IREDELL MEMORIAL HOSPITAL

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FINANCIAL ASSISTANCE/CHARITY CARE POLICY

POLICY STATEMENT

In order to serve the health care needs of our community, Iredell Memorial Hospital, Inc. (the "Hospital") will provide financial assistance to patients without financial means to pay for medically necessary inpatient, outpatient, and emergency department hospital services. Financial assistance will be available to all patients without regard to race, creed, color, national origin, sex, disability, or any other protected status.

PURPOSE

To properly identify those patients who are eligible for financial assistance, and to provide such assistance with their inpatient, outpatient, and emergency department medical expenses under the guidelines for financial assistance set forth herein. This Policy constitutes a Medical Debt Mitigation Policy for purposes of North Carolina Medicaid.

ELIGIBILITY FOR FINANCIAL ASSISTANCE/CHARITY CARE

1. **FULL BALANCE CHARITY CARE:**

   Full balance charity care is available to North Carolina residents who meet the established criteria of this policy and have a household income below 200% of the Federal Poverty Guidelines ("FPG").

2. **SLIDING SCALE DISCOUNT:**

   North Carolina residents with a household income between 200% and 300% of the FPG will be eligible for a discount based on the sliding scale set forth below.

Household Income as % of FPG	Discount on Balance
351%-400%	Reviewed for Adjustment
200%-350%	75%

3. **AMOUNT GENERALLY BILLED**

   Section 501(r)(5)(A) of the Internal Revenue Code requires hospital organizations to limit the amounts charged for emergency and other medically necessary care provided to individuals eligible for assistance under the organization's financial

assistance policy to no more than the amounts generally billed to individuals who have insurance covering such care ("AGB"). For uninsured patients, the sliding scale discounts set forth above shall apply to the AGB.

4. SCOPE

Subject to applicable law, the Hospital may choose not to offer discounts on (1) co-payments owed by insured patients; (2) physician services; (3) services that are not medically necessary, such as cosmetic procedures; and (4) accounts where the patient has submitted false information or otherwise failed to show good faith in participating in the Hospital's financial assistance program.

STANDARDS AND PROCEDURE

1. MEDICAID ELIGIBILITY SCREENING

All uninsured patients will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. If the patient is eligible for such coverage, the Hospital or its designee shall assist the patient in enrolling in the program(s) for which the patient is eligible.

2. PRESUMPTIVE ELIGIBILITY

A. Patients shall be deemed presumptively eligible for financial assistance on the basis of non-income individual life circumstances, including (but not limited to):

- Homelessness.
- Mental incapacitation with no one to act on the patient's behalf;
- Enrollment in Medicaid of the patient or a child in the patient's household; and/or
- Enrollment in a means-tested public assistance program (including, but not limited to, Women, Infants, and Children Nutrition Program; Supplemental Nutrition Assistance Program).

B. The Hospital will not require a patient to provide documentation or other verification in order to qualify for presumptive eligibility.

C. Patients will be screened for presumptive eligibility for financial assistance based on non-income criteria and notified of the results of such screening on the following timeline:

- *Non-emergency services*: Patients will be screened prior to or at check-in and will be notified of results prior to discharge.
- *Emergency department services*: Patients will be screened as soon as possible (prior to discharge if feasible) and will be notified of results prior to the issuance of a bill.

3. ALTERNATE SCREENING PROCESS FOR PERSONS NOT PRESUMPTIVELY ELIGIBLE

A. Patients seeking financial assistance who do not meet the presumptive eligibility criteria set forth above must provide the income and family size information, and documentation thereof necessary to determine whether they qualify for financial assistance. Such patients will be asked to complete the Application for Financial Assistance form "AFA" (Exhibit "C") during the registration or the financial counseling process.

B. The completed AFA will be sent to the Business Office for review by the Financial Counselor.

C. If the Financial Counselor believes that the patient qualifies for financial assistance, she/he will give the completed AFA to the Assistant Director or Director of Patient Financial Services for approval authorization, prior to write off.

