**GREAT PLAINS HEALTH & AFFILIATES**

**DEPARTMENT:** Patient Financial Services

**POLICY NUMBER:** 8210-0008

**SUBJECT:** Financial Assistance/Charity Care

**EFFECTIVE DATE:** 02/01/2018

**OWNER:** Senior Director of Revenue Cycle

**PAGE:** 1 of 15

**DATE REVIEWED:**
01/09/19
02/04/19

**APPROVED BY:**
Sr Director Revenue Cycle
CFO

## POLICY STATEMENT

Great Plains Health shall contribute appropriate resources, advocacy and community support to promote the health status of the community, which it serves, within its economic ability to do so. Financial assistance will be provided to patients with a demonstrated inability to pay. The purpose of this policy is to establish criteria for determining if a patient's account qualifies for financial assistance. The amount of financial assistance to be made available, as well as any other changes to this policy, shall be assessed and determined on an annual basis, and will adhere to federal and state guidelines for tax-exempt and non-profit facilities, as applicable.

## KEY PRINCIPLES

1, **Eligibility for Financial Assistance Discounts; Maximum Charge Levels**. Hospital patients receiving emergency or other medically necessary care with Family Income of less than 450% of the federal poverty guidelines are eligible for Financial Assistance. System hospital will apply presumptive eligibility criteria to facilitate prompt recognition of eligibility for financial assistance. Patients who qualify for Financial Assistance will not be charged more for emergency or medically necessary care than the amounts generally billed (AGB) to patients who have insurance coverage.

2. Uninsured Patient Discounts. Discounts on hospital charges are available to uninsured patients through an automatic forty percent (40%) discount. Uninsured patient discounts are not considered Financial Assistance under this Policy.

3. Hospital Financial Assistance Committee(s) are responsible for reviewing data on financial assistance granted by the hospital and considering special circumstance exceptions to provider higher than the standard level of financial assistance discounts, or discounts to persons in need who otherwise would be not eligible for assistance.

## DEFINITIONS

1. **AGB** means amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage. AGB refers to the amount due to the hospital after applicable insured discounts are applied.

2. **Application Period** means the period during which Great Plains Health must accept and process an application for financial assistance under this Policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the date the care is provided and ends on the latter of the 240$^{th}$ day after the date that the first post-discharge billing statement for the care

is provided or at least (30) days after Great Plains Health provides the individual with a written notice that sets a deadline after which extraordinary collection actions (as defined in the Collections of Accounts Policy 8210-245 may be initiated.

3. **Automatic Uninsured Self-Pay Discount** means a discount of forty percent (40%) in gross charges, automatically provided to all Uninsured Patients without requiring evidence of inability to pay. This discount is not considered Financial Assistance under this Policy.

4. **Catastrophic Discount** means a discount provided with the patient responsibility portion specific to medical debt including and outside of Great Plains Health and Great Plains Health Physicians Network even after payment by third party payers, exceeds 7.5% of the patient's family annual gross income. This discount is intended to help patients and their families avoid bankruptcy and insolvency as a result of hospital costs and is considered Financial Assistance under this Policy.

5. **Exempt Assets** means the following forms of assets, which will not be considered in determining a patient's ability to pay or a financial need; the patients primary residence, personal property exempt from judgment under (Nebraska Revised Statute 77-202) and any amounts held in a pension or retirement plan (exclusive of distributions and payments from such plans.

6. **Family** means the patient, his/her spouse (excluding a legal common law spouse which is not recognized in the State of Nebraska) and his/her legal dependents claimed on filed tax returns or otherwise in accordance with Internal Revenue Service rules.

7. **Family Income** means the sum of a family's gross annual earnings and cash benefits from all sources before taxes, less payment made for child support. Sources of income include but are not limited to: Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.

8. **Financial Assistance** means the term used to refer to the value of free or discounted healthcare services provided to individuals who have been determined to be eligible for Financial Assistance under this Policy based on financial need.

9. **Financial Assistance (Council)** means a Health System council responsible for overseeing the implementation of this Policy. The Financial Assistance Council includes representation from the following areas: C-Suite, Senior Leadership and Ethics.

