

Financial Assistance Policy	
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STATEMENT OF PURPOSE

This policy is intended to establish guidelines for a structured procedure so as not to exclude anyone from seeking medical services on the grounds that such a person may not have adequate resources to pay for those services rendered at Shelby County Memorial Hospital Association, DBA: Wilson Health. It is intended to address those that do not have the ability to pay and to offer a discount from billed charges for those who are able to pay a portion of the costs of their care. This policy set forth the basic framework for Wilson Health and all entities that are owned, leased or operated by Wilson Health. Upon adoption by the Board of Directors, this policy represents the official financial assistance policy, herein called the Financial Assistance Policy (FAP), and follows the guidelines set forth in the Internal Revenue Code Section 501(r). Wilson Health also reserves the right to attempt by the use of all legal means to recover payment for those medical services received at Wilson Health.

FINANCIAL ASSISTANCE POLICY DEFINITIONS

Amounts Generally Billed (AGB) means the Usual and Customary Charges for Covered Services provided to individuals eligible under the Basic Financial Assistance Program, multiplied by Wilson Health-Specific AGB Percentage applicable to such services.

Assets Liquid assets that can be converted to cash to meet financial obligations.

Billing and Collections Policy means Wilson Health’s Policy entitled: “Patient Financial Services: Billing and Collection Policy for Self-Pay Accounts” is the same and may be amended from time to time.

Emergency Services means a medical condition of a patient that has resulted from the sudden onset of a health condition with acute symptoms which, in the absence of immediate medical attention, are reasonably likely to place the patient’s health in serious jeopardy, result in serious impairment to bodily functions of the patient or result in serious dysfunction of any bodily organ or part.

Extraordinary Collection Actions (ECA) Actions taken by Wilson Health against an individual related to obtaining payment of a bill for care that requires a legal process, selling an individual’s debt to another party, or reporting adverse information to consumer credit reporting agencies.

FAP-Eligible means an individual eligible for financial assistance under this Policy.

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Federal Poverty Guidelines measures of income levels issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for this financial assistance program.

Hospital Facility and Hospital Owned Entities Wilson Health and all Hospital owned or partially owned entities that are disregarded as separate from the Hospital for federal tax purposes are required to follow the 501(r) requirements with respect to care provided for emergency and medically necessary services

Limitation on Charges refers to limiting the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to not more than the amounts generally billed to individuals who have insurance covering the same care. In addition for billing and collection, Wilson Health may not engage in ECAs before reasonable efforts have been made to determine whether the individual is eligible for financial assistance.

Medically Necessary Services means those inpatient and outpatient services required to identify and treat an illness or injury.

PFS means Patient Financial Services, the operating unit of Wilson Health responsible for billing and collecting self-pay accounts for hospital services.

Plain Language Summary is a written statement that notifies an individual that Wilson Health offers financial assistance under a FAP and provides the information in a clear, concise, and easy to understand description.

FINANCIAL ASSISTANCE POLICY

This policy refers to medical services rendered to patients who claim they are not able to pay all or any of the costs when healthcare services are rendered. Although designated as charity, when Wilson Health believes that a patient who claims charity has assets usable for payment of services given, the Hospital policy is to make every reasonable attempt to collect payment for medical services rendered.

It is the policy of Wilson Health that no patients seeking medical service that can be provided by Wilson Health will be denied access to those services solely because of the inability to pay for those services. Wilson Health will provide without discrimination, care for emergency services, and medically necessary services to individuals regardless of whether they are eligible based on the Hospital's Financial Assistance Policy (FAP). Debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provisions of emergency or medically necessary care are prohibited.

Wilson Health may make available services without charge or at a reduced charge, based on the ability to pay as determined by Wilson Health. The amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance will not be more than the amounts generally billed (AGB) to individuals who have insurance covering the same care.

Wilson Health reserves the right to investigate and inquire as to the available assets, income, and other factors which would assist Wilson Health in making the determination of the ability to pay.

