POLICY NO. 2.012

PARMER MEDICAL CENTER
POLICIES AND PROCEDURES

Department: Business Office

Subject: Financial Assistance Program (Charity Care)

Effective: August 1, 2017

Purpose:

The purpose of this **Financial Assistance Policy ("FAP")** is to specify:

- Eligibility criteria for Financial Assistance in the form of free or discounted care;
- How to apply for Financial Assistance;
- How the Hospital calculates amounts charged to patients;
- How the FAP is widely publicized within the community served by the Hospital

Policy:

1. As a tax-exempt nonprofit organization, and a National Health Service Corps certified Rural Health Clinic, Parmer Medical Center and the Friona Rural Health Clinic serves the healthcare needs of its community and is committed to providing charity care to any person who has healthcare needs. Consistent with its mission to deliver compassionate, high-quality, affordable healthcare services, and to advocate for the poor and underserved, Parmer Medical Center will provide care, without discrimination, for emergency medical conditions regardless of people's ability to pay. This policy will be made readily available to prospective and current patients and to the community at large.

2. Patients who are eligible for financial assistance – free or discounted care – under this program are any Parmer Medical Center patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Financial assistance under this policy is available to residents of the hospital's service area (Parmer County).

3. "Financial Assistance" or "Charity" refers to healthcare services provided by Parmer Medical Center without charge or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance under this policy:

    a. Emergent medical services provided in an emergency room setting, including the fees for physician services related to the care received in the emergency room setting.
    b. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual, deemed necessary by a physician.
    c. Non-elective services provided in response to life-threatening circumstances in a non-

emergency room setting deemed necessary by a physician.

4. The following services are specifically ***excluded*** from financial assistance under this policy:

    a. Healthcare services provided in an emergency room setting that are deemed non-emergent by the physician.
    b. Services not covered or deemed medically necessary by the Medicare/Medicaid programs.
    c. Healthcare services performed/billed by a third party (i.e., Radiologists fees for the reading/interpretation of X-rays).
    d. Physician services related to inpatient healthcare services received.

Procedure:

ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE:

The amount of Financial Assistance an individual may be eligible for will depend on several factors. The following factors are considered in determining eligibility for Financial Assistance:

1. Whether the patient received medically necessary, non-elective medical care and treatment.
2. Annual gross family income of the patient or party responsible for the patient's bill.
3. Family size of the patient or party responsible for the patient's bill.
4. Employment status and earnings capacity.
5. Other financial resources that are potentially available to pay for the health care services provided, including, but not limited to, potential financial resources from a third party which may have caused the patient's injuries, or from insurance coverages such as Uninsured Motorist, Personal Injury Protection, Workers Compensation, or from claims funds such as, but not limited to, Crime Victims Compensation Act funds, or from Estate or Probate proceedings.
6. Availability of health insurance.
7. The amount of hospital/medical bill.
8. The Federal Poverty Guidelines and definitions of "Family", "Income" and "Exclusion from Income" as outlined in such Guidelines.
9. Whether free and/or discounted care is available through other government programs.

HOW TO APPLY FOR FINANCIAL ASSISTANCE:

1. Patients may apply or reapply for financial assistance, before, during or after care by contacting a financial counselor at (806) 250-2754. Applications submitted after care has been provided, must be submitted within sixty (60) days of receiving the initial statement for services.

2. Patients with Medicare and/or commercial insurance may apply for financial assistance to assist with co-pays and deductible amounts. Eligibility will be determined under the provisions of this policy. Payment plans may also be requested and may be granted

according to this policy on a case-by-case basis.

3. Completing, signing and submitting an application for Financial Assistance as well as the required documentation set out in this policy is required in order to determine if an individual qualifies for Financial Assistance.

