Thorek MEMORIAL HOSPITAL

ADMINISTRATIVE POLICY

CATEGORY: ADMINISTRATION **POLICY:** AD-115

TITLE: FINANCIAL ASSISTANCE/UNINSURED PATIENT DISCOUNT / PRESUMPTIVE ELIGIBILITY **INITIATED:** 3/04

REVISED: 5/04, 7/04, 2/05, 4/06, 6/07, 11/07, 4/08, 2/09, 1/11, 6/11, 6/12, 1/13, 1/14, 12/15, 5/16.

Thorek Memorial Hospital (TMH) is committed to meeting the needs of everyone in their communities, including those who cannot pay for their care. Therefore, TMH is providing financial assistance to all patients who qualify under this policy to receive financial assistance and discounted services.

Commitment to Provide Emergency Medical Care

TMH provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. TMH will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd (EMTALA), are provided to all TMH patients in a non-discriminatory manner, pursuant to the TMH's EMTALA policy.

Eligible Services

This policy applies only to charges for emergency or other medically necessary services provided by TMH. Elective services are not eligible for financial assistance. Attached to this policy as **Attachment A** is a list of all providers, in addition to TMH itself, delivering emergency or other medically necessary care at TMH that specifies which providers are covered by this policy and which are not covered.

Financial Assistance Policy

TMH patients whose income level falls below 600% of the federal poverty level (FPL) will be considered for financial assistance. Financial assistance is defined as the forgiveness of all or a percentage of the outstanding patient debt for an inpatient admission, an outpatient encounter at TMH or any medically necessary care provided by the hospital. Financial assistance will be granted to those patients, regardless of sex, race, color, creed or religion, who:

- Lack third party insurance coverage,
- Have inadequate insurance coverage,
- Fail to be approved for financial assistance through established programs, such as Public Aid,
- Have filed for bankruptcy and have had debt discharged,
- Meet the eligibility criteria below,
- Credit report indicating credit score of under 600 and/or multiple creditors identifying accounts as seriously delinquent,
- Have limited assets to fulfill financial obligations.

Financial Assistance Eligibility and Application

Eligibility for financial assistance shall be determined solely by TMH based upon obtaining financial information from the patient in a sensitive and confidential manner. Patients must submit an application form **(Attachment B)** and submit it to TMH in person, by mail, by electronic mail, or by fax (see below for contact information) in order to apply for financial assistance. Determination of financial assistance eligibility shall be at the earliest opportunity but in no manner will it interfere with rendering of care. The financial information to be provided and reviewed for eligibility includes, but may not be limited to:

- A completed asset and liability information worksheet (see attached application for financial assistance),
- Proof of income (e.g. 1040 tax return, W-2 forms and three recent pay check stubs),
- A copy of the most recent bank statements for all checking, savings, and investment accounts,
- A computer printout from the State of Illinois showing unemployment benefits received during the last year if any,
- Documentation of monthly living expenses,
- Any other pertinent information provided and/or requested that would help determine eligibility.

Approval will be granted based upon the following:

- Federal poverty income guidelines:
    1. Income level 200% or below the FPL – 100% forgiveness,
    2. Income level 201%-600% of the FPL –
        a. For uninsured patients, the patient pays the lesser of the following two methods: 135% of cost (per Uninsured Patient Discount Policy below), or AGB (the Medicare allowable amount),
        b. For insured patients, with regard to the patient-responsible balance after insurance, the patient pays no more than AGB (the Medicare allowable amount),
    3. Forgiveness amounts determined by TMH are dependent upon asset/liability considerations,

- Patient cooperation in applying for medical assistance or other financial resources that may be available from outside sources,
- Patient/Guarantor payment history,
- Other patient assets available to pay the bill,
- Total resources available to patients,
- Verification that no other source of payment (Title XIX, local welfare, guardian, etc.) is available to the patient,
- Application and all supporting documentation are received at time of service or within 60 days of service date or determination of patient responsibility.

Approval for the financial assistance will be based on the level of outstanding debt, as follows:

Account Balance	Approval Authority
Up to $2,500	Collection Supervisor
$2,501-$5,000	Director, Patient Accounts
$5,001 to $25,000	Chief Financial Officer
$25,001 and above	President

The hospital will notify the patient of eligibility determination by letter within ten days after approval. A patient may reapply at any time if there are changes in income, assets or family size.

The approved application is effective for six (6) months unless patient financial information has changed since application.

As of the date of this revision, the table in **Attachment C** summarizes the current federal poverty guidelines as published in the Federal Register and will be updated annually.