10. **Hospital Financial Assistance Committee** means a team of hospital leaders that meets monthly (as needed) to review data relating to Financial Assistance applications and determinations. The committee will consist of Chief Financial Officer, Revenue Integrity Director, Case Management Director, and Financial Counselor, or similar mix of responsible hospital leaders.

11. **Nebraska Resident** means a person who currently lives in Nebraska and who intends to remain living in Nebraska indefinitely.

12. **Medically Necessary Service** means any inpatient or outpatient service, including pharmaceuticals or supplies provided by the hospital to a patient covered under Title XVII of the Federal Social Security Act for beneficiaries with the same clinical presentation as the uninsured patient. A Medically Necessary service does not include: (1) non-medical services such as social or vocational services; (2) Elective self-pay packages as defined by Self-Pay Package policies, or

(3) elective cosmetic surgery (exclusive of plastic surgery designed to correct disfigurement cause by injury, illness or congenital defect or deformity).

13. **Medicare Cost to Charge Ratio** means the ratio determination by Medicare which calculates Great Plains overall cost to provide services compared to charges for services. This ratio will be used in calculating possible discounts for uninsured patients.

14. **Uninsured Patient means**:

- A patient of the hospital who is not covered under any commercial health insurance policy (including third party liability coverage) and is not a beneficiary or eligible to be covered by any governmental or other coverage program, including Medicare, Medicaid, Tricare, high deductible insurance, or other coverage agreements.

  If a patient's insurance coverage is exhausted, or the patient's insurance does not cover medically necessary hospital services provided to the patient, the patient will be considered an Uninsured Patient for purposes of Financial Assistance and the Automatic Uninsured Self-Pay Discount will apply to these cases.

## REQUIRED PROCESSES

A. Identification of Potentially Eligible Patients

1. Non-Discrimination. The hospital is a non-profit corporation offering financial assistance to qualified patients. The hospital will not discriminate on the basis of race, ancestry, religion, national origin, citizenship status, age, disability or gender in its consideration of a patient's qualification for financial assistance.
2. Offering Financial Assistance Information at Intake/Discharge. All patients will be offered a plan language summary of this Policy as part of the intake or discharge process. In addition, any patient may request Financial Assistance information at any time.
3. Financial Assistance Evaluation Prior to or After Admission/ Pre-Registration: Non-ED Patients. When possible, prior to the admission or pre-registration, the hospital will conduct an appropriate pre-admission/pre-registration interview with or for any patient other than one who has come to a hospital's Emergency Department, to determine eligibility for Financial Assistance. If a pre-admission/pre-registration interview is not possible, a Financial Assistance interview should be conducted upon admission or registration or as soon as possible thereafter.
4. Evaluation for Financial Assistance Eligibility for Emergency Medical Treatment. For patients who have come to the hospital's Emergency Department, the hospital's evaluation of payment ability to pay or eligibility for Financial Assistance should not take place until an appropriate medical screening has been provided, and in the case of patients determined to have an emergency medical condition, until after such condition has been stabilized.
5. Other Payor Sources. Patients must fully cooperate and comply with eligibility requirements for any other healthcare program(s) for which they may be qualified prior to their evaluation for financial assistance. Federal and/or state assistance may be available for those who meet qualifications. Before financial assistance is provided, all available avenues of assistance from third-party payors must be exhausted.

B. Presumptive Eligibility Criteria

1. Any patient meeting any of the criteria set forth below will be considered presumptively eligible for Financial Assistance without further documentation requirements. In such situations, the patient is deemed to have a family income of 250% or less of the Federal Poverty Level, and therefore eligible for a 100% reduction from Medically Necessary charges (i.e. full charity write-off). Patients will receive a minimum of one (1) statement to provide a summary of services and account information.

