in the Charity Care eligibility determination process including, without limitation, any Responsible Party's failure to apply for applicable third-party coverage that may be available. Responsible Parties will be considered for Charity Care on the following basis:

1) **FINANCIALLY INDIGENT**:

A. To be eligible for charity care as a financially indigent patient, the patient's total household income shall be at or below 400% of the current Federal Poverty Income Guidelines.
The Hospital will use the Federal Poverty Income Guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The Sliding Fee Schedule will be updated annually in accordance with the Federal Poverty Guidelines published in the Federal Register.

B. All Responsible Parties with household income equal to or below the federal poverty standard and are not covered by private or public third-party coverage shall be determined to be Indigent Persons qualifying for Charity Care with a cost reduction extended to third-party payers.

C. Reasonable Parties with household income between one hundred and three hundred percent of the Federal Poverty standard, adjusted for household size, shall be determined to be Indigent Persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with the Sliding Fee Schedule and such additional amounts as the Hospital shall determine in its sole discretion, depending on individual financial circumstances and including asset limits.

D. The Hospital will also take into account any other outstanding medical debt and deduct the amount of payments from the Responsible Party's income. The Responsible Party's income will be reduced by their income level and percentage owed on the sliding fee schedule.

E. The Hospital may classify Responsible Parties, whose income exceeds three hundred percent of the federal poverty standard, adjusted for household size as an Indigent Person eligible for a discount from charges based upon the Responsible Party's financial circumstances, as described in the following section.

2) **MEDICALLY INDIGENT**:

A. The Hospital, in its sole discretion, may classify any individual Responsible Party whose income exceeds 400% of the federal poverty standard, as adjusted for household size, as "Medically Indigent" and eligible for Charity Care, as described in this section.

B. The Hospital will also take into account any other outstanding medical debt and deduct the amount of payments from the Responsible Parties income. The Responsible Parties income will be reduced by their income level and percentage owed on the sliding fee schedule.

C. A Medically Indigent patient is a person whose medical bills after party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.

D. If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later dated should there be a change in the patient's financial status.

E. Responsible Parties receiving discounts under this Charity care Policy shall remit the balance of the discounted charges in accordance with the Hospital's ordinary billing and collection practices of 120 days from the 1st billing statement.

THE PROCESS

1) **IDENTIFICATION OF CHARITY CASES**:

A. Patients and Responsible Parties may qualify for Charity Care at any time, once the paperwork is completed and processed. In the event of the death of the guarantor prior to filing for assistance or paperwork completion a financial assessment will take place with limited information. This will include all estate information published or non-published. Where dependent children are present within the household there will be a state Medicaid assessment where past and present coverage will become the determining factor regarding eligibility.

B. The Hospital must make reasonable efforts to determine whether an individual is eligible before engaging in extraordinary collection efforts against the individual. The hospital will still accept a completed application after having made reasonable efforts to determine whether an individual is eligible or provide required notices during a notification period of 180 days from the date of first billing. The hospital will suspend all extraordinary collection efforts for a period of 180 days from the date the applicant received his/her application.

C. The Hospital may request a down payment at the time of service and monthly payments as determined by the Financial Councilor during the application screening process if it is deemed by the Financial Councilor (based on verbal information received by the patient) that the recipient would not qualify for a 100% of financial assistance.

D. All self-pay accounts will be screened for potential Medicaid eligibility first as well as coverage by other sources, including governmental programs. During this screening process a "Financial Assistance" form, **Exhibit** "C" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.

E. The Hospital will rely on information provided by the Responsible Party to make an initial determination of Charity Care eligibility. Charity Care forms and instructions shall be furnished to patients when Charity Care is requested, when need is indicated, or when financial screening indicates potential need.

F. Any or all of the following documents will support a final determination of Charity Care eligibility: W-2 withholding statement; pay stubs; an income tax return from the most recently-filed calendar year; forms approving or denying eligibility for Medicaid and/or state funded medical assistance; forms approving or denying unemployment compensation; or written statement from employers or welfare agencies. Hospital will request further financial information should it consider extending Charity Care to Responsible Parities in excess of the amount indicated by the sliding schedule, Exhibit "B" including but not limited to copies of current monthly expenses/bills , proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills.

G. Information requested may not be used to discourage applications for Charity Care and duplicate forms of verification shall not be demanded from Responsible Parties. In the event that the hospital is unable to complete the charity care application it may employ and utilize alternative charity documentation. This alternative charity documentation process is outlined in Exhibit "D".

