Val Verde Regional Medical Center	REFERENCE #:
SUBJECT: Financial Assistance/Charity Policy	Page 1 of 5
DEPARTMENT: Patient Financial Services	EFFECTIVE: July 9, 2014
APPROVED BY: Board of Trustees	REVISED: February 27, 2018

POLICY STATEMENT

Val Verde Regional Medical Center is committed to providing charity care to persons who have healthcare needs and are uninsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Val Verde Regional Medical Center will provide, without discrimination, care for **emergency** medical conditions to individuals regardless of their eligibility for financial or government assistance. Patients are advised on their first statement that they can contact the hospital for assistance if unable to pay their bills.

Accordingly this written policy:

- Includes eligibility criteria for financial assistance
- Describes the method by which patients may apply for financial assistance

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Val Verde Regional Medical Center's procedures for obtaining charity or other forms of financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

In order to manage its resources and to allow Val Verde Regional Medical Center to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Trustees establishes the following guidelines for the provision of patient charity.

DEFINITIONS

"Applicant" means an individual applying for Assistance.

"Assistance" means the financial assistance provided by Val Verde Regional Medical Center to Eligible Residents pursuant to this Policy.

"Eligible Resident" means an individual who has been determined to be eligible to receive Assistance.

"Household" means a person living alone, a married couple, or two or more persons living together who are related by birth, marriage, or adoption where legal responsibility for support exists.

"Household Income" means the amount of all sources of income received by people in a Household:

- It includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental, public assistance (welfare), veterans' payments, alimony,

child support, assistance from outside the household, and other miscellaneous sources.
- Noncash benefits (such as food stamps and housing subsidies) are not counted.
- Determined on a before-tax basis.
- It includes the income of ALL family members in the household.

"Uninsured" is an individual who has no insurance coverage, governmental, or third party assistance to assist with meeting his/her payment obligations.

"Medically necessary" as defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of an illness or injury).

"Amounts Generally Billed" are the amounts charged for each test or service provided to patients based on the facility's chargemaster at the time services are provided. All patients are charged the same amount for services rendered regarding of their payor source.

ELIGIBILITY

An Eligible Resident must:

(1) Be a resident of Val Verde County for a minimum of three (3) consecutive months;
(2) In the month of service, have had a Household Income equal to or less than two hundred percent (200%) of the federal poverty level for that year, based on the federal Office of Management and Budget poverty index ("FPL") to be eligible for Assistance;
(3) Have no coverage for health related expenses from any third party payor source, including, but not limited to, private insurance, worker's compensation, the Veteran's Administration, military health care, the Children's Health Insurance Program, Medicare or Medicaid. For patients who have large deductibles, individual situation will be evaluated for possible assistance.

COVERED SERVICES

The following services provided by the Val Verde Regional Medical Center that are eligible for charity:

- Emergency medical services (as defined by EMTALA) provided in an emergency room setting;
- Services for a condition which, if not promptly treated that require surgery or Observation, would lead to an adverse change in the health status of an individual;
- Inpatient hospitalizations;

- Elective medically necessary services will be evaluated on a case-by-case basis at discretion of the Hospital

VVRMC may coordinate payment or other arrangements with outside providers for continuation of patient care as outlined in the patient's discharge instructions, not to exceed 30 days from the point of discharge. All arrangements will require prior approval of the Chief Financial Officer (CFO).

No other healthcare or medical services offered by or through any entity affiliated with the District or Hospital are Covered Services including, but not limited to, (i) physician services offered through various physician practices or (ii) clinics affiliated with the District or the Hospital. Eligible Residents may be eligible for other programs offered by the Hospital designed to reduce, discount or otherwise offset the cost of healthcare or medical services that are not Covered Services.

AMOUNT OF ASSISTANCE

The granting of charity shall be based on an individualized determination of financial need. If no public or private third-party source of payment is available, amounts generally billed for Covered Services are discounted one hundred percent (100%) for Eligible Residents.