Presumptive eligibility for 100% Financial Assistance will be made for patients meeting any of the following criteria:

a. Patient is homeless (with such status verified after review of available facts).
b. Patient is deceased with no estate.
c. Patient is mentally or physically incapacitated and has no one to act on his/her behalf.
d. Patient is currently eligible for Medicaid, but was not on a prior date of service or for non-covered services.
e. Patient is enrolled or covered b:
   Women's, Infants and Children Nutrition Program (WIC).
   Supplemental Nutrition Assistance Program
   Free Lunch Program
   Low Income Home Energy Assistance Program (LIHEAP)
f. Patient or family is a qualified participant in an organized community-based program for providing access to medical care that accesses and documents limited low-income financial status criteria.
g. Patient receives or qualifies for free care from a community clinic affiliation with the hospital or known to have eligibility standards substantially equivalent to that of the hospital under this Policy, and the community clinic refers the patient to the hospital for treatment or for a procedure.
h. Patient is a recipient of grant assistance for medical services.
i. Patient participates in state-funded prescription programs.
j. Patient or patient's family is enrolled in Nebraska Housing Authority's Rental Housing Support Program (Section 8)
k. Patient or patient's family has been determined and verified by an independent third-party reporting agency to have family income of 250% of less than the FPL.

C. Standard Determinations of Eligibility

1. Income Documentation. Patients other than those determined to be presumptively eligible for Financial Assistance must provide at least one of the following forms of income documentation with their Financial Assistance application:

a. Copy of the most recent Federal income tax return (preferred) or statement income tax return;
b. Copy of the most recent W-2 for and 1099 forms, or similar forms issued to members of partnerships, limited liability companies or other entities.
c. Copies of two (2) most recent pay stubs;
d. Written verification from an employer if paid in cash; or
e. One (1) other reasonable form of third party income verification deemed acceptable to the hospital.

2, Expectations of Patient Cooperation. It is expected that patients will cooperate with the information gathering and assessment process in order to determine eligibility for Financial Assistance.

3. Residency Requirement. Financial Assistance and other patient discounts under this Policy will be provide to Nebraska Residents and eligible visitors as set forth in sub-section c below)

a. Proof of residency. Residency may be evidenced by any of the following:

i. Any of the income documentation listed in Paragraph C.1. above.
ii. Valid state-issued identification card or driver's license.
iii. Recent utility bill;
iv. Lease agreement (for housing);
v. Vehicle registration card;

vi. Mail addressed to the patient at a Nebraska address from a government or other credible source;
vii. Statement from a family member of the patient who resides at the same address and presents verification of residency;
viii. Letter from a homeless shelter, transitional house or other similar facility verifying that the patient resides at the facility.

b. Eligible Out-of-State Service Area Residents. Patients who are residents (using the verification standards applicable to Nebraska residents specified above) of an adjacent state who reside in an area of such state that falls within the hospital's primary service area will be considered eligible for Financial Assistance for services provided on the same basis as Nebraska residents.

c. Visitors Eligible for Financial Assistance. Patients who are not residents of Nebraska, but who state or verify that they did not come to Nebraska for the primary purpose of receiving medical care will be evaluated for eligibility for Financial Assistance on the same basis as Illinois residents. Financial Assistance applications by all other non-Nebraska residents, including those where the primary reason for the patient visit is not clear, must be reviewed by the (Committee) for a determination of whether granting Financial Assistance is consistent with the purposes of this Policy, under the circumstances.

4. Review of Applications with Special Circumstances. The Financial Assistance Committee will review patient accounts identified by a Financial Counselor that involve unique circumstances indicating financial need despite the absence of the standard eligibility criteria set forth in this Policy. The hospital (Committee) may recommend exceptions to this Policy for specific patients based on unusual or uncommon circumstances relating to financial need. The basis for all exception decisions must be documented and maintain in the account file and must be made consistently across the organization.

a. Asset consideration. Assets will not be used for initial Financial Assistance eligibility, except to the extent the presence of substantial assets (other than Exempt Assets) indicates the existence of significant unreported additional sources of income that would show the patient's actual family income to be more than 450% of the FPL.

5. Approval Authorities. Approval threshold levels are as follows:

a. Financial Counselor(s) may approve up to $10,000
b. Business Office Manager/Director may approve up to $25,000
c. Senior Director of Revenue Cycle may approve up to $50,000
d. Amounts greater than $50,000 will be approved by the hospital's CFO.

Approval amounts must be in compliance with is Policy.

