PATIENT FINANCIAL ASSISTANCE INSTRUCTION LETTER

Dear Patient:

You may qualify for Partial or Full Financial Assistance, a program provided by York General Health Care Services. If you are unable to pay for health care services and do not qualify for Federal or State Medical assistance programs, please complete the enclosed Financial Assistance application and return with **all** the required proof of income.

Please be advised that a determination for discount cannot be made until we are in receipt of all the following required information (check the items you have enclosed). **Please return the application by _______________________________, or contact our office by that date if you are still in the process of gathering the needed documentation.** The necessary documents we require are:

- ☐ **Federal Tax Return including W-2 forms for tax year ______________.**
  If you did not keep a copy, you can contact the IRS at 1-800-829-0922 or www.irs.gov to request a free transcript of the Federal Tax Return. If you did not file taxes, you must explain in writing why you did not file.
- ☐ **Proof of income for the 3 most recent months for guarantor and spouse**
  Proof of income can be copies of pay stubs, a copy of an unemployment check, a copy of a disability check, a copy of the Social Security Award Letter and/or copy of a pension letter.
- ☐ **Copies of bank statements for the 3 most recent months for all accounts (checking, savings, etc)**
- ☐ **Letter of Denial from the Department of Health & Human Services**
- ☐ **Verification of liabilities with large balances (Ex: school loans)**
- ☐ **A letter of explanation for any documentation you are unable to obtain.**
- ☐ **Each box must be filled in on the enclosed application.**
  For any item that does not apply, please write "N/A"

If you are unable to include one or more of the items above, provide an explanation. This application should be received in our office with all required documentation attached within 2 weeks.

If you have any questions, please call one of the numbers listed below.

Sincerely,

Patient Accounts
Pam: 402-362-0429
Sara: 402-362-0435

Please return application to:

YORK GENERAL

APPROVED BY: Name	Date
Board of Directors	4/2016
CEO	4/2016
CFO	4/2016
DISTRIBUTION	Intranet

POLICY NO.	1000.0470		
SUBJECT	Financial Assistance		
PAGE	1	OF	7
ORIG. DATE	1/94	EFFECT DATE	5/2016
DATE TO BE REVIEWED			5/2017
SUPERSEDES POLICY DATED			4/15

KEYWORDS

SUBJECT: FINANCIAL ASSISTANCE POLICY

PURPOSE

The purpose of this policy is to further the charitable mission of York General Health Care Services (YGHCS) by providing financially disadvantaged and other qualified patients with an avenue to apply for and receive free or discounted care consistent with requirements of the Internal Revenue Code and implementing regulations.

I. ELIGIBILITY CRITERIA

The following classes of individuals and categories of care are eligible for financial assistance under this policy:

A. Financially Indigent

To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or less than 200% of Federal Poverty Level; provided, however, that patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of 20% percent of total outstanding medical bills do not qualify as Financially Indigent. The following definitions apply to such eligibility criteria:

"Uninsured": A patient who (i) has no health insurance or coverage under governmental health care programs, and (ii) is not eligible for any other third party payment such as worker's compensation or claims against others involving accidents.

"Underinsured": A patient who (i) has limited health insurance coverage that does not provide coverage for YGHCS services or other medically necessary services provided by YGHCS, or (ii) has exceeded the maximum liability under his/her insurance coverage, or (iii) has a copay or deductible assessed under the patient's insurance contract that is in excess of 30% of the patient's Net Worth.

"Household Income": The total income of all members living in the patient's household and/or all parents' income of a minor child.

. "Net Worth": Net asset value (assets – liabilities (excluding YGHCS liabilities)) of all members living in the patient's household. The asset value of a primary residence and personal retirement plans will be excluded from the calculation. Primary residence mortgage liabilities will be excluded from total liability calculation.

B. Medically Indigent

To qualify as Medically Indigent, the patient must have medical bills from YGHCS in excess of 30% percent of the greater of the patient's Household Income or Net Worth. Under the medically indigent category, an eligible patient's responsibility will never exceed 30% of their annual income.

C. Failure to Apply for Medicaid

Patients who may be eligible for Medicaid and fail to apply for Medicaid within thirty (30) days of YGHCS's request are not considered eligible for financial assistance under this policy.

D. Categories of Care Eligible for Financial Assistance

Provided that the patient qualifies as either Financially Indigent or Medically Indigent, the following classes of care are eligible for financial assistance under this policy:

- Emergency medical care
- Medically necessary care

Medical necessary: According to 42 C.F.R. §411.15(k) [Medicare] and C.F.R. §199.4(g)(1) [CHAMPUS], "medical necessity" generally means that the service is "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed bodily member", that the service in question is safe and effective and not experimental, that the service is generally accepted in the medical community as safe and effective for the condition for which it is used, and that the service was ordered by a licensed physician, osteopathic physician, dentist, podiatrist, optometrist, chiropractor, physician assistant, certified registered nurse anesthetist, advanced practice registered nurse, or certified nurse midwife. YGHCS Policy **1000.0330.**

Regardless of a patient's status as Financially Indigent or Medically Indigent, cosmetic procedures are not eligible for financial assistance under this policy.

