POLICY:

Bell Hospital and Bell Medical Center are committed to providing Financial Assistance/Charity Care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with our mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who have a financial need, Bell Hospital/Bell Medical strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Financial Assistance/Charity Care is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Bell Hospital/Bell Medical procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow Bell Hospital/Bell Medical to provide the appropriate level of assistance to the greatest number of persons in need, Bell Hospital/Bell Medical establishes the following guidelines for the provision of patient charity.

DEFINITIONS:

Charity Care – Healthcare services that have or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria**.**

Family – Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income – Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines**:**

-Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, 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;
-Noncash benefits (such as food stamps and housing subsidies) do <u>not</u> count;
-Determined on a before-tax basis;
-Excludes capital gains or losses; and
-If a person lives with a family, includes the income of all family members (Non-relatives, such as housemate, do not count).

Uninsured – The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured – The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities**.**

Net Equity – net equity equals the state equalized value of any real estate times **2.0** (a guarantor/patient my own only one residence) plus any/all savings account balance(s), plus any/all checking account balance(s) plus any/all retirement saving(s) account balance(s) minus any mortgage balance(s) minus any home equity loan balance(s), minus any/all installment loan(s) and minus any/all revolving charge account balance(s).

Service Area –Principally, primary care patients residing in the following zip codes: 48949 (Ishpeming), 49866 (Negaunee), 49814 (Champion), 49879 (Republic), 49861 (Michigamme), 49871 (Palmer), and 49841 (Gwinn). Patients residing in the Upper Peninsula of Michigan receiving specialty services from employed physicians in Obstetrics/GYN, Vascular, Urology, and Otolaryngology specialty care services are also considered in our service area. Other service areas will be considered on a case by case basis.

FINANCIAL ASSISTANCE PROCEDURES:

Services Eligible Under this Policy. For purposes of this policy, "charity" refers to healthcare services provided without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

-Emergency medical services provided in an emergency room setting;
-Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
-Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
-Medically necessary services, evaluated on a case-by case basis at Bell Hospital/Bell Medicals' discretion.

Basic Eligibility Requirements:

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. Patients who are already qualified under the County's MCAC Program shall be considered qualified for assistance under this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. This Policy shall also apply to those individuals needing assistance for deductibles, co-insurance, or co-payment responsibilities.

A. In order to be eligible for financial assistance a patient must live within the Bell Hospital and Bell Medical Center service area as defined in this policy and receive medically necessary services from Bell Hospital and/or Bell Medical Center (excluding cosmetic and non-acute, elective procedures).

and

B. In order to be eligible for financial assistance, the patient's family income must be under 200% of the Federal Poverty Guidelines for Gross Income as published in the Federal Register. In order to determine the family income when a patient might qualify, the patient/guarantor will be asked to provide the Financial Counselor with a brief financial statement and be made aware that additional verification may be requested if they are offered financial assistance.

and

C. In order to be eligible for financial assistance, the patient household's net equity (as defined) must not exceed $100,000.

and

D. In instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a 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 financial assistance. In the event there is no evidence to support a patient's eligibility for charity care, Bell Hospital/Bell Medical may use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

-State-funded prescription programs;
-Homeless or received care from a homeless clinic;
-Participation in Women, Infants and Children programs (WIC);
-Food stamp eligibility;
-Subsidized school lunch program eligibility;
-Eligibility for other state or local assistance programs that are unfunded (e.g., Adult Benefit Waiver program);
-Low income/subsidized housing is provided as a valid address; and
-Patient is deceased with no known estate.

Determination of Financial Need Guidelines:

The Financial Counselor initially contacted by a patient/guarantor will be responsible for the financial assistance process for both Bell Hospital and Bell Medical Center by notifying the other Financial Counselors of the initial contact and getting a list of open accounts; by initially explaining the process to the patient/guarantor; by assisting the patient/guarantor with the documentation necessary to render a determination; by submitting the completed documentation to the Business Office Manager(s); by sending written notification to the other Financial Counselors and patient/guarantor of the determination(s) and by maintaining the completed packet.

1. The financial counseling process begins with a financial credit assessment worksheet (Financial Assessment Analysis Form) which must be completed by the guarantor/patient addressing the following criteria:

Marital Status
Number of Dependents
Patient Financial Status
Other Hardships

2. The Financial Counselor must provide the guarantor/patient with guidance for applying for any available assistance through external agencies.

3. The Financial Counselor will follow the guarantor/patient's application through the process and assist where possible in order to seek a determination as soon as possible.

4. The “financial assistance” qualification decision will be determined after the evaluation of the guarantor/patient's financial status (following this policy) has been completed. The Financial Counselor will notify the guarantor/patient of eligibility for “financial assistance” within 30 days of the completed and approved application.

5. In the case where it is determined that the guarantor/patient does not qualify for “financial assistance”, or partial “financial assistance”, every effort will be made to set up a convenient payment schedule plan according to the Collection Policy and Procedures. The Financial Counselors at Bell Hospital and Bell Medical Center will each be responsible for establishing their own payment arrangements.

Procedures:

To be eligible for “financial assistance” the guarantor/patient must meet the following criteria:

1. The guarantor/patient must first apply to the Department of Human Services for public assistance. If the Department of Social Services deems him/her ineligible for public aid, the patient/guarantor must present a statement of said ineligibility. The Patient Resource Consultants Agency is also consulted to make sure no other financial assistance is available. Documentation of these steps must be attached to the Financial Assistance Analysis Form.

2. The guarantor/patient must present proof of the household's gross income (paycheck stubs, social security check stubs, W-2's, etc.) received during the three months prior to the patient's services and the past two years Federal Tax returns, if available. These documents are used to project an annual income.

3. The guarantor/patient's household's gross income less any child support payments made during the prior three months (child support payments must be supported by documentation that they were actually made) in combination with the number of family members living in the household must be equal to or less than the Income Level Chart to be eligible for

“financial assistance”. The patient/guarantor is required to disclose all household income, asset and expense information (with the appropriate documentation) that is requested on the Financial Assistance Analysis Form before a determination of “financial assistance” eligibility can be made.

4. The Financial Counselor will compile the documentation acquired during the “financial assistance” process, make a recommendation for disposition, and submit it to the Business Office Manager(s) for approval. Once the financial assistance process is complete, the Business Office Manager(s) will provide the appropriate documentation for the account(s) adjustment(s).

5. Account balances subject to financial assistance will be net as of the date of the determination. Under no circumstances will accounts be considered for financial assistance which have dates of service more than 180 days prior to the date of the guarantor/patient's submission of a completed application for financial assistance or more than 180 days after the date of approval of the completed application. An updated application will be required for services occurring more than 180 days after the approval of a completed application.