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| <b>TITLE: Madison Health Financial Assistance Program Policy (MH-FAP)</b>   |  |
| <b>POLICY NUMBER: ADM-FIN-B-003</b>   |  |
| <b>APPROVED BY:</b><br><br><b>Dana E. Engle, CEO</b> | <b>DATE: 02/2024</b>   |
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| <b>DEVELOPED/REVISED BY: Michele Veltre, Revenue Cycle Director</b>   |  |
| <b>REVIEWED BY: Finance</b>   | <b>DATE(S): 02/2024</b>  |
| <b>DISTRIBUTION: Administrative Policy Manual</b>   |  |

**PURPOSE:**

Madison Health will provide Financial Assistance to qualified applicants in need of emergency and other medically necessary healthcare services.

**POLICY:** Madison Health is a not-for-profit entity established to meet the health care needs of residents in Madison County and its surrounding communities. In fulfilling the hospital’s mission, we recognize that we will not receive full payment from certain individuals for care that has been rendered, and a certain degree of judgment will be required in determining Charity Care. Madison Health (MH) will provide emergency and other medically necessary hospital services at no cost or for a reduced fee to those individuals who demonstrate a need for the services and who qualify for financial assistance under the policy. Madison Health disallows actions that discourage individuals from seeking medical care, such as by demanding that emergency room patients pay before receiving treatment or by permitting debt collection activities that interfere with the provision of emergency medical care. The hospital will provide charity consideration to individuals on a sliding scale basis under the Madison Health Financial Assistance (MH-FAP) program up to 400% of the Federal Income Poverty Guidelines as set by the Ohio Department of Jobs and Family Services. MH will follow standard procedures in determining eligibility for financial assistance. The hospital shall comply with the rules and follow the guidelines of OAC rule 5101:3-2-0717 Hospital Care Assurance Program (HCAP) and will follow guidelines for Madison Health Financial Assistance Program.

**PROCEDURE:** The hospital has an obligation to provide emergency, trauma, and obstetrical care before determining the source of payment.

The hospital will inform Ohio residents, who are not recipients of the Medicaid program, whose gross income is at or below the federal poverty level, of their right to receive all emergency and other medically necessary hospital services at no cost (HCAP). The hospital will inform Madison County residents, who are not recipients of the Medicaid program, whose gross income falls within the MH-FAP sliding scale, of the right to receive all emergency and other medically necessary hospital services at a discounted cost. Upon registration, all patients will receive a packet of information addressing the FAP and a copy of the Plain Language Summary for Financial Assistance. Patients being discharge from Madison Health, after their inpatient stay, will receive a Patient Payment Opportunities brochure and the Plain Language Summary in their discharge packet.

Additionally, the hospital will make the FAP application process easy to understand, and available to all patients and the process will be applied on a consistent basis. **SEE ATTACHMENT (E)**

Notices will be posted in the registration areas, the emergency room, the cashier's office, and the customer service area specifying the rights of individuals with incomes at or below the federal poverty level to receive, at no cost or at a discount, emergency and other medically necessary hospital services. The income guidelines and a telephone number to call for an application will be printed on the back of the patient's monthly statement.

Madison Health will direct patients to apply for Medicaid if there is a chance they meet the qualifications, but will accept MH-FAP applications in the interim if the patient does not qualify for Medicaid approval. Applicants shall cooperate in supplying information about health insurance or medical benefits available so the hospital may determine any potential third-party resources that may be available. A patient with insurance cannot be considered for Financial Assistance until all insurance payments have been made.

The Federal Income Poverty Level Guidelines (FIPLG) through 400% of the FIPL shall be used as the threshold to determine income eligibility for the Madison Health Financial Assistance (MH-FAP) program. The scale shall be updated annually based on changes to the annually updated FIPLG. **SEE FINANCIAL COUNSELOR FOR MOST CURRENT FIPLG**

