POLICY: **CHARITY POLICY**
Policy Number: **PTA 10.25**
Effective Date: **4/30/19**
Revision Date: **6/30/20**
Review Date:

In accordance with the Partnership Agreement, "Agreement" between Billings Clinic, St. Vincent Healthcare and Kindred Healthcare, 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 whose 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 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, 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 my contact the hospital either in person or over the phone at 416-403-6200.

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 case 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 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 or to the Hospital.

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.

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 determined eligible under this policy.

F. Medically Indigent: patients who are capable for paying for their living expenses, but whose 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.

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

EXHIBIT 1 (Continued)

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION							
Patient Name			Age	Telephone No.			Patient No.
Home Address □ □				Rent Own			Live with parents? No □ Yes □
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				

MONTHLY INCOME				ASSETS	
ITEM	□ Patient □ Spouse □ Father □ Mother	□ Patient □ Spouse □ Father □ Mother	□ Patient □ Spouse □ Father □ Mother	Checking Account(s) – bank & account number	Balance
Base Income					
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
TOTAL				**TOTAL ASSETS**	

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			□ **No** □ **Yes**
Rent					□ **No** □ **Yes**
Mortgage					□ **No** □ **Yes**
Electricity					□ **No** □ **Yes**
Gas/Propane					□ **No** □ **Yes**
Water					□ **No** □ **Yes**
Refuse		Personal Loan (name & purpose)			□ **No** □ **Yes**
Telephone					□ **No** □ **Yes**
Cable TV		Automobile Loan (name)			□ **No** □ **Yes**
Food					□ **No** □ **Yes**
Clothing		Real Estate Loan (name)			□ **No** □ **Yes**
Medicine					□ **No** □ **Yes**
Baby Sitter		Cellular Phones/Pager			□ **No** □ **Yes**
Transportation					□ **No** □ **Yes**
Alimony/Child Support		Miscellaneous (name & purpose)			□ **No** □ **Yes**
Auto Insurance					□ **No** □ **Yes**
Home Insurance					□ **No** □ **Yes**
Life Insurance		**TOTALS**	**TOTAL MONTHLY PAYMENTS**	**TOTAL BALANCE**	
Health Insurance					
Personal Property Tax					
Real Estate Tax		**SUMMARY**			
Sub-total					

Total Monthly Income $_____

Total Monthly Expenses $_____

Discretionary Income $_____

Monthly Payment Arrangements $_____

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

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%

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.)