D. Eligibility Determination Process and Notification.

1. Normal Processing Period. Clear expectations as to the length of time required to review a financial assistance application and provide a decision to the patient should be communicated at the time of application. A written decision will be made within a reasonable time period after the hospital's receipt of the completed application, including, if applicable, the assistance for which the individual is eligible and the basis for this determination. Collection activity on the account will be suspended while the Financial Assistance application is pending.

2. Incomplete Applications. If an application is missing the minimum information or documentation necessary for determination of Financial Assistance eligibility, Great Plains Health representatives will notify the patient in writing, specifying the additional information needed to complete the application. If the application remains incomplete for 45 days after such written notice, and after reasonable attempts to obtain the necessary documentation or equivalent information, collection actions may be taken or resumed.

3. Denials; Patient Right to Appeal. Patients will be notified of a denial of a financial assistance application in writing, including reason(s) for the denial, and appeal rights. If a patient disagrees with the Financial Assistance eligibility determination, including the extent of discount for which a patient is eligible, the patient may appeal in writing within 45 days after denial. System Financial Counseling will review the appeal, and make a recommendation to the Financial Assistance Committee. Decisions reached will normally be communicated to the patient within 60 days, and reflect the Committee's final review. Collection activity will be suspended during the appeal process.

4. Suspension of Collection Activities Pending Eligibility Determination. When an application for Financial Assistance has been received, a note will be entered into the patient's account to suspend collection activity until the Financial Assistance process is completed. If the account has been placed with a collection agency, the agency will be notified to suspend collection efforts until a determination is made, with such notification documented in the account notes.

5. Application of Catastrophic Discount. The Catastrophic Discount will be available to patients who have medical expenses over a 12-month period for Medically Necessary Services from a Great Plains Health service that exceed 7.5% of the patient's family's annual gross income, even after payment by third party payers. Any patient responsibility in excess of 7.5% will be written off to charity. Services that are not Medically Necessary will not be eligible for this discount.

6. Change in Status Notifications. If the patient with an outstanding bill or payment obligation has a change in his/her financial status that may result in eligibility for Financial Assistance or a higher Financial Assistance discount, the patient should promptly notify the Great Plains Health Financial Counselor(s) or System designee. The patient may request a reevaluation and apply for Financial Assistance or a change in payment plan terms.

7. Payment Arrangements for Balances Due. After the Financial Assistance discount has been applied, any remaining patient balances will be eligible for payment arrangements in accordance with System Patient Financial Services policies. If a patient is unable to meet the payment arrangement guidelines due to special patient or family circumstances limiting the patient's payment ability, the Financial Counselor or similar representative may review and recommend additional Financial Assistance to the System Financial Assistance Committee for the Committee's review and recommendation.

8. Application of Financial Assistance Discounts to Patient Accounts. Once a Financial Assistance eligibility determination is made, the applicable discount will be applied to all of the patient's open (defined as open accounts receivable) or bad debt accounts for services prior to the approval date. Refunds will be provided to the extent of the approved Financial Assistance discount on payments submitted within the Application Period.

9. Re-application of Financial Assistance. Approval for Financial Assistance will be available for up to 6 months or within the defined period of the calendar year of the approval date. Patients may be required to verify information that was provided on a prior application submitted more than 6 months before a Financial Assistance approval date.

E. Uninsured Self-Pay Discount

1. There is no application process for the patient to receive the Uninsured Self-Pay Discount. The discount is applied based on the account's self-pay/uninsured status.

2. Patients receiving pre-negotiated discounts (package pricing) for hospital services will not be eligible for the Uninsured Self-Pay Discount.

3. If a patient is subsequently approved for Financial Assistance, the Uninsured Self-Pay Discount will be reversed so that the full amount can be recognized as a charity discount.

