



Procedure Title: Financial Assistance Policy  
 Date Originally Written: January 4, 1990  
 Last Revision Dates: June 30, 2011, June 6, 2012, February, 14, October, 14  
 Reference Info:  
 Written by: Dee Driskell  
 File Name: PD\_Charity.V25  
 Attachments: Assistance Application – IHA Memorandum – uninsured – worksheet A and B  
 Approved by: Steve Hall, CFO

Board approval date:	July, 2012, Feb, 2014, Oct, 2014, Jan 2016
----------------------	--

**I. Purpose**

This policy is intended to provide the framework under which Financial Assistance will be made available to patients of the Hospital (the “Policy”). The Policy identifies the specific eligibility criteria and application process under which the Hospital will provide care free of charge or at a reduced charge, the criteria used in calculating the amount of the discount, the actions the Hospital may take in the event of nonpayment after reasonable efforts are taken to determine whether an individual is eligible under this Policy, and the measures the Hospital will take to widely publicize this Policy within the community served by the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services, including physicians who treat Hospital patients on an inpatient or outpatient basis.

**II. Policy Statements**

- A. In keeping with its mission, Pekin Hospital (the “Hospital”) is dedicated to making health care services accessible to all patients without discrimination based on race, religion, gender, national origin, sexual orientation, or ability to pay, including whether or not the patient is eligible for Financial Assistance, or is medically indigent. The Hospital recognizes and acknowledges the financial needs of patients and families who are unable to afford the charges associated with their medical care. In that regard, the Hospital when necessary provides medically necessary healthcare services to patients who reside in Illinois.
- B. Financial Assistance described within this Policy will be offered in a manner that preserves the overall resources of the organization so that the Hospital can continue to make health care services possible for those patients residing in Illinois who are in need of care. Patients and families must cooperate with the Hospital in the identification of, application for and procurement of payment sources including public assistance, where available. Such efforts must be exhausted before a patient is eligible for Financial

Assistance. Patients and families are expected to notify the Hospital if there is a change in financial status.

- C. To manage its resources and responsibilities and to allow the Hospital to provide assistance to the greatest number of patients in need, the Board of Trustees will approve guidelines for the provision of Financial Assistance.
- D. Scope: This policy applies to:
  - 1. Pekin Memorial Hospital
  - 2. Pekin Emergency Room Physicians
  - 3. Pekin Urgent Care Physicians

***Note that physicians associated with Pekin Hospital, but who bill “privately” are encouraged, but not required, to follow this policy.***

### III. Definitions

- A. *Amounts Generally Billed:* Charges for medically necessary services shall be limited to no more than amounts generally billed to individuals who have insurance covering such care (“AGB”).
  - i. In calculating the AGB, the Hospital has selected the “look-back” method whereby the AGB is determined based on actual past claims paid to the Hospital by Medicare fee-for-service together with all private health insurers paying claims to the Hospital.
  - ii. The AGB percentage will be calculated at least annually by dividing the sum of all claims that have been paid in full during the prior 12 month period by the sum of the gross charges for those claims. This resulting percentage is then applied to an individual’s gross charges to reduce the bill.
    - iii. A revised percentage will be calculated and applied by the 45<sup>th</sup> day after the first day of the start of the fiscal year used to determine the calculations.
  - iv. For information on the calculation of the ABG percentage you may contact the Controller Office at the following address:

Pekin Hospital  
600 SOUTH 13TH STREET,  
PEKIN, ILLINOIS 61554

- B. *Application Period:* During the Application Period, the Hospital must accept and process an application for Financial Assistance (“Application”). The Application Period begins on the date the care is provided to the individual and ends on the 240<sup>th</sup> day after the Hospital provides the patient with the first billing statement for the care.
- C. *Completion Deadline:* The Completion Deadline is the date after which a Hospital may initiate or resume ECAs (as defined below) against an individual who has submitted an incomplete Application if that individual has not provided the Hospital with the missing information and/or documentation necessary to complete the Application. The Completion Deadline must be no earlier than the later of 30 days after the Hospital provides the individual with this written notice; or the last day of the Application Period.