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All patients have the opportunity to apply for financial assistance prior to Wilson Health engaging in any extraordinary collection activities (ECA). Wilson Health will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAPeligible for the care.

In the event the patient dies, Wilson Health reserves the right to pursue all possible claims against the decedent's estate or against any other person or entity having a legal obligation to pay for the decedent's medical services to recover all or as much as possible amounts owing to Wilson Health by the decedent for Hospital services rendered which were unpaid at the time of the decedent's death.

This policy is posted on the Hospital's website and is available at various locations throughout the Hospital including the Emergency Department and Registration areas. In addition, each Hospital's billing statement includes a notice regarding the availability of financial assistance. The patients and the Hospital community are also notified via signage located throughout the Hospital.

A plain-language summary of the FAP is available upon request and is offered as part of the intake process in both the Emergency Department and Registration areas.

FINANCIAL ASSISTANCE POLICY INSTRUCTIONS

The following are instruction statements regarding how the policy is executed.

All commercial, federal, and state health and medical payment sources including automobile and homeowner's policies available to the patient will be billed prior to receiving financial assistance under the Hospital's FAP.

Eligibility Criteria and Determination

In determining the adequacy or inadequacy of income, the most current federal poverty income guidelines for the low end and 400% of the guidelines for the high end will be used as a scale based on the gross income of the patient and the patient's household, the patient's household size, and other medical/financial obligations. In addition, determination will include the availability of all other assets (i.e., savings accounts, CDs, etc.).

Presumptive Financial Assistance Eligibility

Patients who are deemed to be presumptively eligible for financial assistance will receive a financial adjustment to their final statement balance based on the patient's individual scoring criteria.

Limitation of Charges/Amounts Generally Billed

Wilson Health limits the amounts charged for emergency and medically necessary services provided to individuals eligible for assistance under this Policy to not more than the amounts generally billed to individuals who have insurance coverage for such care. The AGB is derived by dividing (1) the sum of all claims for Medically Necessary services provided at Wilson Health and paid during the relevant period by Medicare fee-for-service and all private health insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-pays, co-insurance or deductibles, by (2) the charges set forth in the Wilson Health Chargemaster at the time the services are rendered. Wilson Health-Specific AGB Percentage shall be calculated annually for a twelve (12) month period from January 1 to December 31 and allows 120 days for such calculation to be made

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and updated in the FAP. The calculation of the Hospital-Specific AGB Percentage shall comply with the “look-back method” described in the IRS Regulation 501(r)-5(b) (1) (B).

Methods for Applying for Financial Assistance

Patients may apply for financial assistance by completing the FAP application prior to, at the time of, or after services are rendered. Applications may be accessed by PFS, Patient Access, from the Hospital website, or requesting an application by phone at (A-K) 937-498-5330 or (L-Z) 937-498-5331. Applications may also be mailed to the Hospital at:

Wilson Health
Patient Accounts/Financial Assistance
PO Box 966
Sidney, OH 45365-0966

Notification Requirements

The availability of the FAP will be widely publicized within the communities serviced by Wilson Health. All admitting areas shall have posters prominently displayed that advise patients of the existence of Wilson Health and will make reasonable efforts to distribute a plain language summary (PLS) of the FAP and offer a FAP application form to individuals before being discharged from Wilson Health; or by including a PLS of the FAP with all billing statements during the 120-day notification period. There is direct web access to the PLS; and Wilson Health will provide at least one written notification informing the patient of any ECAs Wilson Health may take if the FAP application is not received or payment has not been received.

Write-Offs and Adjustments

Emergency and medically necessary services will be written off, in whole or in part, if the patient’s financial assistance application is approved. All determinations pertinent to this FAP are to be made by the Financial Counselor, the Patient Account Representatives, and approved by the Director of Patient Financial Services.

Signature Authority

FAP write-offs will be granted subject to the following approval limits:

1. Up to \$10,000 – Director of Patient Financial Services

Financial Assistance Policy Procedures

CHARITY CARE DISCOUNT PROGRAM GUIDELINES

PROCEDURE

- I. Notification:
 - A. Notices regarding the requirements for the HCAP program are located at the Cashiers Office, Outpatient Registration, and Emergency Department within the Hospital.