F. Financial Assistance Guidelines and Eligibility Criteria

1. General. The Financial Assistance Guidelines and Eligibility Criteria below are designed to assure that patients with financial need are charged at a rate substantially less than insured patients, including the opportunity to receive 100% free care. The table below is used to determine the Financial Assistance discounts by tier for Uninsured Patients.

| | Eligibility Criteria | | |
|---|---|---|---|
| Percentage of Poverty Guidelines | Discount Percentage for Uninsured Patient (off Gross Charges) | Discount for Insured Patient (off Patient Balance) | Annual Maximum Catastrophic Payment Payment (% of Patient Family Income) |
| Up to 250% | 100% | 100% | N/A |
| 251 – 300% | 75% | Discount equal to 100% of Medicare Cost to Charge Ratio | 7.5% |
| 301 – 350% | 50% | Discount equal to 100% of Medicare Cost to Charge Ratio | 7.5% |
| 351 – 400% | 25% | Discount equal to 100% of Medicare Cost to Charge Ratio | 7.5% |
| 401 – 450% | 10% | Discount equal to 100% of Medicare Cost to Charge Ratio | 7.5% |
| Over 451% | Determined on an Exception Basis | Determined on an Exception Basis | 7.5% |

2. Annual Updates of Criteria Levels. The Federal Poverty Guideline calculations will also be updated annually in conjunction with the published updates by the U.S. Department of Health and Human Services.

3. Pre-Negotiated Rates Package Pricing. Patients receiving pre-negotiated discounts (package pricing) for services will not be eligible for Financial Assistance.

4. Financial Assistance for Certain Crime Victims. Individuals who are deemed eligible by the State of Nebraska to receive assistance under the Crime Victim Reparations Act or SANE Program shall first be evaluated for eligibility for Financial Assistance based on the Financial Assistance Guidelines and the Eligibility Criteria. Applications for reimbursement under such Crime Victims Funds will be made only to the extent of any remaining patient liability after the Financial Assistance eligibility determination is made.

5. Financial Assistance for Insured Patients. Financial Assistance in the form of 100% discounts (free care) are available for patient-liability amounts remaining after insurance payments, for insured patients who are Nebraska residents with family gross income less than or up to 250% of the Federal Poverty guidelines. For insured patients with family gross income between 250 and 450% of the Federal Poverty guidelines, the expected patient payment will be the lesser of patient's out of pocket (OOP) liability reduced by 100% of the hospital's Medicare cost-to-charge ratio or the amount the patient would have been responsible for had they been uninsured. The amount of Financial Assistance will be determined once all third-party payment amounts have been identified.

In addition, insured patients with high hospital bills may receive a Catastrophic Discount. Patients who are insured and at or below the 450% of FPL Guidelines must first satisfy any related co-payments, deductible/coinsurance based upon a sliding scale per episode of care based on eligibility criteria and % of financial assistance approved.

6. Financial Assistance for Students. Financial Assistance for verified full-time enrolled students with income of 250% or less of the Federal Poverty Level will be eligible for a 100% reduction from charges (i.e., full charity write-off).

7. Timing of Financial Assistance Application. A patient may apply for Financial Assistance at any time during the billing and collection process.

G. Patient Responsibilities

1. Patients Potentially Eligible for Public Programs. Patients who are identified as potentially eligible for healthcare coverage from a governmental program or other source will be referred to a Financial Counselor and expected to cooperate with efforts to determine their eligibility for coverage (e.g. Medicaid), prior to consideration for Financial Assistance. Such coverage eligibility efforts will be made at the hospital's expense, and will promote public policy goals by assuring eligible patients are covered by available health coverage programs.

2. Verification. It is the responsibility of the patient to provide any additional required supporting documentation to confirm Presumptive Eligibility determination. Patients will receive a minimum of one communication to provide any needed verifying documents. Financial assistance will not be denied based on the omission of information or documentation, if that information or documentation is not specifically required by this policy or by the Financial Assistance Application.

H. Billing

1. No Bill May Be Issued Pending Processing of Financial Assistance Application. If a partial Financial Assistance application is provided, no bill will be issued to an Uninsured Patient until 45 days after a reasonable attempt is made to obtain outstanding verifying documents. A reasonable attempt is defined as using available patient contact information, including current address, phone number, and email, to correspond with the patient for at least 45 days about outstanding documents and how eligibility might be obtained.