WHERE AND HOW TO OBTAIN AN APPLICATION:

An application for Financial Assistance may be obtained by one of the following means:

- From the Hospital's Admission/Registration Department
- Download an application from our website at www.parmermedicalcenter.com.
- Request an application by calling (806) 250-2754
- Request an application by mail at the following address:

Parmer Medical Center
Attn: Financial Assistance Program
1307 Cleveland Ave.
Friona, TX 79035

INFORMATION AND/OR DOCUMENTS REQUIRED TO BE SUBMITTED WITH THE COMPLETED APPLICATION:

The following information and/or documentation is needed in order to determine eligibility for Financial Assistance, for all household members:

1. One of the following valid documents, for all adult family members, as proof of identity:
    a. State-issued driver license
    b. State-issued identification card
    c. Student ID with picture
    d. Passport with picture
    e. U.S. immigration documents with picture

2. If a picture Identification is not available, one of the following documents may be used:
    a. Birth certificate
    b. Marriage license
    c. U.S. naturalization, citizenship, or other federal document showing identity
    d. Adoption records

3. One of the following documents as proof of income and residency:
    a. Last year's Federal income tax return
    b. Last two paycheck stubs
    c. Unemployment benefit confirmation slip from most recent unemployment check
    d. Social Security check and/or current social security award letter showing the amount being received
    e. A current utility bill, rental agreement, or voter registration card.

HOW TO GET HELP COMPLETING OR SUBMITTING THE APPLICATION:

The Hospital will provide help in obtaining, completing or submitting the Application and anyone may obtain such help by contacting the phone number listed below, or by visiting the Hospital's business office.

For questions regarding the application for Financial Assistance, please contact the Hospital's business office directly at (806) 250-2754.

THE TIME PERIOD WITHIN WHICH TO APPLY FOR FINANCIAL ASSISTANCE:

It is preferred, but not required that a request for financial assistance and a determination of need occur prior to rendering of non-emergent medically necessary services. However, the determination may be made at any time prior to an account being referred to a collection agency. The need for financial assistance may be reevaluated at each subsequent time of service if the last financial evaluation was completed more than six (6) months prior, or at any time additional information relevant to the eligibility of the patient or responsible party becomes known.

WHERE TO RETURN COMPLETED APPLICATION AND REQUIRED DOCUMENTATION:

The completed application and required documentation for Financial Assistance may be delivered to:

- The Hospital's Admission/Registration department; or
- May be mailed to:

  Parmer Medical Center
  Attn: Financial Assistance Program
  1307 Cleveland Ave.
  Friona, TX 79035

NOTIFICATION THAT AN INDIVIDUAL HAS BEEN APPROVED FOR FINANCIAL ASSISTANCE:

The Hospital will notify the individual in writing of the determination of eligibility under this FAP and the basis for the determination. If eligibility cannot be determined due to missing information or documentation, the individual will also be notified in writing.

INCOME GUIDELINES USED IN DETERMINING ELIGIBILITY FOR FINANCIAL ASSISTANCE:

Services eligible under this policy will be discounted to the patient on a sliding scale, in accordance with their financial need, as determined in reference to Federal Poverty Guidelines in

effect at the time of the determination. This discount will be applied to individuals eligible for financial assistance who have completed a financial assistance application and provided all necessary documentation required for qualification. The basis for the amounts charged to patients are as follows:

1. If an uninsured patient's Annual Gross Family Income is equal to or less than one hundred percent (100%) of the current Federal Poverty Guidelines[1], as set forth on the Gross Monthly Income Financial Assistance Eligibility Table, the patient (or other responsible party) will be eligible for assistance with one hundred percent (100%) of medically necessary services as outlined in 3.a-c of this FAP and will not owe any portion of the account balance.

2. Uninsured patients whose annual Gross Family Income exceeds one hundred percent (100%) of the current Federal Poverty Guidelines but does not exceed two hundred percent (200%) of the current Federal Poverty Guidelines, will be eligible for a discount, assuming they meet the other eligibility criteria set out in this FAP.

3. For those uninsured patients/individuals eligible for a discount, they will be responsible for paying no more than the hospital's current Amount Generally Billed (AGB) of the remaining outstanding account balances owed on their hospital bills. The percentage the patient would be responsible for is less than the AGB. The AGB for PMC is calculated using the average reimbursement as a percentage of total claims allowed for the past year by all private health insurers that pay claims to the Hospital.