H. Once application is received, the financial class will be changed to the appropriate financial class until the application is approved and the adjustments are posted.

I. An application for Charity Care may be reopened and reconsidered for charity once the required information is received.

2) **DENIAL OF CHARITY CARE:**

In the event that The Hospital denies an application for Charity Care, The Hospital shall notify the Responsible Party in writing of the denial and the basis for the denial. All Responsible Parties denied Charity Care shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial and results in review of the documentation by the Hospital Chief Financial Officer or equivalent. Responsible Parties shall be notified that they have thirty (30) calendar days within which to request an appeal of the final determination of Charity Care eligibility. Within the first fourteen (14) days of the appeal period, The Hospital may not refer the account to an external collection agency. After the fourteen (14) day period, The Hospital may not refer the account to an external collection agency. After the fourteen (14) day period, if no appeal has been filed, The Hospital may initiate collection activities. If The Hospital initiates collection activities and thereafter discovers that an appeal has been filed, it will cease collection efforts until the appeal is finalized.

In the event The Hospital's final decision on appeal upholds the previous denial of Charity Care eligibility, the Responsible Party will be provided with copies of the documentation upon

which the decision was based. The Hospital will make every reasonable effort to reach Charity Care eligibility determinations in a timely manner, and shall make such determinations at any time upon learning of facts or receiving financial documentation identified above indicating that the Responsible Party's income is equal to or below 400% of the federal poverty standard, as adjusted for household size.

3) **FAILURE TO PROVIDE APPROPRIATE INFORMATION**

Failure on the part of the Responsible Party to cooperate with The Hospital in the Charity Care eligibility process shall be grounds for denial of Charity Care.

4) **EXCEPTION TO DOCUMENTATION REQUIREMENTS**

The CFO may waive the documentation requirements and approve a case for Charity Care at his/her sole discretion based on their belief the patient does/should qualify for charity. The amount or percentage of charity care discount will be left to the CFO's discretion. Waiver of the documentation requirements should be noted in the comments sections on the patient's account, as well as the percent or dollar amount approved for Charity adjustment, printed out and attached to the Financial Assistance (FA) form.

5) **TIME FRAME FOR ELIGIBLITY DETERMINATION**

The Hospital must notify persons applying for Charity Care in writing of the final eligibility determination within 30 days of receiving the **completed** application, including one or more of the financial documentation identified above. Such determination must include a determination of the amount for which the Responsible Party will be held financially accountable.

6) **DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF**

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes, The CEO, CFO, or BOM will signify their review and approval of the write-off by signing the appropriate Accounts receivable documentation. These requirements will be based on the Hospital financial policy for approving adjustments.

7) **CONFIDENTIALITY**

All information relating to Charity Care applications will be kept confidential. Copies of documents that support the application will be kept with the application form. All records will be retained for 7 years or such other time period as may be required by applicable law.

Exhibit A

Hospital
Moab Regional Hospital

Family Medicine
Dr. Dylan Cole
Dr. Kenneth Williams
Dr. Jonas Munger
Dr. Katherine Williams
Dr. Whitney Mack
Dr. Pablo Johnson
Eve Maher-Young, PA-C
Keely Hanson, PA-C Desiree
Westfall, PA-C Hannah
Bodenhamer, PA-C

Specialty Medicine
Dr. Lauren Prest
Dr. Kim Brandau
Dr. Kimberly Franke
Dr. Michael Quinn
Dr. Eric Hanly
Dr. Michael White
Dr. Amir Beshai
Pam Marsing, LCSW
Antje Rath, Counselor
Janel Arbon, Dietician

Emergency Medicine
Dr. Patrick Scherer
Dr. Paul Reay
Dr. Angela Alexander
Dr. Michael Kueber
Georgia Russell, APRN
Angela Mercier, APRN

Anesthesia
Dr. Phillip Kopell
Laird Clark, CRNA
Daniel Roush, CRNA

Any provider who is not listed and has assigned billing rights to Moab Regional Hospital will also be covered in the Financial Aid Policy. These providers might be temporary, visiting, locums, etc.

Any visiting provider that sees patients in Moab Regional Hospital or Moab Regional Health Center but bills for their services are not covered in this Financial Aid Policy.