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- B. Patient Financial Counselors (PFC) will assist in educating patients on the availability of the Financial Assistance Programs.
 - 1. The Patient Financial Counselor will discuss the determine eligibility for a Charity Care Discount.
 - a. During the application process the PFC will query the patient; ***Were you an active Medicaid recipient at the time of your hospital service?***
 - b. The PFC will make a determination based on the information the patient and/or guardian has provided on Wilson Health's ***Application for Financial Assistance form***. If the patient qualifies, the PFC will review Presumptive Eligibility. The patient and/or guardian will be instructed the Presumptive Coverage will only be valid for services from the application date going forward for 30 days and that the patient and/or guardian will need to follow up with ODJFS for continued coverage.
 - c. If the Patient has a previous service(s) that the applicant would like to have covered by ODJFS, the patient and/or guardian will be referred to the office of ODJFS.
 - 2. When a self-pay patient is admitted to a bed on an inpatient floor, including OB and newborn patients, PFC will visit the patient in their room and advise the patient and/or their family of a Charity Care Discount.
 - C. Each billing statement the patient receives will have the financial assistance information, including the poverty guidelines, on the reverse side of the statement.
 - 1. All billing statements have a message located on the front of the statement, which directs the patients to see the back of the statement for free or discounted care.
- II. Eligibility Requirements:
- A. The patient must be financially or medically indigent to qualify for either a total or partial Charity Care Discount. These patients are defined as follows:
 - 1. Financially Indigent ~ a patient who is uninsured or underinsured and whose bill will result in no obligation or a discounted obligation to pay for the services rendered.
 - a. The patient's total "family" income before taxes must not exceed 400% of the Federal Poverty Guidelines (FPG), as established by the U.S. Department of Health and Human Services, for the year in which the date(s) the services were provided.
 - 2. Medically Indigent ~ a patient whose unpaid hospital charges exceed their ability to pay and whose bill will result in a discounted obligation to pay for the services rendered.
 - a. The patient's liability for services received, for the timeframe in which the patient is applying for financial assistance, exceeds 25% of their family income, resulting in excessive hardship. This timeframe is defined as:
 - i. A period of 3 months in which the patient's responsibility on accounts results in excessive hardship.

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- ii. A patient experiences an unscheduled, emergent encounter that results in excessive hardship.
 - B. The patient must not be under arrest or under detention at the time of service, as the city or county is to arrange for medical care for these individuals.
 - 1. If a patient was with an officer, but not yet under arrest, or was released from detention for sole purpose to receive medical care, then the patient is eligible to apply for a Charity Care Discount.
 - C. The patient must not be enrolled in any traditional Medicaid or Medicaid Managed Care Program.
 - 1. Patients who are Medicaid recipients via the “spend-down” provision are eligible to apply for a Charity Care Discount, for any date(s) of service that occurred prior to meeting their spend-down requirement for each applicable month.
 - D. The patient must fully cooperate with any requests for information.
 - 1. If a third party payer denies a claim due to non-cooperation with repeated requests for information, patients are not eligible to apply for a Charity Care Discount.
- III. Eligibility Determination:
 - A. Determination of “Family” Size:
 - 1. Patients age 18 and over – “family” includes the patient, the patient’s spouse (regardless of whether the spouse lives in the home), all of the patient’s children (natural or adoptive) under the age of 18 who live in the home, and any other children under the age of 18 who live in the home in which the patient has a responsibility to provide for the child either through a court order or through legal guardianship.
 - a. Children under the age of 18 who live in the home under a court order or through legal guardianship will be considered part of the “family,” as long as legal documentation or a copy of the most recent tax return is provided to the Hospital.
 - 2. Patients under the age of 18 – “family” includes the patient, the patient’s natural or adoptive parent(s) (regardless of whether both parents live in the home), and the parent(s)’ children (natural or adoptive) under the age of 18 who live in the home.
 - 3. Patients of a minor parent residing in the patient’s grandparents home – “family” includes only the patient, the parent(s) (regardless if both parents live in the home) and any of the parent(s)’ children (natural or adoptive) who reside in the home.
 - B. Determination of “Family” Income:
 - 1. Income includes total salaries, wages, and cash receipts before taxes.
 - a. Reasonable business expenses may be deducted for self-employed patients or their families.
 - 2. In situations where the income of a spouse or a parent of a minor child who does not live in the home cannot be obtained, or the absent spouse or parent or a minor child