### **Eligibility Requirements – MH-FAP**

- Service Date:
  - Outpatient Services: Eligibility determination is effective for 90 days from the initial service date, during which time a new eligibility determination need not be completed. Effective date for outpatient eligibility is to be documented on the account, under system notes.
  - Inpatient Services: Eligibility determination will be performed separately for each admission, unless the patient is readmitted within 45 days of discharge for the same underlying condition.
  - Chemotherapy Services: Eligibility will be effective for the entire length of the chemotherapy treatment plan.
- Services provided were “all emergency and other medically necessary hospital level services” defined as all allowable hospital inpatient and outpatient services per Ohio Department of Jobs and Family Services. Cosmetic and other elective services, as well as services not performed by Madison Health are not covered.
- Patients must not be a recipient of Medicaid or any other state public assistance program.
- If the financial screening indicates a patient may be eligible for Medicaid, the patient must apply for Medicaid and cooperate with the application process or the charity adjustment may be reversed.
- Patient must meet the income guidelines. **SEE FINANCIAL COUNSELOR FOR MOST CURRENT CHARITY SLIDING SCALE.**
- Patients must cooperate and comply with the application process. **SEE APPLICATION REQUIREMENTS AND PROCESSING ON PAGE 5 OF THIS POLICY**
- Date of write-off must be within fiscal year of application.
- Patient is required to make arrangements for payment of the remaining balance.
- Patient qualifying for 100% discounting must be an Ohio resident. (HCAP)
- Patient qualifying for less than 100% discounting must be in Madison Health's primary service area. (See attachment A for primary service area)

**FAMILY** – Family shall be defined as the patient, the patient's spouse, and all of the patient's children, natural or adoptive, under the age of eighteen (18) who live in the home. If the patient is under the age of eighteen (18), the “family” shall include the patient, the patient's natural or adoptive parent(s), and the parent(s), natural or adoptive under the age of eighteen (18) who live in the home. If the patient is the child of a minor parent

who still resides in the home of the patient's grandparents the "family" shall include only the parent(s) and any of the parent(s) children, natural or adoptive who reside in the home.

## **Staff Responsibilities**

### ***Patient Financial Services Director***

1. Provides the MH-FAP sliding scale to Financial Counselor:
2. Approves MH-FAP write-offs.
3. Responsible for updating of printed statements with poverty level guideline information.
4. Monitor the financial counselor's work queue containing accounts with self-pay financial class.
5. Approves applications for Financial Assistance.

### ***Admitting Manager***

1. Reviews Information Sheets and signage to ensure compliance with current charity guidelines. Requests printing of updated forms and signs.
2. Provides Financial Assistance forms to registration areas and Financial Counselors.
3. Ensures that all signs are correct and displayed in appropriate areas.

### ***Registration Clerk/Cashier (Financial Counselor, if applicable)***

1. Provides patients/responsible parties with Patient Payment Alternative Pamphlet and application. Collects application forms and gives applications to Financial Counselor on a daily basis. Refers the patient to the Financial Counselor for assistance.
2. Informs the financial counselor of any self-pay inpatient within the first hour after admission.
3. Reviews charity vouchers (**ATTACHMENT B**) provided by the patient for a new registration and selects the appropriate financial class based on the coverage identified on the voucher.
  - a. In the event the patient says they are approved for charity, but they do not have a voucher, assigns a financial class based on the patient's primary insurance or self-pay (SP) if the patient is uninsured. Emails the account number to the financial counselors informing them the patient claimed they were covered by charity.
  - b. Inpatient admissions require a new application. These should be given a financial class associated with the primary insurance or self-pay (SP) if the patient is uninsured. The registrar will contact the financial counselor in these cases.

### ***Financial Counselor***

1. Responsible for maintaining the MH-FAP programs.
2. Responsible for screening the patient for Medicaid eligibility prior to initiating any adjustment to the patient's account.
3. The Financial Counselor will ensure that application opportunities are made available, will monitor and ensure program compliance, quality controls, and will provide guidance to patients and other hospital service personnel who are assisting the patient.
4. Provide assistance to patient/responsible party, if needed, to complete the charity application.
5. Reviews each application and ensures that all required information is attached and complete.
6. The Financial Counselor will submit the patient's completed application along with supporting documentation for MH-FAP adjustment consideration to the Director of Patient Financial Services within 20 days of receipt. The Director of Patient Financial Services must review and initial the application before an approval is communicated to the patient.
7. The Financial Counselor will mail letters of approval or denial to all MH-FAP applicants. **SEE ATTACHMENTS B AND C.**
8. The Financial Counselor will instruct the patient to present the charity voucher (**ATTACHMENT B**) to registration for any future services at the hospital within the covered time period.

9. The Financial Counselor will review queries containing newly registered accounts that are approved for MH-FAP consideration.
  - a. For MH-FAP approved accounts, the Financial Counselor will verify the coverage for the patient. If verified, they will put through an adjustment for the approved percent of charges. If a balance remains, they will ensure the account is listed as patient responsibility.