If TMH is not able to obtain appropriate information to determine eligibility for financial assistance for any reason, including lack of cooperation, the associated amounts will NOT be considered for or granted financial assistance consideration.

Uninsured Patient Discount Policy

All TMH uninsured patients whose family income is between 201% and 600% of the FPL will be considered for a discount under the Illinois Hospital Uninsured Patient Discount Act (Act). The discount is determined by multiplying the hospital's charges by an uninsured discount factor of 135% of costs, as defined in the Act. The maximum amount that may be collected in a 12-month period for health care services provided by TMH under this provision is 25% of the patient's family income, and is subject to the patient's continued eligibility under the Act; provided, however, that this maximum collectible amount does not apply to uninsured patients who own assets with a value of more than 600% of the FPL (excluding the patient's primary

residence, personal property exempt from judgment under Illinois law, or certain amounts held in a pension or retirement plan).

For purposes of this provision, an "uninsured patient" means an uninsured Illinois resident, who is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, workers' compensation, accident liability insurance, or other third party liability.

An uninsured patient who receives a discount rate must cooperate with the hospital to establish a reasonable payment plan, which takes into consideration available income and assets, amount of the discounted bill(s), prior payments, and other outstanding medical claims. The patient must make a good faith effort to honor the payment plan agreed upon. Patients are responsible to communicate any change in their financial situation that may impact their ability to pay their discounted hospital bills or to honor the provisions of their payment plans.

Basis for Calculating Amounts Charged to Patients

Following a determination of eligibility under this policy, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care (AGB). TMH calculates AGB under the Prospective Medicare Method, which means that TMH determines AGB for any emergency or other medically necessary care provided to an individual eligible for financial assistance by using the billing and coding process TMH would use if the individual were a Medicare beneficiary and setting the AGB for the care at the amount Medicare would allow for the care (including both the amount that would be reimbursed by Medicare and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance and deductibles). TMH does not bill or expect payment of gross charges from individuals who qualify for financial assistance under this policy.

Measures to Widely Publicize the Availability of Financial Assistance

TMH will provide a means of communicating the availability of financial assistance to all patients to include signage in appropriate areas of the hospital, such as the admitting office, the emergency room and the ambulatory clinics. The communication will also be in languages appropriate to the hospital's service area. Upon patient request, designated departments and individuals will be available to explain the financial assistance policy. Annual education in-service classes will be conducted to ensure the staff fully understands this policy and can answer patient questions.

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Presumptive Eligibility Policy

Uninsured patients who meet one or more of the criteria listed below will be deemed presumptively eligible for financial assistance without any further scrutiny from the hospital. This Presumptive Eligibility Policy shall be applied as soon as possible after receipt of health care services and prior to the issuance of any bill. The following is a list of the presumptive eligibility criteria:

- Homelessness;
- Deceased with no estate;
- Mental incapacitation with no one to act on patient's behalf;
- Medicaid eligibility, but not on date of service or for non-covered service;
- Enrollment in the following assistance programs for low-income individuals having eligibility criteria at or below 200% of the federal poverty income guidelines:
    - Women, Infants and Children Nutrition Program (WIC);
    - Supplemental Nutrition Assistance Program (SNAP);
    - Illinois Free Lunch and Breakfast Program;
    - Low Income Home Energy Assistance Program (LIHEAP);
    - Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low-income financial status as a criterion for membership;
    - Receipt of grant assistance for medical services.

Actions Taken in the Event of Nonpayment

Additional information regarding the actions that TMH may take in the event of nonpayment are described in a separate Billing and Collection Policy. Members of the public may obtain a free copy of this separate policy from TMH via the contact information listed below.

Hospital Contact Information

Website: www.thorek.org

Telephone: 773-975-6843

Fax: 773-975-3220

Mail or In Person:
Thorek Memorial Hospital
850 W. Irving Park Road
Chicago, IL 60613
Attn: Patient Financial Services (Financial Counselor)
(When visiting in person, ask for a Financial Counselor at the Hospital Front Desk.)

Ned Budd, President and CEO

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ATTACHMENT A
PROVIDER LIST

Thorek Memorial Hospital maintains its provider list in a document separate from this Financial Assistance Policy. The list may be accessed at www.thorek.org, or contact Thorek Memorial Hospital for more information as follows:

Telephone: 773-975-6843

Mail or In Person:

Thorek Memorial Hospital

850 W. Irving Park Road

Chicago, IL 60613

Attn: Patient Financial Services (Financial Counselor)

(When visiting in person, ask for a Financial Counselor at the Hospital Front Desk.)

