Policy #: PFS-03

Section: Patient Financial Services

Topic: Financial Assistance Program

Date Adopted: Reviewed:

Last Revision: 06/28/16

Authorized by:

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I. Purpose:

Mountainview Medical Center and its affiliates (collectively, "MMC") are not-for-profit, tax-exempt entities with a charitable mission of providing emergency and medically necessary health care services to residents of Mountainview Medical Center service area regardless of their financial status and ability to pay. The purpose of this Financial Assistance Policy is to ensure that processes and procedures exist for identifying and assisting hospital patients whose care may be provided without charge or at a discount commensurate with their financial resources and ability to pay. This Policy applies to each hospital department in the facility operated by Mountainview Medical Center.

II. Overview:

In furtherance of its charitable mission, the Hospital will provide both (i) emergency treatment to any person requiring such care; and (ii) medically necessary health care services to patients who are permanent residents of the Mountainview Medical Center service area (and others on a case-by-case basis) who meet the conditions and criteria set forth in this policy; in each case, without regard to the patients' ability to pay for such care.

The Hospital will provide financial assistance (care either for free or at discounted rates) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example, Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information demonstrating financial need, or other facts and circumstances readily demonstrate financial need; and (iv) the Hospital makes an administrative determination that financial assistance is appropriate based on the patient's ability to pay (as established by family

income or based on criteria demonstrating presumptive eligibility) and the size of the patient's medical bills.

After the Hospital determines that a patient is eligible for financial assistance, the Hospital will determine the amount of financial assistance available to the patient by utilizing the Financial Assistance Guidelines (set forth as **Exhibit 1**). The Guidelines reflect family income levels tied to the most recent Federal Poverty Guidelines, and establish corresponding discount percentages. The Guidelines are to be adjusted annually to reflect the annual update to the Federal Poverty Guidelines, and to adjust the corresponding discount percentages to ensure that, in all cases, a patient determined to be eligible for financial assistance will not be billed more than the amounts generally billed (AGB) by the Hospital for the same emergency or medically necessary services to individuals who have insurance covering such care.

MMC will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the mission of MMC; (ii) explains the decision processes of who may be eligible for financial assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to patients who are uninsured or otherwise eligible.

III. Nondiscrimination:

A. The Hospital will render health care services, inpatient and outpatient, to all Montana residents who are in need of emergency or medically necessary care, regardless of the ability of the patient to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this policy.

B. The Hospital will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

C. US Citizenship and Residency Requirement - Applicants for charity care shall provide the hospital with proof of US citizenship. The applicant shall provide the hospital with any of the identification documents listed in the identification section that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in the US during the time of service, has no residency in any other country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and issue a determination of ineligible until which time the patient meets one of these requirements for proof of citizenship.

IV. Definitions:

A. Assets: Cash or any item of economic value owned by the patient that can be readily converted into cash. Examples are cash, savings and checking accounts, certificates of deposit, treasury bills, stocks, bonds or other securities, accounts receivable, inventory, equipment, a house (other than primary residence), a car, and other property. For these purposes, assets do not include a primary residence or other property exempt from judgment under Montana law, or any amounts held in pension or retirement plans (although distributions and payments from such plans may be included as family income for purposes of this policy)

B. Bad Debt Expense: Uncollectible accounts receivable (where reasonable attempts to collect have been made), excluding contractual adjustments, arising from the failure to pay by patients: (i) whose health care has not been classified as financial assistance care; or (ii) who have qualified for financial assistance in the form of discounted care but have failed to pay the remaining balances due after application of discounts pursuant to this policy.

C. Family: The patient, his or her spouse (including a legal common-law spouse), any minor children supported by the patient, and any adults for whom the patient is legally responsible. In the case of a minor patient, family includes both parents, the spouse of a parent, minor siblings, and any adults for whom the patient's guarantor is legally responsible. If a patient or guarantor has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.

D. Family Income: The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, training stipends, military allotments, regular support from family members not living in the household (other than child support), government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.

E. Financial Assistance: Either full or partial reduction in charges to patients for emergency or medically necessary care, in the case of patients who are Financially Eligible, Presumptively Eligible, or Medically Indigent, as those terms are defined in this policy. Financial assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles, or both.

F. Financially Eligible: A patient who meets both of the following criteria: (i) the patient's family income is at or below 400% of the Federal Poverty Guidelines, as set forth in **Exhibit 1** hereto; and (ii) the patient's individual assets as of the date of service or of application do not exceed $7,500, and the patient's family assets do not exceed $15,000 as of the date of service or of applications demonstrated based, in each case, on factual information provided by the patient on the Financial Assistance Application.

G. Medically Indigent: A patient who incurs catastrophic medical expenses is classified as Medically Indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

H. Medically Necessary: Any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Medicare. Medically necessary services do not include: (i) non-medical services such as social and vocational services; (ii) elective cosmetic surgeries (for these purposes, cosmetic plastic surgery procedures designed to correct appearance for personal reasons are not considered "elective"); (iii) gastric bypass surgeries; (iv) tubal ligations and/or vasectomies; or (v) convalescent care.

I. Patient: As applicable depending on context, either the patient or his or her guarantor, *i.e.*, the person having financial responsibility for payment of the account balance.