### **Application Requirements and Processing**

- Completion of the Application for Financial Assistance
  - The application must be fully completed with all requested information.
  - The application must be signed and dated by the patient, patient's spouse, guarantor or Power of Attorney.
  
- Approval or Denial
  - The approval or denial of the application will be made by the Director of Patient Financial Services in the Finance Department.
  
- Incomplete Applications
  - Incomplete applications will not be considered.
  - One letter will be sent to the patient requesting completion of the application or clarification of inconsistent information.
  - These applications will be held for 45 days. If the requested information is not received within this time frame a new application must be submitted.
  
- Discount Determination
  - Madison Health will apply a 64% discount of all charges for patients that qualify for Financial Assistance
  - The discount will be applied prior to the additional discounting based on the Federal Poverty Level Guideline. (**SEE MADISON HEALTH SLIDING SCALE**).
  
- **Expiration of Eligibility**
  - Inpatient Hospital Services - Eligibility for MH-FAP is approved for 45 days from the discharge date or readmission date within 45 days, if the admission is for same underlying condition.
  - Outpatient Hospital Services - Eligibility for MH-FAP is approved for 90 days from the initial date of service.
  
- **Approval notification to patients. SEE ATTACHMENT B**
  - If MH-FAP is approved, notification will be sent to the patient. The notification will include an expiration date if appropriate and will be notated on the patient's account in the patient accounting system.

- **Denial notification to patients. SEE ATTACHMENT C**
  - If MH-FAP is denied, notification will be sent to the patient and will be notated on the patient's account in the patient accounting system.
  - **Employee Charity** - Effective 4/1/2018, all hospital employees and eligible dependents are eligible for charity discount regardless of their home address.
- **Billing and Collection Policy.** Madison Health has a separate Billing and Collections policy available upon request by calling the Patient Financial Counselor at 740-845-7033 or 740-845-7031 and can be viewed on the Madison Health website [www.madison-health.com](http://www.madison-health.com) Section- Patient and Visitor / Section - Billing and Insurance.
- **Third Party Involvement.** Madison Health does not use third parties to obtain financial information for patient application detail.

### **Establishing Patient Income**

- Income is defined as the total salaries, wages and tips, cash receipts, income from Social Security, disability payments, retirement benefits, child support (Child support is considered only if the child who is receiving the child support is the patient), alimony, interest earnings, dividends, and monies from any other source.
- A signed application will be considered a declaration of income and can be accepted as proof of income for MH-FAP. Further documentation, including but not limited to, a more detailed application and tax schedules itemizing deductions and business expenses MAY be required for MH financial assistance but is not required for approval.
- Compare the last three month's income times four or the last twelve month's income prior to the date of service. Use whichever calculation is the most beneficial to the patient to determine eligibility for financial assistance. **SEE ATTACHMENT D AND MOST CURRENT SLIDING SCALE**

### **Eligibility Requirements**

- Financial assistance is generally determined by a sliding scale of total household income based on the Federal Poverty Level (FPL). If the patient and/or the responsible party's income combined are at or below 100% of the federal poverty guideline, and meet all other criteria, the patient will have no financial responsibility for the care given by Madison Health. (HCAP). The patient must be a resident of the State of Ohio to qualify for a discount of 100%. If the patient falls between 101% and 400%, they may qualify for discounted rates for the care given by Madison Health if the patient is a resident of Madison County or Madison Health's Primary Service Area **See Attachment A** No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If the patient has sufficient insurance coverage or assets available to pay for their care, they may not be eligible for financial assistance. Please refer to the Financial Counselor for a complete explanation and details.

### **.Documentation for Establishing Income**

- The most common documents for establishing income are the patient’s pay stubs. Tax returns and schedules, bank statements, and credit history may also be used. This information will be maintained with the completed assessment. Any of this information may be requested to verify income.
- Madison Health also recognizes that not all patients are able to provide complete financial and/or social information. Therefore, approval for financial support may be determined based on available information. Income documentation that is not representative of the previous 12 months will not be used for income verification and will not be attached to the application.

### **Timeline for Establishing Financial Eligibility**

- Every effort will be made to determine a patient’s eligibility prior to or at the time of admission or service. However, determination for financial support can be made during any stage of the patient’s stay after stabilization or during the six months following final payment from the health insurance company or following the date of discharge if there is no insurance.
- Determination for financial support will be made after all appropriate efforts to qualify the patient for governmental financial assistance or any other programs have been exhausted.
- Madison Health will make financial support determination in a timely fashion. If other avenues of financial support are being pursued, Madison Health will communicate with the patient regarding the process and expected timeline for determination.