- D. *Extraordinary Collection Actions (ECAs)*: These collection actions are defined as those requiring a legal or judicial process and involve selling debt to another party or reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include 1) placing a lien; 2) foreclosing on real property; 3) attaching or seizing of bank accounts or other personal property; 4) commencing a civil action against an individual; 5) taking actions that cause an individual's arrest; 6) taking actions that cause an individual to be subject to body attachment; and 7) garnishing wages. The Hospital will not engage in ECAs before it has made Reasonable Efforts to determine if the patient is eligible for Financial Assistance. Further information on the Hospital's use of ECAs can be found in the Hospital's separate Collections Policy.
- E. *Family Income*: Family Income is defined based on definitions used by the U.S. Bureau of the Census and includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as food stamps and housing subsidies) are not considered income.
- F. *Federal Poverty Guidelines ("FPL")*: Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).
- G. *Financial Assistance*: Financial Assistance applies to medically necessary services rendered to patients who cannot afford to pay, who are not eligible for public programs, and for which the Hospital has received financial documentation that the patient cannot make payment for services rendered. This includes care provided to uninsured, low income patients and those patients who have partial coverage but who are unable to pay some or all of the remainder of their medical bills. Financial Assistance does not include contractual allowances with insurance companies and other third party payers.
- H. *Financial Assistance "Board"*: The Board is comprised of the hospital board members. Board members names are available upon request.
- I. *Notification Period*: The Notification Period is defined as the period during which the Hospital must make a Reasonable Effort to notify the patient of the Policy. The Notification period begins on the first date care is provided to the patient and ends on the 120th day after the Hospital provides the patient with the first billing statement.
- J. *Plain Language Summary*: A Plain Language Summary of the Hospital's Financial Assistance Plan must contain:
- i. A brief description of the eligibility requirements and assistance offered;
  - ii. A listing of a website or location as to where Applications may be obtained;
  - iii. Instructions on how to obtain a free copy of the Financial Assistance Policy and Application by mail;
  - iv. Contact information of someone to assist with the process as well as any other organization that the Hospital has identified to assist with Applications;
  - v. Availability of translations; and
  - vi. A statement that no Financial Assistance eligible patient will be charged more than AGB for emergency or medically necessary services.

- K. *Reasonable Efforts*: The Hospital will have been considered to having made a Reasonable Effort in regard to having provided notification to the patient about the Hospital's FAP if the Hospital distributes a Plain Language Summary of the FAP to the patient and offers an Application to the patient prior to discharge from the Hospital. The Hospital must provide a Plain Language Summary of the FAP with all (and at least three) billing related written communications.

More specifically, the Hospital will have considered to have made a Reasonable Effort:

- i. When the patient and/or family submits an incomplete Application, and the Hospital:
  - (a) suspends any ECAs against the patient;
  - (b) provides written notification that describes what additional information or documentation is needed and includes a Plain Language Summary of the FAP; and
  - (c) provides at least one written notice informing the patient about the ECAs that might be taken (or resumed) if the Application is not completed or payment made by a deadline specified in the written notice, which shall be no earlier than 30 days from the date of the written notice or the last day of the Application Period; or
- ii. When the patient and/or family submits a complete Application, and the Hospital:
  - (a) suspends any ECAs against the patient;
  - (b) makes and documents a determination on whether the patient is eligible for Financial Assistance in a timely manner; and
  - (c) notifies the patient in writing of the determination (including, if applicable, the assistance for which the patient is eligible) and the basis for this determination; or
- iii. when a patient and/or family have been determined to be eligible for Financial Assistance, if the Hospital:
  - (a) provides the patient with a billing statement that indicates the amount owed after subtracting Financial Assistance;
  - (b) refunds any excess payments made by the patient; and
  - (c) takes all reasonably available measures to reverse any ECAs taken against the patient.

#### **IV. Eligibility Criteria**

- A. To be considered eligible for financial assistance or care at a reduced rate, the patient or family must apply by completing the Application (*see* Attachment 1) and providing supporting documentation. Supporting documentation includes (as applicable): current pay stubs, bank statements, prior year's tax returns, a signed letter from employer, and social security or disability checks. Failure to provide any of these documents, if required by the Application, may result in a denial of Financial Assistance, however, verbal and oral attestations may be considered despite the absence of such documentation. Applicants will not be denied Financial Assistance based on their failure to provide information or documentation that this Policy or the Application does not explicitly require.
- B. The decision to provide Financial Assistance will be based on a review of the following specific criteria: income, assets and liabilities of the family at the date of service. Additional extenuating criteria which may also be considered including:
  - i. family size;