II. COVERED PROVIDERS

Care provided by YGHCS employees and contracted staff is covered by this policy.

Patients may obtain a current list of providers who are and are not subject to this policy at no charge by visiting YGHCS Patient Accounts Department, calling (402) 362-0429 or visiting www.yorkgeneral.org.

III. LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED

Patients who are deemed to be eligible for financial assistance under this policy will not be charged for care covered by this policy more than Amounts Generally Billed by YGHCS to individuals who have health insurance covering such care. Discounts granted to eligible patients under this policy will be taken from gross charges.

A. Calculation of Amounts Generally Billed

The "Amount Generally Billed" or "AGB" is the amount YGHCS generally bills to insured patients. YGHCS determines its AGB utilizing the method detailed below.

YGHCS utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is YGHCS's gross charges multiplied by the AGB Percentage. Patients may obtain YGHCS's most current AGB Percentage and a description of the calculation in writing free of charge by visiting YGHCS's Patient Accounts office at 2222 North Lincoln Avenue, York, Nebraska, the emergency room, front desk, or the admissions desk, by calling 402-362-0429, or by visiting www.yorkgeneral.org.

YGHCS calculates its AGB Percentage on an annual basis. For purposes of this policy, each new AGB Percentage will be implemented within 120 days of the 12 month period used by YGHCS to calculate the AGB Percentage.

B. Amount of Financial Assistance/Discount

Patients who qualify for financial assistance as **Financially Indigent** are eligible for financial assistance based upon the following sliding fee scale:

FPL	**100%**	**125%**	**150%**	**175%**	**200%**
Discount	**100%**	**75%**	**50%**	**35%**	**25%**

Patients who qualify for financial assistance as **Medically Indigent** will be responsible for their medical bills up to 30% of their Household Income. Any remaining amount will be considered financial assistance under this policy.

If financial assistance provided to the patient results in a charge of greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, YGHCS considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

IV. APPLICATION PROCESS & DETERMINATION

Patients who believe they may qualify for financial assistance under this policy are required to submit an application on YGHCS's financial assistance application form during the Application Period. Completed applications must be returned to YGHCS Patient Accounts 2222 North Lincoln Avenue, York, Nebraska 68467.

For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 240th day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date

YGHCS provides the patient the requisite final notice to commence extraordinary collection actions ("ECAs").

Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial assistance application free of charge (i) by mail by calling (402) 362-0429, (ii) by download from www.yorkgeneral.org, or (iii) in person at (a) the emergency room, (b) any admission areas, or (c) YGHCS Patient Accounts.

A. Completed Applications

Upon receipt, YGHCS will suspend any ECAs taken against the patient and process, review and make a determination on completed financial assistance applications submitted during the Application Period as set forth below. YGHCS may, in its own discretion, accept complete financial assistance applications submitted after the Application Period.

Determination of eligibility for financial assistance shall be made by the following individual(s):

Potential Write-off Amount	Approval Authority
$0.00 - $50.00	CEO, CFO, ACFO
$50.01 and above	YGHCS Finance Committee

Unless otherwise delayed as set forth herein, such determination shall be made within 45 days of submission of a timely completed application. Patients will be notified of YGHCS's determination by the United States Postal Service.

To be considered "complete" a financial assistance application must provide all information requested on the form and in the instructions to the form.

YGHCS will not consider an application incomplete or deny financial assistance based upon the failure to provide any information that was not requested in the application or accompanying instructions. YGHCS may take into account in its determination (and in determining whether the patient's application is complete) information provided by the patient other than in the application.

For questions and/or assistance with filling out a financial assistance application, the patient may contact patient financial services at (402) 362-0429 or by visiting 2222 North Lincoln Avenue, York, Nebraska 68467 between the hours of 8:00 a.m. – 5:00 p.m. Monday – Friday.

If a patient submits a completed financial assistance application during the Application Period and YGHCS determines that the patient may be eligible for participation in Medicaid, YGHCS will notify the patient in writing of such potential eligibility and request that the patient take steps necessary to enroll in such program. In such circumstances YGHCS will delay the processing of the patient's financial assistance application until the patient's application for Medicaid is completed, submitted to the requisite governmental authority, and a determination has been made. If the patient fails to submit an application within thirty (30) days of YGHCS's request, YGHCS will process the completed financial assistance application and financial assistance will be denied due to the failure to meet the eligibility criteria set forth herein.]

B. Incomplete Applications

Incomplete applications will not be processed by YGHCS. If a patient submits an incomplete application, YGHCS will suspend ECAs and provide the patient with written notice setting forth the additional information or documentation required to complete the application. The written notice will include the contact information (telephone number, and physical location of the office) of patient financial assistance. The notice will provide the patient with at least 14 days to provide the required information; provided, however, that if the patient submits a completed application prior to the end of the Application Period, YGHCS will accept and process the application as complete.