Exhibit B

Household Size	Yearly Income Range										
1	$12,760	$16,588	$19,140	$22,330	$22,968	$23,606	$25,520	$28,710	$31,900	$44,660	$51,040
2	$17,240	$22,412	$25,860	$30,170	$31,032	$31,894	$34,480	$38,790	$43,100	$60,340	$68,960
3	$21,720	$28,236	$32,580	$38,010	$39,096	$40,182	$43,440	$48,870	$54,300	$76,020	$86,880
4	$26,200	$34,060	$39,300	$45,850	$47,160	$48,470	$52,400	$58,950	$65,500	$91,700	$104,800
5	$30,680	$39,884	$46,020	$53,690	$55,224	$56,758	$61,360	$69,030	$76,700	$107,380	$122,720
6	$35,160	$45,708	$52,740	$61,530	$63,288	$65,046	$70,320	$79,110	$87,900	$123,060	$140,640
7	$39,640	$51,532	$59,460	$69,370	$71,352	$73,334	$79,280	$89,190	$99,100	$138,740	$158,560
8	$44,120	$57,356	$66,180	$77,210	$79,416	$81,622	$88,240	$99,270	$110,300	$154,420	$176,480
Patients Share	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**95%**
% poverty 100%		***130%***	***150%***	***175%***	***180%***	***185%***	***200%***	***225%***	***250%***	***350%***	***400%***
What portion of the outside bill will be use to reduce the total annual household income? *	***100%***	***90%***	***80%***	***70%***	***60%***	***50%***	***40%***	***30%***	***20%***	***10%***	***5%***

Note: For families with more than 8 persons, add $4,480 for each additional person.

Exhibit C

FINANCIAL AID APPLICATION

If you need any assistance to complete this form please contact our Financial Navigator, Tala Kent, at 435-719-3542. Please review our website (www.mrhmoab.org) for additional information including frequently asked questions, plain language summary, and our Financial Assistance Policy.

INSTRUCTIONS TO COMPLETE THIS FORM:

Please fill out the form completely and returned all required documents to our financial assistance department. Financial assistance will not be awarded to those who do not complete the application process; including the requirement for the patient to apply for other programs for which they may qualify. (e.g. Medicaid).

Please refer to the checklist (separate document) of all required information to be submitted with this application form.

INFORMATION ABOUT YOU

Patient Name		Social Security Number	
Date of Birth	Daytime Phone Number	Other Phone Number	
Person Responsible for Bill	Relationship to Patient	Social Security Number of Responsible Person	
Spouse Name	Spouse Date of Birth	Spouse Social Security Number	
Street Address	City	State	Zip Code
Mailing Address (if Different from Street)	City	State	Zip Code
Length of Time at Above Address	Employer Name	Work Phone Number	

ADDITIONAL HOUSEHOLD MEMBERS

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

MONTHLY INCOME OF YOUR ENTIRE HOUSEHOLD

If you are unable to provide copies of the verified information; please provide 2 months of bank statements with an explanation on the back of the form.

Type	Responsible Party Income	Spouse Income	Type of Income Verification Required
Employment Income (Monthly Before Taxes)	$	$	□ Provide paycheck stubs for the last two pay periods or 2 months bank statements or most recent W2
Self-Employment Income (Monthly Before Taxes)	$	$	□ Provide IRS wage and tax statement for self-employed (Form 1099) or bank statements for 2 months
Pension, Retirement, Social Security Monthly Income	$	$	□ Provide your Pension/Retirement statement, and/or Social Security award letter
Unemployment, Disability Income, etc. (Monthly) Copy of check if Disabled/Unemployed longer than 6 months	$	$	□ Provide Unemployment, disability award letter, or 2 months bank statements
Child Support, Alimony (Monthly)	$	$	□ Provide a copy of your divorce decree, legal separation notice or custody agreement
Other (Please list Source):	$	$	□ Provide 2 months bank statements with an explanation of your income source(s)

ASSETS

Type	Financial Institution(s) Name	Total Balance Amount Now (Approximate as accurately as possible)
Cash		$
Savings Account(s)		$
Checking Account(s)		$
Stocks or Bonds		$

For Medicare Patients Only (as required by Medicare)

401 (k) Balance	IRA Balance

OUTSTANDING MEDICAL BILLS:

Please itemize your outstanding medical expenses and, if known, indicate the amount still owed after the insurance company pays. Attach a separate sheet if necessary.

Name of Provider (Hospital/Physician/Pharmacy)	Your Monthly Payments	Balance Due
	$	$
	$	$
	$	$
	$	$

We also ask patients who apply for financial assistance to report other funding. Please check "Yes" or "No".