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ATTACHMENT B
FINANCIAL ASSISTANCE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Thorek Memorial Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Is patient an Illinois resident at the time of service? Y N
Is patient involved in an alleged accident? Y N
Is patient a victim of an alleged crime? Y N

SSN: _____ Telephone Number: _____

E-Mail Address: _____

Family/household information:
Number of persons in the patient's family/household: _____
Number of persons who are dependents of the patient: _____
Ages of patient's dependents: _____

Employer: _____ Address: _____
Monthly Income: _____

Guarantor/(Spouse if Responsible Party, Parent if Minor):
Name: _____ Relationship: _____ Date of Birth: _____
Employer: _____ Address: _____
Monthly Income: _____

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PLEASE ENCLOSE AT LEAST ONE OF FOLLOWING ITEMS TO DOCUMENT INCOME & ASSETS TO SUPPORT THE APPLICATION FOR FINANCIAL ASSISTANCE:

1) A COPY OF THE APPLICANT'S MOST RECENT TAX RETURN & W-2s.

2) A COPY OF ALL PAY STUBS OR WAGE STATEMENTS FROM EMPLOYERS SHOWING ALL GROSS INCOME FOR THE TIME PERIOD SINCE THE TAX RETURN YEAR IN 1) ABOVE.

3) A COMPUTER PRINT OUT FROM JOB SERVICE OF ILLINOIS SHOWING ALL UNEMPLOYMENT BENEFITS DURING THE LAST 4 QUARTERS, IF ANY.

4) A COPY OF MOST RECENT BANK STATEMENTS (3) FOR ALL CHECKING, SAVING AND INVESTMENT ACCOUNTS.

5) A COPY OF ALL HEALTH RELATED BILLS OUTSTANDING TO OTHER INDIVIDUALS OR INSTITUTIONS OTHER THAN THOREK (PHYSICIANS, EMERGENCY ROOM, ETC.)

6) IF ON SOCIAL SECURITY OR DISABILITY BENEFITS PLEASE PROVIDE A COPY OF REWARD LETTER.

If you cannot provide any documentation relating to your income, fill out the statement below:

I, _____ (name), certify that I have no documents that prove my family's monthly income of $ _____.

Presumptive Eligibility: UNINSURED patients who demonstrate one of the Presumptive Eligibility Criteria individually or through the benefits provided to their family are automatically eligible to receive free care and no proof of income will be requested. No further documentation is necessary.

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the hospital bill.

Signature of Patient _____ Date _____

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Office Use Only:

Date Received: _____ Patient Account Number(s): _____

_____

_____

ASSET INFORMATION

1) Savings Account: Current Balance $ _____

Financial Institution _____

Account Number _____

2) Checking Account: Current Balance $ _____

Financial Institution _____

Account Number _____

3) Other Assets: Stocks $ _____ Company _____

Life Insurance Cash Value $_____ Company _____

Other $_____ Please Explain _____

_____

4) Real Property: Auto _____
Make Model Year Value Amount Owed

Residential Property and Other Assets

Describe _____ Value $ _____

Amount Owed $ _____

5) Other Loans or Liabilities _____

Name of Institution	Purpose of Loan	Monthly Payments	Balance
Name of Institution	Purpose of Loan	Monthly Payments	Balance

6) Charge Cards _____

Monthly Payment Balance Credit Limit

_____

Monthly Payment Balance Credit Limit

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7) Please indicate the total amount of your family's monthly living expenses for the following:

Housing	_____
Utilities	_____
Food	_____
Transportation	_____
Child Care	_____
Loans	_____
Medical Expenses	_____
Other Expenses	_____
Total Monthly Living Expenses	$_____

OFFICE USE ONLY:

Annual Income (from tax returns, W-2s, Pay stubs) $ _____

Size of family unit _____ Poverty Guidelines (x2) $ _____

Poverty Guidelines (x3) $ _____

Information verified by: _____

Approved ( ) Disapproved ( )

Authorized Signature (refer to Financial Assistance Policy)

_____

Comments: _____

_____

_____

_____

PA Eligible Yes_____ No _____

SSI Eligible Yes _____ No _____

Credit Score/History:

_____

_____

_____

_____

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ATTACHMENT C
FEDERAL POVERTY GUIDELINES

Family Size	Annual Income	200%	600%
1	$11,880	$23,760	$71,280
2	$16,020	$32,040	$96,120
3	$20,160	$40,320	$120,960
4	$24,300	$48,600	$145,800
5	$28,440	$56,880	$170,640
6	$32,580	$65,160	$195,480
7	$36,730	$73,460	$220,380
8	$40,890	$81,780	$245,340

For families with more than 8 members add $4,160 to the annual income for each additional member. These guidelines will be updated annually after their revision and publication by the federal government in the Federal Register.