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does not contribute income to the family, determination of family income shall proceed with the income information provided on the application.

- a. The spouse or the parent of a minor child must still be counted as part of the family; however “none” should be reported as income on the application for this family member.
3. Income calculations are based on income at the date of service, not at the date of application. Both of the following methods will be applied in determining income for each application; however the method that is most beneficial for the patient to support eligibility for a Charity Care Discount will be used as the final determination:
 - a. Multiply by four the income of the “family” for the three months prior to the date of service OR
 - b. Count the income for every member of the “family” for the year prior to the date of service
- C. A patient’s declaration of family income will be accepted as proof of income.
 1. Documentation of reported income is not required.
 2. Individuals reporting “zero” income must provide a written explanation of how they and/or their “family” survived financially during the 3 and/or 12 months prior to the initial date of service on the application.
- D. The following sources will be used to determine “family” income:
 1. Employment Wage Earnings
 2. Strike Benefits
 3. Unemployment Benefits
 4. Worker’s Compensation Benefits
 5. Alimony Payments
 6. Child Support*
 7. Social Security Benefits*
 8. Disability Benefits
 9. Veteran’s Benefits
 10. Pension Plan Benefits
 11. Interest/Dividends on a non-retirement savings or brokerage account
 12. Monthly/Lump Sum Distributions not previously taxed from a retirement account
 13. Tax return (for the applicable year) ~ if the initial date of service for which the patient is applying for occurs during the month of December or January
 14. Grants, Scholarships and/or Housing Allowance ~ if paid directly to the patient

* Child Support and Social Security Benefits for children would only be included as part of the family income, if the patient is the child who is the receiving the support payments.
- E. The following sources of income will not be used to determine “family” income:
 1. Withdrawals from a savings/brokerage account
 2. Interest/Dividends paid directly to a retirement account

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IV. Validity of Applications:

- A. Documentation necessary to determine eligibility for a Charity Care Discount is a completed Financial Assistance Application signed by the patient, a parent, the spouse, or the patient's legal representative/guardian.
 - 1. Working with the patient, the Patient Financial Counselor will assure that the application is completed in its entirety, addressing the following key patient information:
 - a. Non-existence of qualification for any assistance thru a third party payer/government medical program
 - b. Marital status
 - c. Number of "family" members in the household
 - d. Total family income
 - e. Deductions for self-employed applicants
 - f. Proof of Medical Insurance (if available)
 - 2. In the event that circumstances prevent the patient from coming to the Hospital to fill out an application, we will take the patient's information over the telephone, and the application will be sent to the patient, a parent, the spouse, or the patient's legal representative/guardian for signature.
 - 3. In the event that a patient is physically or mentally unable to sign the application, and no legal representative/guardian is involved, the Director of Patient Financial Services will review and approve/or disapprove the unsigned application.
 - a. The signature of Patient Financial Counselor that received the information and reason why the patient was unable to sign must also appear on the application.
 - 4. In the event that an incomplete application is received by the Hospital, the Patient Financial Counselor will either contact the patient or send the application back to the patient to obtain the additional information required to complete the application.
- B. Applications for a Charity Care Discount will be accepted until three years has elapsed from the date of the first follow-up bill/notice for a given date of service.
 - 1. Applications for outpatient services will be effective for 90 days from the initial date of service. Outpatient services performed during this time period will not need to complete a new application. Services rendered after this time period will require the applicant to go through the charity care process again.
 - 2. Applications for inpatient services must have determination of income for each inpatient encounter, unless the patient is readmitted for the same reason within 45 days from the date of discharge.
 - a. Outpatient services provided within 90 days of the first day of inpatient admission will not need to complete a new application.