4. All patients are expected to pay, or make arrangements for payment, for all hospital services prior to services being provided. Patients with health insurance coverage will be expected to pay deductible balances, estimated coinsurance amounts, and/or any copays due on the day they receive services. Deductible and copays are required in accordance with laws and regulations governing the programs and/or insurance plan. Patients without insurance will be expected to pay a discounted rate within their ability to pay as determined based on this policy.

5. Exceptions for pre-payment:
    a. Emergency or obstetric services, as defined by EMTALA
    b. An approved payment plan in effect, with payments being made accordingly
    c. Medically urgent or emergent services as determined by a physician

6. Financial assistance is not a replacement for financial responsibility. Patients are expected to fully cooperate with the financial assistance application process and procedures for obtaining charity and or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Patients who apply for Financial Assistance will be encouraged to seek coverage through the

[1] *The Gross Monthly Income Financial Assistance Eligibility Table is revised when changes are made* to *the Federal Poverty Guidelines.*

Health Insurance Exchange to ensure access to healthcare services.

7. If a patient refuses to apply for, or follow through with an application for Medicaid and that patient is likely to be eligible for such assistance, the patient's Financial Assistance Application will be denied.

8. If a patient has potential payment resources, such as, but not limited to, third party settlement proceeds, which could be used to pay for the health care services provided, the individual may not be eligible for Financial Assistance under the Hospital's FAP. The Hospital reserves the right to file hospital liens, assert assigned tort and contract claims, intervene in third party lawsuits, and recover such available funds to pay for the health care services that were provided.

COLLECTION PRACTICES

Parmer Medical Center's debt collection policies are available upon request. The Hospital reserves the right to take certain actions in the event of nonpayment or non-participation in the financial assistance application process, including, but not limited to, collections action and reporting to credit agencies. For patients who have submitted a financial assistance application, provided all requested documentation, and are cooperating in good faith to resolve their hospital bills, Parmer Medical Center will not engage in extraordinary collection efforts for a period of 120 days from the date the first statement for services is mailed to the patient. Parmer Medical Center will ensure extraordinary collections actions do not occur without documented reasonable efforts to provide notice and to determine whether the patient is eligible for charity care under this financial assistance policy.

COMMUNITY HEALTH NEEDS ASSESSMENTS:

Parmer Medical Center is a not-for-profit hospital operating to serve the health care needs of Parmer County. A Community Health Needs Assessment ("CHNA") as described in Internal Revenue Code Section 501 (r) (3), will be conducted by the hospital at least once every three (3) years; and the Hospital will then adopt strategies to meet the community health needs identified through each CHNA.

The CHNA is available to the public on Parmer Medical Center's website: www.parmermedicalcenter.com.

DEFINITIONS:

"Annual Gross Family Income" – Determined through computing federal poverty guidelines. It includes all earnings (gross), 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 received from family not living

in the household, and other miscellaneous sources. Non-cash benefits, such as food stamps and housing subsidies, are excluded.

"Amounts Generally Billed" (AGB) - FAP eligible individual will not be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care. The AGB is calculated by taking the average reimbursement as a percentage of total claims allowed for the past year by Medicare fee-for--service and all private health insurers that pay claims to the Hospital.

"Family" – For the purposes of this policy a group of two or more people who reside together. If the patient has claimed someone as a dependent on their income tax return, they may be considered a dependent for purposes of the determining eligibility for financial assistance.

"Emergency Medical Condition" – Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C 1395dd).

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

"Uninsured Patient" – The patient has no insurance, or third-party assistance or funds to meet their payment obligations.

"Underinsured (Medically Indigent)" - refers to individuals who this Hospital determines are unable to pay all or a portion of their remaining bill balance after payment, if any, by third party payors; after crediting all health insurance payments, if any, and such account balance exceeds twenty percent (20%) of the person's annual gross family income.