



# The Rehabilitation Hospital of Montana

In Partnership with  
Billings Clinic & St. Vincent Healthcare

**POLICY:**                      **CHARITY POLICY**  
**Policy Number:**        **BO 165**  
**Effective Date:**        **4/30/19**  
**Revision Date:**        **12/3/24**

## *Business Office Policy & Procedures*

In accordance with the Partnership Agreement, “Agreement” between Billings Clinic, St. Vincent Healthcare and Lifepoint Health, the Hospital is required to maintain consistency with both partners Charity Care Policies. To that end, the Hospital has adopted this policy.

As a part of the Hospital obligation to provide charity care consistent with the charity care policy and as part of the Hospital stewardship duty to use its resources as effectively as possible, manage its business affairs prudently and well, and preserve its capacity to continue serving in future years while fulfilling current needs, the Hospital strives to identify the dollar volume of charity care it provides to patients who cannot pay for hospital care because they lack the necessary financial resources. Identification of Charity Care will assist the Hospital in providing care to a segment of the community served by the Hospital who cannot pay for that care and allow the Hospital to better concentrate its collection efforts on the accounts that are collectible.

### **I. GUIDELINES**

Charity Care includes care to individuals who lack the ability to pay as determined by the Hospital, utilizing the guidelines as outlined below. Uncollected accounts for other patients shall be subjected to full collection efforts, and if not collected, shall be considered for bad debt. All or part of the hospital bill may be considered charity care.

The determination of the ability to pay may take into account a number of variables including, but not limited to:

- Earning status and potential of the patient and family
- Other sources of income and assets
- Level and type of liabilities
- Ability to obtain additional credit
- Amount and frequency of hospital/medical bills
- Family size

Patients eligible for charity consideration include both Financially Indigent and Medically Indigent applicants who have inadequate resources to pay for services provided. The Hospital will use Amounts Generally Billed (AGB) to determine the cost of these services.

Financially Indigent patients include those patients who are uninsured or underinsured, whose annual income is equal to or less than 200% of the Federal Poverty Guidelines, as published and updated annually in the Federal Register, and who have no ability to pay for their medical care.

Medically Indigent patients include those patients earn between 200% and 400% of the Federal Poverty Guidelines, who are capable for paying for their living expenses, but who’s medical and hospital bills, after payment by third party payers, would require use or liquidation of income and/or assets critical to living or earning a living. The identification of charity care begins at time of registration with the gathering information concerning third party payers and the patients and guarantor’s (and/or family) financial data and identification of community resources available to assist in paying the account. Generally, information will be gathered and potential community resources identified during the pre-admission process, where available, and while the patient is in the Hospital because access to the patient and family is greatest during that period. However, identification can occur at any time sufficient



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information is available to make the determination, including well after the normal collection cycle.

The Rehabilitation Hospital of Montana does not ordinarily provide emergency medical care, as it is a rehabilitation hospital. If an individual presented at the facility needing emergency medical care, Hospital personnel would assist to the extent possible and seek to get the individual proper emergency medical care. This would be done regardless of whether the individual is FAP-eligible, and the hospital would not take any actions to discourage the individual from seeking emergency medical care.

Classification of an account as charity care generally will end efforts to collect the accounts from the patient and, in most instances, from family members. Routine activity may continue in order to ensure that the Hospital can identify changed circumstances in the future and ensure continuity with respect to subsequent visits. Efforts to collect from third parties will continue, and any resulting collection would be a charity recovery. Classification of an account as charity care should not occur until:

- It is determined (determination of ability to pay based on variables), the patient and guarantor (and/or family) definitely do not have the financial resources to pay the account (or portions of the account), and treatment as charity is warranted under the circumstances determined by the Hospital in a manner consistent with how the facility makes charity care determinations.

Even if an account is to be considered charity care under this policy, the patient and guarantor should receive at least one statement indicating the AGB. They should also receive the routine follow-up statements and collection letters until such time as the charity care designation is made and it is determined that continuing such mailings will not result in collecting part or all of the account.

- The patient or guarantor will be notified, by letter, as to the determination of approval or denial of the charity care application. (Exhibit 3). This letter will be sent to the patient or guarantor by a member of hospital management or designated collections representative.