V. Completed Applications

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- A. Notification of Eligibility
 1. Individuals who are not eligible for a Charity Care Discount will be sent a letter regarding their ineligibility.
 2. Notification of eligibility is not provided to the patient unless it is required for billing of the emergency room physicians.
 3. Individuals who are eligible for a Charity Care Discount will have the appropriate adjustment credited to their account(s).
 - a. Individuals whose income is between 100% - 125% of the FPG are eligible for a 100% Charity Care Discount.
 - i. Adjustment Code A125FPG will be performed on the patient's account with the appropriate discount amount.
 - b. Individuals whose income is between 126% - 150% of the FPG are eligible for a 80% Charity Care Discount.
 - i. Adjustment Code A150FPG will be performed on the patient's account with the appropriate discount amount.
 - c. Individuals whose income is between 151% - 200% of the FPG are eligible for a 60% Charity Care Discount.
 - i. Adjustment Code A200FPG will be performed on the patient's account with the appropriate discount amount.
 - d. Individuals whose income is between 201%-250% of the FPG are eligible for a 40% Charity Care Discount.
 - i. Adjustment Code A250FPG will be performed on the patient's account with the appropriate discount amount.
 - e. Individuals whose income is between 251%-300% of the FPG are eligible for a 38% Charity Care Discount.
 - i. Adjustment Code A300 FPG will be performed on the patient's account with the appropriate discount amount.
 - f. Individuals whose income is between 301%-400% of the FPG are eligible for a 36% Charity Care Discount.
 - i. Adjustment Code A400FPG will be performed on the patient's account with the appropriate discount amount.
 - g. Individuals who are deemed Medically Indigent are eligible for a 75% Charity Care Discount.
 - i. Adjustment Code AMEDINDCC will be performed on the patient's account with the appropriate discount amount.
- B. Review/Approval
 1. The Director of Patient Financial Services, or designee, will review all documentation used to determine eligibility for financial assistance, and approve the write off for a Charity Care Discount as appropriate.
- C. Application Retention
 1. A copy of all applications and the associated working documents will be filed according to the year in which the application was processed.

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- a. Applications will be retained for a period of six years from the date of payment received by The Ohio Department of Job and Family Services (ODJFS) for those records, or until any audit initiated by the ODJFS within the six year period is completed.

Once the retention period has been met, the applicable documentation and all applications for that cost reporting period will be shredded

CARE ASSURANCE PROGRAM GUIDELINES

PROCEDURE

VI. Notification:

- A. Notices regarding the requirements for the HCAP program are located at the Cashiers Office, Outpatient Registration, and Emergency Room areas within the Hospital.
- B. Patient Financial Counselors will assist in educating patients on the availability of the Financial Assistance Programs.
 1. Patient Financial Counselor will discuss the process to apply for financial assistance with the patient in order to determine eligibility for the Care Assurance Program.
 2. When a self-pay patient is admitted to a bed on an inpatient floor, including OB and newborn patients, the PFC will visit the patient in their room and advise the patient and/or their family of the Care Assurance Program. When the admission occurs during the weekend, the Patient Financial Counselor will visit the patient on the first business day after admission.
- C. Each billing statement the patient receives will have the HCAP notification, including the poverty guidelines, on the reverse side of the statement.
 1. All billing statements have a message located on the front of the statement, which directs the patients to see the back of the statement for free care information.

VII. Eligibility Requirements:

- A. The patient must voluntarily live in the State of Ohio.
 1. This status includes temporary residents such as students or migrant workers, and patients who are temporarily residing with in-state relatives.
 2. This status does not include:
 - a. Out of state patients who are on vacation or patients who come to Ohio solely to receive medical care.
 - b. Patients who are under arrest or are under detention at the time of service ~ as the city or county is to arrange for medical care for persons that they have under arrest or are detaining.