C. Presumptive Eligibility

YGHCS reserves the right to provide financial assistance even though an application has not been submitted for the applicable care. YGHCS will utilize previous FAP applications to determine the assistance provided to the patient. If the patient is provided less than the maximum possible level of financial assistance, YGHCS will:

- Notify the patient regarding the basis for the presumptive financial assistance;
- Notify the patient as to how to apply for potentially more financial assistance;
- Give the patient a reasonable amount of time to apply for more generous assistance before initiating ECAs; and
- If the individual submits a completed application seeking additional financial assistance during the later of the Application Period or the response time set forth in the notice, process the application in accordance with this policy.

V. COLLECTION ACTIONS

Patients will be provided a plain language summary of the financial assistance policy upon admission to YGHCS. Furthermore, all billing statements will include a conspicuous written notice regarding the availability of assistance, including the contact information identifying where the patient may obtain further information and financial assistance-related documents and the website where such documents may be found.

YGHCS or its authorized representatives may refer a patient's bill to a third party collection agency or take any or all of the following extraordinary collection actions ("ECAs") in the event of non-payment of outstanding bills:

- Legal suit
- Garnishment of wages

YGHCS may refer a patient's bill to a collection agency 90 days from the date the first bill for care was provided to the patient. YGHCS will not take ECAs against a patient or any other individual who has accepted or is required to accept financial responsibility for a patient unless and until YGHCS has made "reasonable efforts" to determine whether the patient is eligible for financial assistance under this policy.

The Director of Patient Accounts is responsible to determine whether YGHCS has engaged in reasonable efforts to determine whether a patient is eligible for financial assistance.

A. No Application Submitted

If a patient has not submitted a financial assistance application, YGHCS has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date YGHCS provides the patient with the first post-discharge bill for care; and

2. Provides at least thirty (30) days' notice to the patient that:

    - Notifies the patient of the availability of financial assistance;

    - Identifies the specific ECA(s) YGHCS intends to initiate against the patient, and

    - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;

3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and

4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

5. If the patient has been granted financial assistance based on a presumptive eligibility determination, YGHCS has provided the patient with the notice required in the financial assistance policy.

B. Incomplete Applications

If a patient submits an incomplete financial assistance application during the Application Period, "reasonable efforts" will have been satisfied if YGHCS:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information (telephone number, and physical location of the office) of YGHCS department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 14 days to provide the required information; and

2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, YGHCS must suspend ECAs and make a determination on the application.

C. Completed Applications

If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if YGHCS does the following:

1. Suspends all ECAs taken against the individual, if any;

2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and

3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If YGHCS has requested that the patient apply for Medicaid, YGHCS will suspend any ECAs it has taken against the patient until the patient's Medicaid application has been processed or the patient's financial assistance application is denied due to the failure to timely apply for Medicaid coverage.

If a patient is eligible for financial assistance other than free care, YGHCS will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the ABG for the care provided;

2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to YGHCS (unless such amount is less than $5); and

3. Take reasonable measures to reverse any ECAs taken against the patient.

VI. EMERGENCY MEDICAL CARE

Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under the financial assistance policy. YGHCS will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with YGHCS policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

YORK GENERAL

FINANCIAL ASSISTANCE APPLICATION

GUARANTOR			SPOUSE		
Name		Date of Birth	Name		Date of Birth
Social Security Number	Home Phone	Business Phone	Social Security Number	Home Phone	Business Phone
Street: ______ City/State/Zip: ______ Household size: ______			Street: ______ City/State/Zip: ______ Household size: ______		
Name and address of employer: ______ ______ Position/Title:______ Length of employment: ______			Name and address of employer: ______ ______ Position/Title:______ Length of employment: ______		

MONTHLY INCOME				ASSETS		
	Guarantor	**Co-Applicant**	**Total**	Under "Details" column, please list institution name for all banking information. For autos, please list year, make, model, and mileage		
Gross Earnings					Details	Value
Farm/Self Employed				Cash on Hand		
Disability/SSI				Checking Balance		
Child Support/Alimony				Savings		
Food Stamps/Gov Assistance				Real Estate		
Military/Pensions				Vehicles		
Dividends				Vehicles		
Other				Other (CD, etc)		
Other				Other		

LIABILITIES		
	Balance	**Institution**
York General Hospital		**York General**
Real Estate Mortgage		
Rent		
Vehicle Lien		
Vehicle Lien		
Credit Card		
Credit Card		
Credit Card		
Other Loan		
Other Debts		
Other Debts		
Other Debts		
Total Liabilities		
Net Worth		

PATIENT ACKNOWLEDGMENT

I hereby submit this application for financial assistance to York General Health Care Services (YGHCS). I acknowledge the above information given to be true and correct and authorize YGHCS to verify any information given on this form. It is understood and agreed that any misrepresentation by me in this application will be sufficient cause for automatic denial of financial assistance.

Date ______________________ Signature ______________________