## **II. APPLYING FOR FINANCIAL ASSISTANCE**

To apply for financial assistance, patients must complete a financial application (Exhibit 1). Applications are available:

- In person at The Rehabilitation Hospital of Montana
- By Electronic mail
- By Mail
- Patients will be asked to attest that all information is true. If any information is determined to be false, all discounts afforded to the patient may be revoked, making them responsible for full charges for the services rendered.

In addition to completing a financial application, individuals should provide the following supporting documentation, as directed by the financial application:

- Last year's federal tax return with W-2, W-2G, or 1099-R forms and support schedules.
- Proof of income (i.e., check stubs, Social Security Benefits,



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etc.).

- Bank statements for the past three (3) months.

Individuals who cannot provide the documentation listed above, have questions about or would like help with completing The Rehabilitation Hospital of Montana financial assistance application may contact the hospital either in person or over the phone at 406-413-6200.

The documentation will be reviewed by a Hospital representative for:

- Verification of all health or other insurance coverage has been exhausted, including and potential third-party liability settlements
- Eligibility for government programs. If eligible, a referral will be made to the appropriate agency to facilitate the patient's application for aid
- Resources of the family other than income, e.g., home, land, vehicle(s), personal possessions
- Future earnings potential
- Other financial obligations, e.g., child support, alimony
- Possible use of appropriate gift funds

Patients must notify the Hospital of any changes in financial situation that may further affect ability to pay agreed upon balances or monthly payments.

Financial assistance applications on file at the Hospital may be used for up to 1 year after the date of application.

Failure to provide information necessary to complete a financial assessment may result in a negative determination.

All patients who apply for financial assistance will be notified of the final determination via mail (Exhibit 3).

No person shall be excluded from consideration for financial assistance based on race, creed, color, religion, sex, national origin, or physical disability. The only exclusion would be if the patient does not meet rehabilitation appropriateness.

### **III. DETERMINING DISCOUNT AMOUNT**

Once eligibility for financial assistance has been established, the Hospital will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) for medically necessary care. Patients who have a household income at or below 400% of the Federal Poverty Guidelines may receive free or discounted care as illustrated in Exhibit 2.

### **IV. PRESUMPTIVE ELIGIBILITY**

Absent sufficient information to support financial assistance eligibility, the Hospital may opt to refer to or rely on external sources and/or other program enrollment resources to determine eligibility in the event



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that:

- Patient is homeless;
- Patient is eligible for state or local assistance programs;
- Patient is eligible for food stamps;
- Patient is eligible for state-funded prescription medication program;
- Patient is deceased and without an estate;
- Patient files bankruptcy; and or
- Patient received care from a community clinic primarily serving an uninsured population and is appropriately referred to RHOM for care.

The Hospital may use previous financial assistance eligibility determinations as a basis for determining eligibility in the event that the patient does not provide sufficient documentation to support and eligibility determination.

In connection with presumptive eligibility, the Hospital will inform patients determined to be eligible for less than 100% assistance of the basis for the determination and the way to apply for more generous assistance available under this policy. The Hospital will provide such patients 30 days to submit an application for further assistance.

### **V.        COMMUNICATON OF FINANCIAL ASSISTANCE PROGRAM**

The Hospital will communicate the availability and terms of the financial assistance program to all patient through means with include, but are not limited to:

- Notifications on patient bills/statements;
- Posted statements on the hospital's website;
- Applications available to patients at the RHOM;
- The RHOM new patient packet; and
- Hospital staff knowledgeable on the financial assistance policy to answer patient questions or who may refer patients to the program.

Requests for financial assistance can be made by a patient, their family members, friend, or associate, but will be subject to applicable privacy laws.

Patients concerned about their ability to pay for services or who would like to know more about financial assistance should be direct to [www.rehabhospitalofMontana.com](http://www.rehabhospitalofMontana.com) or to the Hospital.



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## **VI. CONTACT INFORMATION**

The Hospital has English speaking representatives as well as the use of a Language Line to assist patients with their questions regarding the Financial Assistance program. Individuals who have questions about or would like help completing the financial assistance application can call the hospital at 406-413-6200. Information concerning the financial assistance application can also be found at [www.rehabhospitalofmontana.com](http://www.rehabhospitalofmontana.com).