Question			
Does your employer or spouse's employer offer group health insurance?	□ Yes	□ No	If yes, list insurance company here:
Do you have other types of insurance such as Allstate, AFLAC, etc.?	□ Yes	□ No	If yes, list insurance company here:
Do you have a Health Savings/Flex Spending Account	□ Yes	□ No	If yes, what is the available balance:
Does your employer reimburse you for any deductible or healthcare costs?	□ Yes	□ No	Terms of reimbursement:
Were you denied for Medicaid?	□ Yes	□ No	If yes, please attach copy of the Medicaid denial.
Have you applied for state assistance programs (CHIP, PCN, Crime victims, etc.)?	□ Yes	□ No	If yes, which program?
Are you eligible for COBRA through a previous employer?	□ Yes	□ No	If yes, please provide your insurance information here.
Do you have family or church assistance?	□ Yes	□ No	If Yes, please provide detail here.
Is this related to a car accident?	□ Yes	□ No	If Yes, please provide information about the car insurance here.

Please explain any situation that we should be informed of in order to understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional verification may be required.

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Is there any other information that you would like us to know to help us make a decision?

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I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. In 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 may not pertain to other healthcare providers.

Responsible Party Signature______________________________________ Date _________________

QUESTIONS? Please contact our financial navigation team. 435-719-3500.

FINANCIAL ASSISTANCE PROGRAM CHECKLIST

PATIENT NAME: ____ **DATE:**____________________

If you have difficulty providing these documents, please discuss alternatives with your Financial Navigator.

PROOF OF INCOME:

- ☐ Complete most recent Federal Tax Returns including all schedules
- ☐ If employed: Paycheck stubs for the last 2 pay periods or 2 bank statements
- ☐ If self-employment: Please provide at least one of the following:
    1. IRS Wage and Tax Statement for Self Employed (Form 1099).
    2. Bank statements for 2 months
- ☐ Unemployment, Disability Income, etc. (monthly). Copy of check if disabled/unemployed longer than 6 months
- ☐ Child Support, Alimony (monthly): copy of your divorce decree, legal separation notice or custody agreement
- ☐ Other (as requested by your Financial Navigator): ___________________________________

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MEDICAL BILLS

- ☐ Copies of all outstanding medical bills from all sources
- ☐ Documentation of any payment plans for medical bills outstanding

MEDICAID APPLICATION

- ☐ Completed Medicaid Application
- ☐ Denial letter from Medicaid

OTHERS: ____

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Please contact our financial navigation team. 435-719-3500

EXHIBIT D

Moab Regional Hospital
Patient Financial Services
Effective Date:

SUBJECT:
Presumptive Charity Care (alternative charity documentation)

PURPOSE:
PFS (Patient Financial Services) staff process Charity Care requests in accordance with the MRH Charity Care Policy. In the event that the primary Charity Care Policy Application requirements are not met, accounts may undergo a charity review process where the complete financial assistance application may not be available, but substitute documentation establishing financial need will be obtained. The hospital may offer Charity Care discounts on the basis of individual life circumstances (presumptive eligibility) without requiring the patient to complete a financial assistance application.

Presumptive charity describes this situation where need has already been established and the patient therefore has been presumed eligible for assistance.

Patients may be reviewed for presumptive (alternative) charity after all other sources of funding have been exhausted.

PROCEDURE:
Accounts will be screened for charity as outlined in the Charity Care Processing. Patients may be identified as falling under presumptive, alternative criteria; examples include, but are not limited to:

1) Patient did not have Medicaid coverage at the time of service, but was eligible for Medicaid within twelve months of that date of service.
   - Documentation: Medicaid eligibility verification showing effective dates of coverage.
2) Patient is receiving food stamps, is participating in subsidized school lunch programs, and/or is receiving assistance from Women's, Infants, and Children's (WIC) programs.
   - Documentation: copies of the financial assistance determination from the local/state/county program or agency showing that the patient's need for charity care has been established.
3) Patient is deceased, with no estate (the spouse can fill out the application, providing required documentation), and no surviving spouse (The Charity Committee and Administration will review the situation and make a determination).
   - Documentation: record of the death certificate on file, account records regarding status of surviving spouse, record of at least four probate inquires with the court.
4) Patient's street address is for "homeless" or for a local shelter.
   - Documentation: assessment supporting a "lack of housing" and a record of account notes showing attempts to locate a place of address for the patient.

Presumptive Charity will only be offered after the primary MRH Charity Care Policy has been fully reviewed.