2. Billing Statement. When a patient is deemed eligible for Financial Assistance (not under presumptive eligibility), the System will provide the patient with a new billing statement indicating the amount owed after Financial Assistance. This billing statement will include the AGB for care provided and how that amount was determined.

3. Amounts Generally Billed Percentages

   a. Patients who are eligible for Financial Assistance shall not be billed more than AGB in the case of emergency or other medically necessary care, and shall be billed less than gross charges in the case of all other medical care covered under this Policy.

   b. The AGB for all of Great Plains Health services will be calculated annually, as the lowest AGB percentage of all System entities using the "lookback" method. The "look-back" method requires determining the total amount received by System for Medicare fee-for-service and private health insurer allowed claims, divided by the gross charges for those claims for a 12-month period. The current AGB will be set forth by System Financial Patient Services as of the 120th day after the start of the calendar year. Individuals may obtain the specific AGB percentage and accompanying description of the calculation in writing and free of charge by contacting a financial counselor via the telephone numbers provided below.

I. Collection Practices.

1. See the System Hospital Billing and Collection for Uninsured and other Patients Policy for additional information on billing and collection practices. Individuals may obtain a copy of such policy by contacting a financial counselor via the telephone numbers provided below.

J. Patient Awareness of Policy and Availability of Financial Assistance

1. Signage. Signs, placards or similar written notices regarding the availability of Financial Assistance will be visible in all hospitals at points of registration and other patient intake areas, to create awareness of the Financial Assistance program. At a minimum, signage will be posted in the emergency department, and the admission/patient registration area.

2. Application Forms. In addition to offering a copy of the plain language summary of this Policy as part of the intake or discharge process, Financial Assistance Applications and other forms used to determine a patient's eligibility for Financial Assistance will be made available at the System entity and provided at registration to all patients who are identified as uninsured or at other appropriate times or locations if the patient's uninsured status is determined after registration.

3. Languages for Financial Assistance Policies and Notices. All public information and/or forms regarding the provision of Financial Assistance will use languages that are appropriate for the hospital's service area in accordance with the state's Language Assistance Services Act. This Policy will be translated to and made available in those languages that constitute the lesser of 1,000 individuals or 5% of the community served by the hospital or the population likely to be affected or encountered by a Great Plains Health facility.

4. Notices on Hospital Bill/Invoice. Patient bills, invoices or other summary of charges shall include a prominent statement (in English and Spanish) that patients who meet certain income requirements may qualify for Financial Assistance and information regarding how a patient may apply for consideration under this Policy.

5. Policy Availability. Upon request, any member of the public or state governmental body will be provided with a copy of this Policy. A summary of the Financial Assistance is available pursuant to this Policy and will be available on the Great Plains Health website in those languages that are appropriate for the Great Plains' Health service areas as set forth in J.3 above.

6. List of Participating Providers. Great Plains Health will list all physicians and other providers who will apply System-determined Financial Assistance discounts for medically necessary hospital services provided at the hospital ("**501(r) Provider Participation List**"). Great Plains Health will update the 501(r) Provider Participation List quarterly.

**IMPLEMENTATION FORMS AND OTHER DOCUMENTS** The following documents are available at the System website and internally at the web page for Billing Information:
A. Plain Language Summary of Financial Assistance Policy
B. Financial Assistance Program Application
C. Room and Board Statement
D. Financial Assistance Policy Provider List
E. Federal Poverty Guidelines

**RELATED SYSTEM POLICIES**
Collection of Accounts Policy

Attachment A

Plain Language Summary of Financial Assistance Policy

As part of its contribution of resources, advocacy and community support to promote the health status of the community, which it serves, Great Plains Health System will provide financial assistance to patients with a demonstrated inability to pay for medically necessary services in accordance with the System's Financial Assistance Policy.

Please note.
These financial assistance programs apply only to Great Plains Health charges. Please be aware that you will receive separate bills from each independent practitioner or group of practitioners for services provided. Please see the Financial Assistance Provider List on our website to determine if these practitioners apply this Financial Assistance policy to their bills.