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- I. If a patient was with an officer, but not yet under arrest, or was released from detention for sole purpose to receive medical care, then the patient is eligible to apply for HCAP.
- B. The patient must not be enrolled in any traditional Medicaid or Medicaid Managed Care Program.
 1. Patients who have Disability Assistance automatically qualify for the Care Assurance Program.
 - a. Patients must have a copy of their Disability Assistance (DA) card with proof of eligibility for the date in which services were rendered.
 - b. If there is no copy of the DA card, the Medicaid Billing Representative will check the Medicaid system for eligibility.
 - c. A claim will be submitted to Medicaid for denial/approval; once the remittance advice is received back from Medicaid, it will be filed for future reference and/or audit purposes.
 2. Patients who are Medicaid recipients via the “spend-down” provision are eligible to apply for the Care Assurance Program, for any date(s) of service that occurred prior to meeting their spend-down requirement for each applicable month.
- C. The patient must fully cooperate with any requests for information.
 1. If a third party payer denies a claim due to non-cooperation with repeated requests for information, patients are not eligible to apply for Care Assurance.
- D. The patient’s total “family” income before taxes must not exceed 100% of the Federal Poverty Guidelines (FPG), as established by the U.S. Department of Health and Human Services, for the year in which the date(s) the services were provided.
 1. Determination of “Family” Size:
 - a. Patients age 18 and over – “family” includes the patient, the patient’s spouse (regardless of whether the spouse lives in the home), and all of the patient’s children (natural or adoptive) under the age of 18 who live in the home.
 - b. Patients under the age of 18 – “family” includes the patient, the patient’s natural or adoptive parent(s) (regardless of whether both parents live in the home), and the parent(s)’ children (natural or adoptive) under the age of 18 who live in the home.
 - c. Patients of a minor parent residing in the patient’s grandparents home – “family” includes only the patient, the parent(s) (regardless if both parents live in the home) and any of the parent(s)’ children (natural or adoptive) who reside in the home.
 2. Determination of “Family” Income:
 - a. Income includes total salaries, wages, and cash receipts before taxes.
 - i. Reasonable business expenses may be deducted for self-employed patients or their families.
 - b. In situations where the income of a spouse or a parent of a minor child who does not live in the home cannot be obtained, or the absent spouse or parent or a minor child does not contribute income to the family, determination of

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- family income shall proceed with the income information provided on the application.
- i. The spouse or the parent of a minor child must still be counted as part of the family; however “none” should be reported as income on the application for this family member.
- c. Income calculations are based on income at the date of service, not at the date of application. Both of the following methods will be applied in determining income for each application; however the method that is most beneficial for the patient to support eligibility for Care Assurance will be used as the final determination:
- i. Multiply by four the income of the “family” for the three months prior to the date of service OR
 - ii. Count the income for every member of the “family” for the year prior to the date of service
- d. A patient’s declaration of family income will be accepted as proof of income.
- i. Documentation of reported income is not required.
 - ii. Individuals reporting “zero” income must provide a written explanation of how they and/or their “family” survived financially during the 3 and/or 12 months prior to the initial date of service on the application.
- e. The following sources will be used to determine “family” income:
- i. Employment Wage Earnings
 - ii. Strike Benefits
 - iii. Unemployment Benefits
 - iv. Worker’s Compensation Benefits
 - v. Alimony Payments
 - vi. Child Support*
 - vii. Social Security Benefits*
 - viii. Disability Benefits
 - ix. Veteran’s Benefits
 - x. Pension Plan Benefits
 - xi. Interest/Dividends on a non-retirement savings or brokerage account
 - xii. Monthly/Lump Sum Distributions not previously taxed from a retirement account
 - xiii. Tax return (for the applicable year) ~ if the initial date of service for which the patient is applying for occurs during the month of December or January
 - xiv. Grants, Scholarships and/or Housing Allowance ~ if paid directly to the patient
- * Child Support and Social Security Benefits for children would only be included as part of the family income, if the patient is the child who is the receiving the support payments.
- f. The following sources of income will not be used to determine “family” income:
- i. Withdraw from a savings/brokerage account
 - ii. Interest/Dividends paid directly to a retirement account