PRESUMPTIVE FINANCIAL ASSISTANCE ELIGIBILITY:

There may be instances when a patient may appear eligible for charity, but there is no financial assistance form on file due to lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, Val Verde Regional Medical Center could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless or received care from a homeless clinic;
- Participation in Women, Infants and Children programs (WIC);
- Food stamps eligibility;
- Subsidized school lunch program eligibility;
- Low income/subsidized housing – a valid address must be provided, and
- Patient is deceased with no known estate.

DURATION OF ELIGIBILITY

Eligible Residents will remain eligible for Assistance from the time of their application until 90 days following approval of their application. Re-application is required after the 90 day period to verify financial resources.

PROCESS

1. Non-Discrimination. Hospital will not discriminate on the basis of race, ancestry, religion, national origin, citizenship status, age, disability or gender in its consideration of a patient's qualification for Assistance.

2. Patient Classification. The classification of a patient as being eligible for Assistance shall occur at the time sufficient information has been obtained to verify the patient's inability to pay for needed medical services, and as soon as possible after the patient first presents for services or indicates an inability to pay for services.

3. Time of Qualification. Hospital personnel shall attempt to identify all cases that qualify as Eligible Residents at the time of pre-registration or admission. Patients identified as possible Eligible Residents will be given an application and policy guidelines together with directions on completing the paper work and any additional documentation needed to consider the application. Patient and/or Guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. Applicants will also be given contact information for the Financial Counselor to whom they should return the application. Every effort should be made to provide information within thirty (30) days.

4. Other Payor Sources. Applicants must fully cooperate and comply with eligibility requirements for any other healthcare program(s) for which they may be qualified prior to their evaluation for Assistance. Federal and/or State assistance may be available to those who meet qualifications. Before Assistance is considered, all available avenues of assistance from third-party payors must be exhausted.

5. Required Documentation. In order to be considered for Assistance, all income information must be obtained regarding the applicants household. Eligibility documentation must be maintained in the applicant's financial file. The following is a list of documents that may be required from the patient in order to determine income and assets of the patient.

    a. Financial application, with attestation:

b. Bank Statements; checking/savings
c. Social Security card for patient and of all dependents; (if applicable)
d. Proof of any income received by the members of the Household, including, but not limited to: (i) pay stubs of any employed Household members or, if not available, a letter from the employer verifying wages; (ii) Social Security award letters, or copy of Social Security checks (iii) Pensions, 401(k) statements, or other information regarding income following retirement based on years of service with a business or other entity (iv) Child Support (v) Unemployment Benefits (vi) Rental Property Income (vii) Profit/Loss form (viii) tax return(s).
e. Utility Bill;(electricity/water-gas) (established residency consists of more than 3 continuous months in Val Verde County)Proof of residence; letter of living arrangement (established residency consists of more than 3 continuous months in Val Verde County)Government issued identification with a photograph for patient and spouse.

6. Administrative Approval. All Assistance applications based on dollar criteria shall be forwarded to the Director of Patient Financial Services for review and recommendation and then to the Chief Financial Officer for final approval

7. Notification Process. The process of application review, approval or denial, and notification of decision shall not take more than thirty (30) days from the date that the application is received with all required information. Applicants shall receive a letter stating whether the application was approved, denied, or pending additional documentation.

8. Patient Account Adjustment. Once a favorable determination is made to provide Assistance, an adjustment will be made to the Eligible Resident's account.

9. Publication of Policy. The Hospital's Financial/Charity Assistance Policy must be available to the public. In addition to the prominent posting of a Financial Assistance notice in the Admissions and Emergency Department area, a copy of the policy can be issued to all patients upon request.

10. Bad Debt. Once an account has been written off to bad debt, the patient may be allowed to amend original application to include accounts that may not have been included. A hospital representative will contact any vendor who may be working the account, to stop all collection efforts on the account.