This brochure is a summary of our financial assistance program. For full information about eligibility and program details, please see the Financial Assistance Policy posted on our website at ***www.gphealth.org***. You can also receive our full Financial Assistance Policy and a copy of the application by mail, for free, by calling one of the phone numbers on the back and requesting a copy mailed to you. You can also receive a copy of our Collections of Accounts Policy, which details how we may handle the portion of costs that you may be responsible for, by calling one of the phone numbers on the back and requesting a copy. Already received a bill and have questions? Call our Customer Service at 308-568-8600.

Our programs:

Financial Assistance
Offers free or discounted care based on family size and income according to the Federal Poverty Guidelines (FPG). Available to uninsured patients and insured patients with out-of-pocket expenses. To apply, complete the Financial Assistance Program Application at gphealth.org/financial-assistance.

Automatic Uninsured Self-Pay Discount
Provides an automatic 40% discount to uninsured patients for all medically necessary health care services. No application necessary. Those who receive a pre-negotiated discount will not be eligible.

Catastrophic Discount
Limits out-of-pocket costs over a 12-month period for medically necessary services when it exceeds 7.5% of your family's gross income. Available to uninsured and insured patients. To apply, complete the Financial Assistance Program Application.

Payment Plan
Assists patients with financial needs through payment arrangements. Available to both uninsured and insured patients. One of our financial counselors will help you set up a payment plan. If you do not qualify for assistance but believe you have special circumstances, you can request a review by the hospital's financial assistance committee by completing the Financial Assistance Program Application.

You may also be eligible for public programs such as Medicaid or Medicare. Applying for such programs may be required before requesting financial assistance.

Learn more.
gphealth.org/financial-assistance
Our mission is to inspire health and healing by putting patients first—always.

Applying is easy.

Request an application. Find forms at the hospital or online at: gphealth.org/financial-assistance. Fill out and return. Complete the application and provide any supporting documents soon after receiving care and return to the hospital or mail to:

**Great Plains Health**
**Financial Counseling**
**PO Box 1167**
**North Platte NE 69103**

For help filling out the application, call the number for your hospital below or visit Patient Financial Counseling at the hospital. We review your application. We will review your application to see if you qualify based on the guidelines in the Financial Assistance Policy. If there are special circumstances that affect your ability to pay, these may be reviewed by the hospital's financial assistance committee.

You receive an answer. We will send you a written decision within a reasonable time period. In the meantime, payment of your bill will be suspended. If your request is denied, you will be given an explanation and information on setting up a payment plan and how to appeal the decision, if applicable.

Already eligible? If you have already qualified for certain government-sponsored programs, such as food stamps or subsidized housing, you will be presumed eligible for assistance from us. No application necessary. Just supply us with verification that you are enrolled.

It's confidential.
All applications for financial assistance are kept completely private. The information you provide is shared only with those responsible for determining your eligibility.

Calculating the level of assistance.

Find out whether or not you may qualify for financial assistance by looking at the chart below. Find your family size in the first column and then look right to see which category your household income falls under. This will tell you what percentage of financial assistance you may qualify for.

Full Financial Assistance
To qualify for 100% financial assistance, your household income must be at or below 250% of the current Federal Poverty Guidelines (FPG).

Uninsured patients who meet this requirement will receive a full write-off of patient charges; insured patients who meet this requirements will additionally qualify after the application of a per episodic payment expectation.

Partial financial assistance
Patients who have an income above 250% of the FPG may also qualify for partial financial assistance for out-of-pocket expenses. A sliding scale is used for insured and uninsured patients to determine a discount percentage on charges.

Get in touch:

Free copies of this Plain Language Summary, the Financial Assistance Policy, and the financial assistance application are available on the hospital's website at gphealth.org are available in the hospital's admissions area and emergency department, can be obtained by calling 308/568/8600 and can be requested by mail at PO Box 1167, North Platte, NE 69103. Translations will be available upon request.

The hospital's Patient Representatives are available to answer questions and provide information about the Financial Assistance Policy and to assist with the financial assistance application process. The hospital's Patient Representatives may be reached between the hours of 8 a.m. and 4:30 p.m. Monday through Friday by calling 308/568/8600 or presenting at 601 W Leota Street, North Platte, NE.