- ii. medical status of the family's main provider;
  - iii. employment status along with future earnings potential of the family's main provider;
  - iv. the willingness of the family to work with the Hospital in accessing all possible sources of payment; and
  - v. the amount and frequency of Hospital and other health care/medication related bills in relation to all other factors considered.
- C. Patient must be an Illinois resident. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy residency. Acceptable verification of Illinois residency include valid state-issued ID card, utility bill, vehicle registration card, voter registration card or statement from a family member of uninsured patient who resides at the same address and presents verification of residency.
- D. This Policy shall apply regardless of the patient's immigration status.
- E. Patients who reside in a foreign country are not eligible for Financial Assistance.
- F. Applicants will not be denied based on race, color, religion, sex, age, national origin, or marital status. Any discounted care offered under this Policy is subject to review to ensure compliance with this Policy.
- G. The necessity for medical treatment of any patient will be based on the clinical judgment of the healthcare provider without regard to the financial status of the patient and/or family. All patients will be treated for emergency medical conditions (within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd)) without discrimination and regardless of their ability to pay or eligibility for discounted care.
- H. Applications may be taken and/or evaluated at any time during the revenue cycle (e.g., scheduling, registration, treatment, discharges, billing and/or collections), or when a change in family size or income becomes known.
- I. It is understood that financial hardship can arise after the date of service. Regardless of the timing of the onset of financial hardship, individual circumstances will be evaluated in any request for Financial Assistance. The Hospital reserves the right to offer either more or less Financial Assistance based, among other things, on the net worth, anticipated earnings and current financial obligations of the patient's family.
- J. Families with Family Incomes exceeding the guidelines stated above can be screened for payment plan consideration.
- K. When a determination of eligibility for Financial Assistance has been made, all accounts of patients within the family shall be handled in the same manner for six months following the date of such determination, without the need for completing a new Application. Discounts will be applied to all open self-pay balances. A new Application will be required for services provided six months or more after the initial (or other prior) determination or if indications are received that the financial status of the patient or family has significantly changed from the initial evaluation period.
- L. Exceptions to the above criteria may be made only with the approval Senior Management.

## **V. Presumptive Eligibility**

Due to a variety of circumstances, all documentation/information may not be available on an account to determine the patient's eligibility for Financial Assistance. If there is an indication that the patient or family is unable to pay all or part, verbal and/or written attestations may be considered. These accounts may be deemed appropriate for Financial Assistance.

Eligibility may be presumed based on the patient's life circumstances and by using the hospital eligibility software. The list below is representative of circumstances under which a patient is deemed to be eligible for a 100 percent reduction without further need to complete an Application:

- i. Participation in state funded prescription programs;
- ii. Participation in Women's Infants, and Patient's Programs (WIC);
- iii. Food stamp eligibility;
- iv. Patient receiving financial assistance from a community clinic and the community clinic refers the patient for treatment or for a procedure
- v. Patient states that he/she is homeless. The due diligence efforts are to be documented;
- vi. Low income/subsidized housing is provided as a valid address;
- vii. Subsidized school lunch program eligibility.

## **VI. Calculation of Discounted Care**

- A. The Hospital will limit amounts charged to patients eligible under this Policy to no more than the lesser of AGB or 135% of costs if the patient is deemed uninsured as noted below. This Policy prohibits the use of gross charges except where the patient's statement may reflect discounts and net charges based on AGB.
- B. The levels of Financial Assistance provided by the Hospital are based on income, family size, and FPL. FPL updates are generally published annually and the Hospital updates its policies with the most recently released Federal poverty guidelines.
- C. In situations whereby the patient is uninsured and whose Family Income is less than 600%, patients may be eligible for free or discounted care. Between 200% and 600% percent of the FPL, patients will be charged no more than the lessor of amounts generally billed or 135 percent of costs as calculated in the Medicare Cost Report – Worksheet S-10. The maximum amount that may be applied for health care services provided by the hospital from the patient determined by the hospital to be eligible under subsection VI.(D) is 25% of the patient's family income and is subject to patients continued eligible under this Act.
- D. Our Extended Payment Plan Program offers reasonable payment arrangements for patients who may be unable to pay the balance at one time.

## VII. Clinical Guidelines

- A. Only medically necessary tests or procedures are eligible for discounts. All elective services, to include cosmetic procedures are not eligible for discounts.
- B. The patient and/or family have the right to appeal the Hospital's denial of Financial Assistance. The appeal must be submitted in writing with 30 days of notification of the original denial. Senior Management will consider all patient and/or family appeals.