D. The Hospital has the option to request documentation and/or obtain a credit report to verify information provided on the AFA.

E. If the AFA is incomplete, it will be the responsibility of the Financial Counselor to contact the patient via mail or phone and attempt to obtain the required information.

F. Applications that remain incomplete after 30 days of request for additional information may be denied or submitted to the Hospital's CFO for consideration/approval. Such eligibility may be determined on the basis of available information including propensity to pay or credit scores in conjunction with verbally provided income and family size information.

G. The application may be reopened and reconsidered for financial assistance/charity once the required information is received.

H. The Director of Patient Financial Services, Assistant Director, or Financial Counselor is responsible for reviewing every application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval.

I. A final determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

PAYMENT PLANS

For individuals with incomes between 200-350% of the FPG who are unable to pay the balance of their hospital bill in full, the Hospital will offer a payment plan of up to 36 months, with monthly payments no greater than 5% of monthly household income ("36 month/5% income plan"). Alternative payment plans that exceed 36 months may be offered, but the aggregate amount collected from the patient—inclusive of principal and interest—shall not exceed what would have been collected under the 36 month/5% income plan.

DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF AND MANAGEMENT OF PATIENT DEBT

A. Once an eligibility determination has been made, the results will be documented in the comments section on the patient's account. The presumptive eligibility approval and/or the approved AFA will be attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, or Director of Patient Financial Services will signify their review and approval of the write-off by signing the bottom of the AFA or documentation of presumptive eligibility. The signature requirements will be based on the Hospital's financial policy for approving adjustments.

B. The account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to Self-Pay.

PUBLICIZING THE FINANCIAL ASSISTANCE PROGRAM

The financial assistance policy shall be publicized in the following ways:

- Signs (in English, Exhibit "A" and Spanish, Exhibit "B") shall be posted in each admitting office, outpatient registration area, and in the Emergency Department.
- The financial assistance policy shall be linked from the Hospital's website homepage.
- A handout summarizing the financial assistance policy shall be provided to patients at the time of registration.
- A copy of the financial assistance policy shall be provided to patients upon request.
- The Hospital shall ensure that the policy is written in plain language and is available in multiple languages.
- The Hospital will provide information on all billing notices about the availability of financial assistance.
- If the Hospital uses a third-party debt collector, that entity must make patients aware of the Hospital's financial assistance policy.

PUBLICIZING THE COLLECTION POLICY

- The hospital does not charge interest on medical debt.
- The hospital will not send medical debt to third-party collectors until 120 days after the first statement is issued to the patient.
- The hospital will not sell debt to third-party collectors for individuals with incomes up to 350% of FPL, unless for the purpose of relieving the debt.
- The hospital may enter into arrangements with a third party to manage debt collection activities, provided that the hospital maintains ownership of the debt; the hospital must ensure that all contracted debt collection entities comply with all requirements applicable to the hospital described herein.
- Medical creditors/debt collectors (including the hospital and any contracted third-party collection agencies) will not take any of the following actions to collect medical debt: a. causing an individual's arrest b. causing an individual to be held in civil contempt of imprisoned c. foreclosing on an individual's real property d. garnishing wages or state income tax refunds.
- Medical creditors/debt collectors will not engage in any permissible extraordinary collection actions until 180 days after the first bill for medical debt has been sent. An extraordinary collection action includes any of the following: selling an individual's debt to another party, except if prior to the sale, the medical creditor enters into a legally binding written agreement with the medical debt buyer establishing certain patient protections related to the debt collections: reporting adverse information about the patient to a consumer reporting agency; actions that require a legal judicial process (e.g. placing a lien on an individual's property, commencing a civil action).
- Medical creditors/debt collectors will provide patients with 30-day notice of any extraordinary collection actions.
- The hospital (and its debt collectors) will reverse any extraordinary collection actions if a patient is later found to be eligible for financial assistance.
- The hospital and contracted collection agencies will not report a patient's debt to a credit reporting agency.
- Previous reports to credit reporting agencies will be taken back if the debt has been forgiven.
- No individual-except for spouses-will be held liable for medical debt owned by the institution or sold to third parties of any other person age 18 or older (individuals may voluntarily assume liability).
- A spouse held liable for a patient's medical debt will be eligible for the same medical debt mitigation policies offered to the patient.
- Medical creditors/debt collectors will not initiate legal action against a patient for any claims where an insurance appeal/review is pending within the previous 60 days.
- Medical creditors will not refer debts to an external debt collector if an insurance appeal/review was pending within the previous 60 days.