Great Plains Health

Patient Financial Services
PO Box 1167
601 W. Leota Street
North Platte, NE 69101
(308)585-8600

**Request for financial assistance**

I ask the hospital and/or physician office to determine if I am eligible for assistance in paying my medical bill. I realize that I will need to give certain information for this to be done, and I freely grant permission to access any credit information necessary for this purpose. I understand I will need to timely provide all documentation requested of me in order to have my application screened for assistance, and the information will be checked for accuracy. I understand filling out this form does not guarantee that I will receive complete or partial assistance. If I am not eligible for complete or partial financial assistance, I will remain responsible for any amounts owing.

I understand this application must be returned within 45 calendar days with the required information in order to be eligible for consideration. This application is valid for Great Plains Health and affiliated physician groups but does not cover elective or cosmetic surgeries.

Applicant Information

Name: _____
First Middle Last

Address: _____
Street City Zip code

Contact phone: _____ Date of birth: _____ SS# _____

Employer name: _____ Phone: _____

Dependents living at home including spouse:

| Name | Relationship | Dependents age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Other unpaid medical expenses you are responsible for at this time:

| Medical provider | Unpaid amount | Medical provider | Unpaid amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Your health is our mission.

Great Plains Health

**Request for financial assistance** **Page 2**

Patient information if different form applicant information. If same as applicant information, enter same on first name.

| First name | Middle name | Last name | Date of birth |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| **Income** | **Monthly Gross** | **Annual Gross** |
|---|---|---|
| Applicant | $ _____ | $_____ |
| Spouse | $ _____ | $_____ |
| Any dependents | $ _____ | $_____ |
| Total | $ _____ | $_____ |

Income verification must accompany this application. Income verification must include the most current tax return and at least one other document listed below.

Most current complete tax return
Last two (2) pay stubs
Last two (2) unemployment checks
W-2's
SSI Disability Determination letter
Other documentation as may be requested (including Room and Board Statement if your housing costs are provided by someone other than yourself)

- I declare under penalty of perjury that the answers I have given are true and complete to the best of my knowledge.
- I agree to tell the provider of services within 10 calendar days, if there are any changes in my (or the person on whose behalf I am acting) income, property, expenses, or in the persons in the household, or of any changes of address that would impact my qualifying for assistance.
- I understand that I may be asked to prove my statement s and that my eligibility statements will be subject to verification by contact with my employer, credit verification, and property ownership searches.
- I understand that the Hospital and/or Physician is required by law to keep any information I provide confidential.
- I further agree, that in consideration for receiving healthcare services as a result of an accident or injury, to reimburse the Hospital and/or Physician from proceeds of any litigation or settlement resulting from such act.
- I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by the Hospital and/or Physician or I may timely appeal the decision in writing with additional documentation.

_____ _____
Applicant's signature Date

_____ _____
Patient representative signature acknowledging receipt Date

Please return completed form and verification documents to the address listed above for consideration.

Your health is our mission.

Great Plains Health

# Room and Board Statement

_____
Patient Name (Print)

The person named above has advised us that you either contribute substantially to their support or you are their sole means of support.

The type of support I/we provide is: (please complete all that apply)

_____ Room and Board, since (date) _____

_____ Allowance of $ _____

every week _____, every 2 weeks _____, every month _____

_____ Other (please explain) _____

_____

I/We, (print) _____ have been the sole/substantial support for the person named above and, to the best of my knowledge, declare that this person has no other primary means of support. I/We will continue to provide room and board, but will not be responsible for medical expenses incurred.

_____ _____
Signature 1 Signature 2

_____ _____
Relationship to Patient Relationship to Patient

_____ _____
Address, Street City, State, Zip

_____ _____
Telephone Date

# Document Information

## Document Title

Financial Assistance - Charity Care

## Document Description

N/A

## Approval Information

**Approved On:** 02/04/2019

**Approved By:** Executive Assistant - Administration [Connie Griebel (d8210cjg)]

**Approval Expires:** 02/06/2022

**Approval Type:** Process

**Document Location:** / Patient Access

**Keywords:** N/A

**Printed By:** Guest User

**Standard References:** N/A

**Note:** This copy will expire in 24 hours