VIII. Validity of Applications:

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- A. Documentation necessary to determine eligibility for Care Assurance is a completed Financial Assistance Application signed by the patient, a parent, the spouse, or the patient's legal representative/guardian.
 1. Working with the patient, the Patient Financial Counselor will assure that a Financial Assistance Application is completed in its entirety, addressing the following key patient information.
 - a. Non-existence of qualification for any assistance thru a third party payer/government medical program
 - b. Marital Status
 - c. Number of Dependents
 - d. Total Family Income
 - e. Deductions for Self-Employed Applicants
 - f. Proof of Medical Insurance (if available)
 2. In the event that circumstances prevent the patient from coming to the Hospital to fill out an application, we will take the patient's information over the telephone, and the application will be sent to the patient, a parent, the spouse, or the patient's legal representative/guardian for signature.
 3. In the event that a patient is physically or mentally unable to sign the application, and no legal representative/guardian is involved, the Director of Patient Financial services will review and approve/or disapprove the unsigned application with the signature of Financial Counselor that received the information and reason why the patient was unable to sign.
 4. When an incomplete application is received by the Hospital, the Patient Financial Counselor will either contact the patient or send the application back to the patient to obtain the additional information required to complete the application.
 - B. Applications for Care Assurance will be accepted until three years has elapsed from the date of the first follow-up bill/notice for a given date of service.
 1. Applications for outpatient services will be effective for 90 days from the initial date of service. Outpatient services performed during this time period will not need to complete a new application. Services rendered after this time period will require the applicant to go through the charity care process again.
 2. Applications for inpatient services must have determination of income for each inpatient encounter, unless the patient is readmitted for the same reason within 45 days from the date of discharge.
 - a. Outpatient services provided within 90 days of the first day of inpatient admission will not need to complete a new application.
- IX. Completed Applications:
- A. Notification of Eligibility
 1. Individuals who are not eligible for the Care Assurance Program will be sent a letter regarding their ineligibility.
 2. Notification of eligibility is not provided to the patient unless it is required for billing of the emergency room physicians.

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3. Individuals who are eligible for the Care Assurance Program will have the appropriate adjustment credited to their account(s).
 - a. Adjustment Code ACAREASSUR will be performed on the patient's account with the appropriate write-off amount.
 - b. In the event that the patient or the responsible party has issued a payment on the eligible account, a refund will be issued to the responsible party or the individual who made the payment on the account.
- B. Review/Approval
1. The Director of Patient Financial Services, or designee, will review all documentation used to determine eligibility for financial assistance, and approve the write off for the Care Assurance Program as appropriate.
- C. Application Retention
1. A copy of all applications and the associated working documents will be filed according to the year in which the application was processed.
 - a. Applications will be retained for a period of six years from the date of payment received by The Ohio Department of Job and Family Services (ODJFS) for those records, or until any audit initiated by the ODJFS within the six year period is completed.
 - i. Once the retention period has been met, the applicable documentation and all applications for that cost reporting period will be shredded.

HOSPITAL BILLING AND COLLECTIONS POLICY

Accounts for Wilson Health services for patients who are able, but unwilling, to pay are considered uncollectible bad debts and will be referred to outside agencies for collection. The unpaid discounted balances of patients who qualify for the FAP are considered uncollectible bad debts and such patients will be referred to outside agencies for collection. The Billing and Collections Policy will be posted to Wilson Health's website. In addition, a free copy of the Billing and Collections Policy can be obtained by request to the PFC.

Patient Financial Services: has the responsibility for monitoring and ensuring that a reasonable effort to determine whether an individual is FAP-eligible and for determining whether and when extraordinary collection actions may be taken in accordance with this policy and the Billings and Collections Policy.

This Billing and Collection policy should be expanded upon and specify to the Hospital.

REFERENCES

Patient Protection and Affordable Care Act, Section 9007
Internal Revenue Code, Section 501(r)