Exhibit A
Example of "Availability of Charity Care" Sign-English Version

FINANCIAL ASSISTANCE POLICY

Financial assistance is available for medically necessary hospital services.

You are <u>automatically</u> eligible for financial assistance if you are:

- Homeless, or
- Enrolled in Medicaid, or have a child in your household who is enrolled in Medicaid, or
- Enrolled in WIC or SNAP.

You may also qualify for financial assistance based on your household income or other circumstances.

For more information, contact _____.

Exhibit B
Example of "Availability of Charity Care" Sign-Spanish Version

Exhibit C
Application for Financial Assistance Program Form

Financial Assistance Program

Our Mission

The mission of Iredell Health System is to support our community's journey toward optimal health, to provide an excellent experience for our patients and their families, and to deliver high quality, affordable health services.

Community Commitment

For over 70 years, Iredell Health System has been proud to offer high quality health care to everyone regardless of their economic means. Iredell Health System carefully considers each patient's ability to pay for their medical care. We are committed to treating patients who have financial needs with the same dignity and consideration that is extended to all of our patients.

Scope

The Financial Assistance Program supports medically necessary hospital services to qualified patients. Financial assistance is not available for copayments for insured patients or for services that are not medically necessary, such as cosmetic surgery. Physician fees (such as anesthesiologist, emergency room physician, hospitalist, pathologist, radiologist, surgeon, etc.) are separate from hospital charges and may not be eligible for discounts.

Eligibility

Patients are presumed eligible for financial assistance if they are:

- Homeless, or
- Mentally incapacitated with no one to act on their behalf, or
- Enrolled in Medicaid, or in the household of a child enrolled in Medicaid, or
- Enrolled in a public assistance program such as WIC or SNAP.

In addition, patients can qualify for financial assistance based on household income:

- Household income below 200% of federal poverty level = 100% discount
- Household income 200-350% of federal poverty level = 75% discount
- Household income 351-400% of federal poverty level = Reviewed for Discount

Iredell can help you assess your household income for purposes of financial assistance.

Applying

If you think you may be eligible for the Financial Assistance Program, we encourage you to **contact the Business Office at 704-878-4600.** An application and financial information may be required to determine eligiblity. You will be notified within one business day of the receipt of your completed application for medical services, not yet provided, and within two weeks for medical services previously provided.

If you receive financial assistance under this Program, we expect that you will also apply for any government assistance for which you may qualify (e.g., Medicaid, Vocational Rehabilitation, etc.) If you need help completing an application for the above programs, we are more than happy to assist.

Patients who do not provide the requested information necessary to completely and accurately assess their financial situation and/or who do not cooperate with efforts to secure governmental health care coverage may not be eligible for Iredell Health System's Financial Assistance Program.

The Business Office can also provide you with information about other ways of handling your medical bills, such as payment plans.

Application for Financial Assistance Program Form

Patient Name _____ DOB_____

Patients with any one of the following circumstances are presumed eligible for financial assistance and do NOT need to complete this form. Please check the appropriate box:

- ☐ Homelessness;
- ☐ Mental incapacitation with no one to act on the patient's behalf;
- ☐ Enrollment in Medicaid of the patient or a child in the patient's household; and/or
- ☐ Enrollment in a means-tested public assistance program (including, but not limited to, Women, Infants, and Children Nutrition Program; Supplemental Nutrition Assistance Program).