## **VII. REGULATORY REQUIREMENTS**

In implementing this policy, the Hospital shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

## **VIII. BOARD APPROVAL**

This policy may not be terminated, modified, or amended without approval of the Hospital Board of Managers. The Hospital Board of Managers may, from time to time, and to the extent not inconsistent with the terms and requirements of the Agreement, develop and adopt and require implementation of changes, modifications, and amendments to this policy that it deems appropriate.

## **IX. FINANCIAL ASSISTANCE DEFINITIONS:**

- A. Amounts Generally Billed: (AGB) Patients determined to be eligible for financial assistance are not charged more than AGB for medically necessary care. Eligible patients with insurance coverage are not personally responsible to pay more than AGB after all payments by the health insurer have been applied. The hospital calculates AGB using a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during the prior 12-month period.
- B. Assets: property of economic value such as but not limited to, cash on hand, checking and savings accounts, certificates of deposit, vehicles, mineral rights, stocks, mutual funds, CDs, retirement funds and any other investments; provided.
- C. Family: Defined by the Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption. Per Internal Revenue Service's 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.
- D. Federal Poverty Guidelines: (FPG) The most recent published federal income poverty guidelines for a household as published by the US Government.
- E. Financial Assistance: Full or partial discounts for medically necessary care for patients



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determined eligible under this policy.

- F. Medically Indigent: patients who are capable for paying for their living expenses, but who's medical and hospital bills, after payment by third party payers, would require use or liquidation of income and/or assets critical to living or earning a living.
  
- G. Medical Necessary care: Any inpatient care, including pharmaceuticals or supplies covered under Medicare.



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## EXHIBIT 1

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Estimated Insurance Liability \$ \_\_\_\_\_ Account Balance: \$ \_\_\_\_\_

Total Amount Due \$ \_\_\_\_\_

Dear \_\_\_\_\_:

Attached you will find a financial assistance application form. Financial assistance is based on current balances. If you qualify for any financial assistance, payments already made to this account will not be refunded. Please fill out the application completely and provide me with the following indicated support documents within two (2) weeks:

\_\_\_\_\_ Last year's federal tax return with W-2, W-2G, or 1099-R forms and support schedules.

\_\_\_\_\_ Proof of income (i.e., check stubs, Social Security Benefits, etc.).

\_\_\_\_\_ Bank statements for the past three (3) months.

The financial statement must be signed by the guarantor and the guarantor's spouse, if applicable.

Thank you for your anticipated cooperation in gathering the information needed for the application. Please be aware that if all information is not received, your application for assistance will not be processed.

Your account will be kept open for 20 days pending the return of the above information. If you have any questions, please call toll-free (406) 413-6200, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Sincerely,

\_\_\_\_\_  
Director, Patient Accounts  
Enclosures



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## EXHIBIT 1 (Continued)

### APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION			
Patient Name	Age	Telephone No.	Patient No.
Home Address <input type="checkbox"/>		Rent	Live with parents? No <input type="checkbox"/> Yes <input type="checkbox"/>
<input type="checkbox"/>		Own	
SSN	Marital Status	Discharge diagnosis	If pregnant, due date?
Name & Address of employer		Employer Telephone No.	How long employed?
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	
RESPONSIBLE PARTY INFORMATION			
Name	Relationship to patient	Age	Telephone No.
Street address, if different from patient			
SSN	Marital Status	Family Size	Names & Ages
Name & Address of Employer		How long employed?	Employer Telephone No.
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment		Position/Title	
Name of Nearest Relative			Relationship
Address			Telephone No.
SPOUSE INFORMATION			
Name	Age	SSN	Name of Employer
Employer Address		How long employed?	Employer Telephone No.
Position/Title		Supervisor's Name	
If unemployed, last date & place of employment			Position/Title