### **Definitions**

- Charity Care:
  - Charity care represents services provided free or at a discount to individuals who meet the established criteria.
- Emergency and Medically Necessary Care :
  - Services or items reasonable and necessary for the diagnosis or treatment of illness or injury.
- 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.
- FAP
  - Financial Assistance Program
- HCAP :
  - Hospital Care Assistance Program
- 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.
- Uninsured:
  - The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

### **Providers Not Covered by the Financial Assistance Program Policy**

Financial assistance only covers services billed by Madison Health. Services not covered include, but are not limited to:

- Associated Anesthesiologists
- Madison Health Specialty Care (includes Madison Health Urgent Care)
- Madison Health Primary Care
- Ohio Emergency Professional Inc.
- Pain Management Group Professional Fees
- Radiology Incorporated



**Madison Health Primary Service Area\*\*\***

| <u>Zip Code</u> | <u>Municipality</u> | <u>County</u> |
|-----------------|---------------------|---------------|
| 43140           | London              | Madison       |
| 43162           | West Jefferson      | Madison       |
| 45368           | South Charleston    | Clark         |
| 43143           | Mount Sterling      | Madison       |
| 45369           | South Vienna        | Clark         |
| 43044           | Mechanicsburg       | Champaign     |
| 43153           | South Solon         | Madison       |

\*\*\* Madison Health has an expanded Service Area - All Ohio zip codes for patients receiving treatment in our Oncology Clinic or having testing ordered by one of our Oncology Providers.





**ATTACHMENT B**

Date:

Patient Name:

Patient Address:

Initial account number:

Dear

I am pleased to inform you that your financial aid application for services rendered at Madison Health has been approved for 100 % HCAP.

Your covered dates will be from \_\_\_\_\_ through \_\_\_\_\_.

Please retain a copy of this letter for your records and bring it with you when you have scheduled testing and/or outpatient services at Madison Health. This letter will be proof of eligibility when you are registered.

Sincerely,

Financial Assistance Counselor  
(740) 845- 703



**ATTACHMENT C**

March X, 20XX

Patient Name  
Address  
London, Ohio 43140

Re: Guar # xxxxx

Dear Mr. and Mrs.

We are sorry to inform you that your application for assistance with your account balance(s) at Madison Health has been denied. According to the federal guidelines that we are required to follow, the income information you provided for the time of service exceeds the amount allowed to qualify for the program for those dates.

If you have not already done so, please contact the Customer Service Department at 740-845-7030 to establish a payment arrangement for the balance due.

We here at Madison Health wish you the best in the future. Should you have any questions concerning this matter, please contact our office at 740-845-7037. Thank you.

Sincerely,

Financial Assistance Counselor  
740-845-7030



**Madison Health Financial Assistance**

**ATTACHMENT D**

**Income Calculation Work Sheet**

Income Applicant

Income Spouse/Family

3 months prior income \_\_\_\_\_

12 month prior income \_\_\_\_\_

Check One - HCAP 100 % \_\_\_ MHFA 100% \_\_\_ 80% \_\_\_ 70% \_\_\_ Denied \_\_\_

| Account Number | DOS | Balance | Write-Off Adjustment | Write-off Date | Patient Balance |
|----------------|-----|---------|----------------------|----------------|-----------------|
|                |     | \$      |                      |                | \$              |
|                |     | \$      |                      |                | \$              |
|                |     | \$      |                      |                | \$              |
|                |     | \$      |                      |                | \$              |
|                |     | \$      |                      |                | \$              |

\_\_\_\_\_ \_\_\_\_\_

Financial Counselor Date Director of Patient Financial Services



**Application for the Financial Assistance Program**

**ATTACHMENT E**

PATIENT NAME: \_\_\_\_\_ DATE OF APPLICATION: \_\_\_\_\_

APPLICATION NAME, IF NOT PATIENT: \_\_\_\_\_  
*(If the applicant is not the patient, please answer the following questions as they apply to the patient.)*

STREET: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ CONTACT PHONE: \_\_\_\_\_