The Hospital reserves the right to request documentation to verify the information you are providing on this Application, including but not limited to the following (for any member of your household):

1) W-2 or 1099 forms
2) Pay stubs
3) Statement of Social Security and or retirement/pension monthly benefits
4) Statement of unemployment income with date benefits started and weekly amount
5) Income tax returns
6) If no income, a letter of support, signed and dated, from the person who is providing for your daily living expenses
7) If self-employed, a statement of earnings for the prior year and the current year minus expenses, plus an inventory and value of equipment used for your business
8) Eligibility decision letter from Medicaid

If you are seeking financial assistance for services not yet rendered, please provide the following:

Type of Service _____
Expected Date of Service _____
Ordering Physician/ Facility _____

P. O. Box 6029
Statesville, NC 28687-6029
704-873-5661

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Patient Name_____ DOB_____ Account #_____
Responsible Party_____ Social Security #_____
Address_____ City, State, Zip _____
How long at Address_____ Home: Rent_____ Own_____ Phone_____
Family # in household_____ - age's ____, _____, _____, _____, _____, _____
Employer_____ Address_____

Please provide the following for all members of the household (insert "0" if none).

INCOME PER MONTH

Patient Gross _____
Responsible Party Gross _____
Spouse Gross _____
Rental Property _____
Child Support _____
Alimony _____
VA _____
Social Security _____
Retirement _____
Dividend/Interest _____
Unemployment _____
Other Household Income _____

TOTAL_____

EXPENSES PER MONTH

Loans _____
House Payment/Rent _____
Food _____
Car Note(s) _____
Gas (Home use)_____
Electric _____
Water _____
Phone _____
Cable _____
Credit Card(s) _____
Child Care _____
School Tuition _____
Ins/Medical _____
Judgments/Fines _____
Child Support _____
Alimony _____
Other _____

TOTAL _____

AVAIL. CASH PER MONTH_____

BANKING
Checking YES ____ NO _____
Saving YES ____ NO _____

NAME OF BANK
_____
_____

I understand the information submitted is subject to verification by this facility, and may include checking my credit report. By signing, I am certifying the above information is true and accurate.

Applicant _____ Date_____
Spouse _____ Date_____
Witness _____ Date_____

Application for Financial Assistance Program Form

APPLICATION FOR FINANANCIAL ASSISTANCE PROGRAM, CONTINUED

Patient Name _____DOB_____

List all assets and liabilities (attach separate sheet if necessary) for all members of the household

ASSETS (Description / Titled or in Name of)	VALUE
Cash on Hand, Checking Accounts, and Saving Accounts	$
Credit Union Savings, Mutual Funds, and Other Type Accounts	$
Stocks, Bonds and Retirement Accounts (Inc. IRA, 401K, etc.)	$
Car and Trucks (Make and Model) **Own or Buying**	$
Other Transportation (Inc. Boats and Recreation Vehicles) **Own or Buying**	$
Home and Other Real Estate (Inc. Rental and Investment Property) **Own or Buying**	$
Furniture and Other Personal Property **(MUST GIVE VALUE)**	$
Cash Value of Life Insurance **(Amount you can cash in now)**	$
Other	$
TOTAL ASSETS	$

LIABILITIES (Company & Location)	AMOUNT OWED
Note: Only the total amount remaining on your loan/debt balance should be entered on the lines below	
Home Mortgage	$
Mortgage on Other Property	$
Loans on Vehicles	$
Credit Card Balance(s)	$
Other Loans	$
Other Debt	$
TOTAL LIABILITIES	$

NET WORTH (assets minus liabilities) $

Note: If self-employed, give value of all equipment, supplies and inventory