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MONTHLY INCOME				ASSETS		
ITEM	<input type="checkbox"/> Patient <input type="checkbox"/> Father	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother	<input type="checkbox"/> Patient <input type="checkbox"/> Father	<input type="checkbox"/> Spouse <input type="checkbox"/> Mother		
Base Income					Checking Account(s) – bank & account number	Balance
Overtime					Savings Account(s) – bank & account number	Balance
Social Security						
Interest/Dividends					Other (bank & account number, money market, CD, IRA)	Balance
Rental Income						
Alimony/Child Support					Life Insurance (company & policy number)	Value
Unemployment						
State Assistance					Stocks, Bonds & Mutual Funds (company)	Value
Food Stamps						
Pension					Automobiles/Trucks (make, model & year)	Value
Disability						
Worker's Compensation						
Other					Other Assets (personal, livestock, machinery, motorcycles, RVs)	Value
					Real Estate (list and describe)	Present Value
<b>TOTAL</b>					<b>TOTAL ASSETS</b>	



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PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX
2. BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)
3. VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC)

MONTHLY EXPENSES		OTHER EXPENSES	MONTHLY PAYMENT	BALANCE	PAYMENT CURRENT?
ITEM	MONTHLY PAYMENT	Charge Accounts			<input type="checkbox"/> No <input type="checkbox"/> Yes
Rent					<input type="checkbox"/> No <input type="checkbox"/> Yes
Mortgage					<input type="checkbox"/> No <input type="checkbox"/> Yes
Electricity					<input type="checkbox"/> No <input type="checkbox"/> Yes
Gas/Propane					<input type="checkbox"/> No <input type="checkbox"/> Yes
Water					<input type="checkbox"/> No <input type="checkbox"/> Yes
Refuse		Personal Loan (name & purpose)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Telephone					<input type="checkbox"/> No <input type="checkbox"/> Yes
Cable TV		Automobile Loan (name)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Food					<input type="checkbox"/> No <input type="checkbox"/> Yes
Clothing		Real Estate Loan (name)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicine					<input type="checkbox"/> No <input type="checkbox"/> Yes
Babysitter		Cellular Phones/Pager			<input type="checkbox"/> No <input type="checkbox"/> Yes
Transportation					<input type="checkbox"/> No <input type="checkbox"/> Yes
Alimony/Child Support		Miscellaneous (name & purpose)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Auto Insurance					<input type="checkbox"/> No <input type="checkbox"/> Yes
Home Insurance					<input type="checkbox"/> No <input type="checkbox"/> Yes
Life Insurance		<b>TOTALS</b>	<b>TOTAL MONTHLY PAYMENTS</b>	<b>TOTAL BALANCE</b>	
Health Insurance					
Personal Property Tax					
Real Estate Tax					
Sub-total		<b>SUMMARY</b>			



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		<b>Total Monthly Income</b>	\$ _____
		<b>Total Monthly Expenses</b>	\$ _____
		<b>Discretionary Income</b>	\$ _____
		<b>Monthly Payment Arrangements</b>	\$ _____

### OTHER EXPENSES

Will the patient be unable to work or go to school due to physical impairment?  No  Yes  
 If yes, what is the disabling condition or diagnosis? \_\_\_\_\_  
 How long will the patient be disabled? \_\_\_\_\_  
 \_\_\_\_\_ (Please attach a statement from the doctor.)

### COMMENTS

### PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Responsible Party or Spouse Signature**

\_\_\_\_\_  
**Facility Representative Department**

\_\_\_\_\_  
**Date**



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## Exhibit 2

### Rehabilitation Hospital of Montana Financial Assistance Guidelines

Level	% FPG	Discount
I	0-200%	100%
II	201-225%	90%
III	226-250%	80%
IV	251-275%	70%
V	276-300%	60%
VI	301-325%	50%
VII	326-350%	40%
VIII	351-375%	30%
IX	376-400%	20%



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## EXHIBIT 3

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Dates of Service: \_\_\_\_\_

\_\_\_ Your application for financial assistance has been approved in the amount of \_\_\_\_\_%. This allowance will be applied to the Hospital charges remaining after all applicable insurance benefits have been paid. This allowance does not apply to your physician’s bill or non-covered items such as private room, take home items, etc. The balance remaining, after financial assistance has been applied, must be paid by cash, personal check, or money order. Please contact the Patient Accounts Department regarding your choice of payment options.

Your current balance after financial assistance is \$: \_\_\_\_\_.

\_\_\_ Your application for financial assistance has been denied. Your level of income is higher than the standard level used to compute our financial assistance allowance.

Sincerely,

Patient Accounts Department  
Monday – Friday (8:30 a.m. to 4:30 p.m.)