DATE(S) OF HOSPITAL SERVICE: From \_\_\_\_\_ To \_\_\_\_\_

- ✓ Were you an Ohio resident at the time of your hospital service? Yes \_\_\_ No \_\_\_ **Account numbers:** \_\_\_\_\_
- ✓ Do you live in Madison County? Yes \_\_\_ No \_\_\_ \_\_\_\_\_
- ✓ Were you an active Medicaid recipient at the time of your hospital service? Yes \_\_\_ No \_\_\_ \_\_\_\_\_  
If yes, Medicaid recipient ID number: \_\_\_\_\_
- ✓ Were you an active recipient of Disability Assistance at the time of your hospital service? Yes \_\_\_ No \_\_\_ \_\_\_\_\_  
(If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.) \_\_\_\_\_
- ✓ Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes \_\_\_ No \_\_\_ \_\_\_\_\_

| <u>Number in Family</u> | <u>Income</u> | <u>Number in Family</u> | <u>Income</u> | <u>Number in Family</u> | <u>Income</u> |
|-------------------------|---------------|-------------------------|---------------|-------------------------|---------------|
| 1                       | \$15,060      | 4                       | \$31,200      | 7                       | \$47,340      |
| 2                       | \$20,440      | 5                       | \$36,580      | 8                       | \$52,720      |
| 3                       | \$25,820      | 6                       | \$41,960      |                         |               |

Please provide the following information for all of the people in your immediate family who live in your home. For purposes of MH-FAP, "family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home.

| Name                    | Age | Relationship to Patient | Income for 3 months prior to hospital service * | Income for 12 months prior to hospital service * | Type of income verification attached **_*** |
|-------------------------|-----|-------------------------|---|--|---|
| (Patient)               |     | Self                    |   |  |   |
|                         |     |                         |   |  |   |
|                         |     |                         |   |  |   |
|                         |     |                         |   |  |   |
| Total persons in family |     | Total family income     |   |  |   |

\*Income verification may accompany this application if available; if you reported \$0 income provide a brief explanation below:

\*\*Income verification may include income tax returns, pay stubs, W-2's or other documents containing income information for the appropriate time period (3 or 12 months prior to hospital service).

\*\*\* If self-employed include your 1040 and Schedule C forms with application.

**By my signature below, I certify that everything I have stated on this application and on any attachments is true and is subject to verification**

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

PFS Director or Patient Access Manager \_\_\_\_\_

Date \_\_\_\_\_



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**Plain Language Summary  
Financial Assistance Policy**

**Overview**

Madison Health is committed to offering financial assistance to people who have health care needs and are not able to pay for care. You may be able to get financial assistance if you are not insured, underinsured, not eligible for a government program, or do not qualify for governmental assistance (for example Medicare or Medicaid). Madison Health strives to make sure that the financial capacity of people who need health care

services does not prevent them from seeking or receiving care. This is a summary of the Madison Health Financial Assistance Policy (FAP).

### **Availability of Financial Assistance**

You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full the expected out of pocket expenses for services at Madison Health. Please note that there are certain service exclusions that are not typically eligible for financial assistance, including, but not limited to transplants and cosmetic services.

### **Eligibility Requirements**

Financial assistance is generally determined by a sliding scale of total household income based on the Federal Poverty Level (FPL). If you and/or the responsible party's income combined is at or below 200% of the federal poverty guidelines and you are a resident of the State of Ohio, you will have no financial responsibility for the care given by Madison Health. If you fall between 200% and 400% of the federal poverty guidelines and are a within Madison Health's primary service area, you may get discounted rates for the care given by Madison Health. No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If you have sufficient insurance coverage or assets available to pay for your care, you may not be eligible for financial assistance. Please refer to the full policy for a complete explanation and details.

### **Where to Find Information**

There are many ways to find information about the FAP application process, or get copies of the FAP or FAP application form. To apply for financial assistance you may: Download the information online at [www.madison-health.com](http://www.madison-health.com) Section- Patient and Visitor / Section - Billing and Insurance. Request the information in writing by mail or visiting the Patient Financial Counselor at Madison Health 210 North Main Street London, Ohio 43140. Request the information by calling 740-845-7033 or 740-845-7031.

### **How to Apply**

The application process involves filling out the financial assistance form and submitting the form along with the supporting documents to Madison Health for processing. You may also apply in person by visiting the Patient Financial Counselor at the address listed below. Financial assistance applications are to be submitted to the following office:

**Madison Health  
Patient Financial Counselor  
210 North Main Street  
London, Ohio 43140**