## VIII. Applying For Financial Assistance

- A. *How to Apply:* Patient and families wishing to apply may complete an Application (included in Attachment 1) or found on the Hospital's web site <http://pekinhospital.org> and submit it, along with supporting documentation, to the Patient Financial Services office. For questions about the application process, please contact the Patient Financial Services at 309-353-0400, or email [patientaccounts@pekinhospital.com](mailto:patientaccounts@pekinhospital.com) or write to :

PFS OFFICE  
PEKIN HOSPITAL  
600 SOUTH 13TH STREET, PEKIN, ILLINOIS  
61554

- B. *Eligibility Determination:* A written decision regarding eligibility will be provided to the patient and/or family within 30 business days of receipt of a completed Application. This notification will also include the partial Financial Assistance percentage amount (for approved Applications) or reason(s) for denial, and payment expected from the patient and/or family. The patient and/or family will continue to receive statements during the evaluation of a completed Application or Applications for other third party sources of payment (i.e., Medicare, Medicaid, etc.). However, the account will not be reported to the collection agency prior to a determination being made. If the account has already been placed with a collection agency, the agency will be notified to suspend collection efforts until a determination is made.
- B. *Incomplete Applications:* If the patient and/or family member submits an incomplete Application, the Hospital will (a) suspend any ECAs against the patient; (b) provide a written notification that describes what additional information or documentation is needed and includes a Plain Language Summary of the FAP; and (c) provide at least one written notice informing the patient about the ECAs that might be taken (or resumed) if the Application is not completed or payment made by a deadline specified in the written notice, which shall be no earlier than 30 days from the date of the written notice or the last day of the Application Period

## IX. Notification

- A. To make our patients, families and the broader community aware of the Hospital's Financial Assistance program, the Hospital has taken a number steps to notify visitors to its facility of this Policy and to widely publicize this Policy to members of the broader community served by the Hospital including:
  - i. Posting of legible signage in heavily trafficked patient areas such as admitting, emergency department and ambulatory registration areas;
  - ii. Providing pamphlets and brochures during the admission and/or discharge process;

- iii. Providing notice of availability of financial assistance or discounted care and other forms of communications;
- iv. Offering patient and family counseling sessions with registrars, patient accounting staff, or financial counselors either before, during or after the time of service, as appropriate; and
- v. Providing information about this Policy on the Hospital's website, including the Application and a Plain Language Summary of the Policy in a widely available format, for example as a PDF document.
- vi. Providing a Plain Language Summary of the Policy with all billing statements (at least 3 billing statements) and all other written communications regarding the bill during the Notification Period;
- vii. Offering an Application before discharge from the Hospital;
- viii. Informing patients about the Hospital's Policy in all oral communication regarding the amount due; and
- ix. Providing at least one written notice stating what ECAs the Hospital may take if no Application is received or no payments are made by a specified date (at least as long as notification period) and this notice is provided at least 30 days before the deadline.

B. Signage must communicate in capital letters "IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE."

C. All printed information and/or forms regarding the Financial Assistance program will be available in primary languages spoken by populations we serve in accordance with state and federal law.

D. Printed copies of this Policy (including the Application), its Plain Language Summary, EMTALA and the Hospital's Collections Policy may be obtained at no extra cost by visiting or calling the Hospital's Business Office at: 309-353-0400

Pekin Hospital  
600 South 13<sup>th</sup> Street  
Pekin, IL 61554

## **X. Reporting Requirements**

At the request of the Office of the Auditor General's office, the Hospital will annually report information regarding the number of Applications completed and approved; the number of Applications completed and not approved; and the number of Applications started but not completed.

## **XI. Cross-References/Related Policies**

- A. Administrative Policies: Collections
- B. Administrative Policies: EMTALA

**XII. Authorizations.** The decision to provide charity care and Financial Assistance, as outlined herein, requires the approval of the following individuals:

Accounts below \$5,000:	Manager or Lead, Patient Financial Services Accounts \$5,001 to
\$30,000:	Above, plus Director of PFS
Accounts over \$30,000:	Chief Financial Officer
High Cost Specialized or	

Elective Services or Exceptions: Senior Management of Pekin Hospital

## **XI. Regulatory Requirements.**

In implementing this Policy, the Hospital will comply with all other federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this Policy.

Date Written: 01/04/1990

Date Reviewed/Revised: March, 09, December 10, January 14 , January 16

Date of Approvals: January, 2016





Important: **YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE:**

It is the policy of Pekin Hospital to provide financial assistance or discounted care to those in need. Completing this application will help Pekin Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

**IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FEE OR DISCOUNTED CARE.** However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required, but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.