J. Presumptively Eligible: A patient who has not submitted a completed Financial Assistance Application, but who nonetheless is subject to one or more of the following criteria:

- Homeless
- Deceased with no estate
- Mentally incapacitated with no one to act on his or her behalf
- Medicaid eligible, but not on the date of service or for non-covered services
- Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines
- Incarceration in a penal institution

The Hospital's trained Financial Service Representatives will routinely review the foregoing criteria with patients, before asking patients to complete the Financial Assistance Application. The Hospital may also utilize other software programs or automated systems to determine Presumptive Eligibility. Patients who meet any of the foregoing criteria for Presumptive Eligibility will be deemed to be eligible for a 100% discount, and will not be asked or required to submit a Financial Assistance Application.

V. Eligibility for Financial Assistance:

A. Financial assistance will be given for emergency or medically necessary services to patients who are Financially Eligible or Medically Indigent (in both cases, based on information provided via the Financial Assistance Application attached as **Exhibit 2**), or to patients who have been determined to be Presumptively Eligible. In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by the MMC CEO in his or her discretion.

B. A determination of qualification for financial assistance will cover services provided by the Hospital on an inpatient or outpatient basis. For these purposes, the policy also covers the rendering of professional services by physicians and other providers employed directly by the Hospital as listed on **Exhibit 3**. Any other physicians or providers of care at the Hospital are not subject to this policy and, accordingly, each patient will be responsible for satisfaction or resolution of any bills issued by such physicians or providers for their professional services.

C. Patients seeking financial assistance will be asked to complete the Financial Assistance Application attached as **Exhibit 2** to this policy. Copies of the application form are available at Mountainview Medical Center. Applications may be completed directly by the patient, by the patient's guarantor and/or other legal representative.

D. Patients completing the Financial Assistance Application must return the signed form and required supporting materials through any of the following measures:

   - Hand-deliver or Mail to Mountainview Medical Center, PO Box Q/16 W Main St, White Sulphur Springs, MT 59645

   Financial Assistance Applications will be considered if received at any time during the 240-day period following the first post-discharge billing statement issued by the Hospital to the patient for such care.

E. Eligibility for financial assistance is conditioned upon (i) the patient's provision of complete and accurate information on the Financial Assistance Application set forth as **Exhibit 2**, (ii) the patient's participation in an education session with a Patient Service Representative regarding insurance options available through the Montana Insurance Marketplace (health insurance exchange), Montana HELP, and (iii) the patient's timely cooperation throughout the financial assistance application process. In connection with determining a patient's eligibility for financial assistance, the Hospital will not request information other than as described on **Exhibit 2**, although patients may voluntarily provide additional information that they believe to be pertinent to eligibility. If the Hospital contacts the patient to request missing information, the patient will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being suspended from further processing; the patient may re-activate the Application by providing the requested

information at any time during the 240-day period following the first post-discharge statement issued by the Hospital to the patient for such care. If a patient provides information that is inaccurate or misleading, he or she may be deemed ineligible for financial assistance and, accordingly, may be expected to pay his or her bill in full.

F. Once a completed Financial Assistance Application is received, a review the application will be done by the CEO for approval.

G. Patients who are uninsured and who do not qualify for financial assistance may contact the Hospital to discuss payment options, including the availability of a payment plan. Financial Service Representatives will inform such patients of any other discounts that may be available under other MMC policies.

VI. Determination and Notification Regarding Financial Assistance:

A. In the case of patients who are determined to be Financially Eligible, patients with family income at or below 200% of the current Federal Poverty Guidelines will receive a 100% reduction in the patient portion of billed charges (*i.e.*, full write-off), as set forth on **Exhibit 1**. Patients with family income between 201% and 400% of the current Federal Poverty Guidelines will receive a sliding-scale discount on the patient portion of the billed charges, as indicated on **Exhibit 1**; *provided, however,* an uninsured patient will receive the discount for which the patient qualifies under **Exhibit 1** to this Policy. In the case of patients who are determined to be Medically Indigent, the patient will receive a 100% write-off of charges exceeding 30% of gross family income and/or an appropriate discount determined by the CEO after review on a case by case basis of annual family income; the 30% threshold needs to be met only once per family in a 12-month period. Patients who are determined to be Presumptively Eligible for financial assistance will receive a 100% reduction in charges (full write-off).

B. The applicable discount percentage from **Exhibit 1** will be applied to the gross charges otherwise billable to the patient. Such discounts have been established in a manner intended to comply with applicable Federal law, which prohibits the Hospital from billing a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients with third-party coverage, calculated in this case using the look-back method set forth in applicable Treasury Regulations, considering amounts allowed by Medicare and commercial payers during a prior 12-month measurement period. The discount percentages set forth on **Exhibit 1** may be adjusted periodically (and at least annually) to ensure that such percentages comply with the foregoing standards under Federal law; any such adjustments will be effectuated through the attachment of an updated **Exhibit 1** to this Policy. The Hospital will begin applying the adjusted discount percentages not later than 120 days after the end of the 12-month measurement period with respect to which the Hospital's adjusted AGB has been calculated.

C. Within 15 business days after submission of a completed Financial Assistance Application, the Hospital will determine whether the patient qualifies for financial assistance based on Financial Eligibility or Medical Indigence and will notify the patient in writing of such determination and the amount of the discount to be provided; if the patient is uninsured, the written notice will indicate that the financial assistance award is conditional upon meeting with a Financial Service Representative to learn about insurance options available through the Montana Health Insurance Marketplace.

VII. Impact on Billing and Collection Process:

A. Patients qualifying for discounted, but not free, care will be notified in writing regarding any remaining balance due.

VIII. Publication:

A. The existence and terms of this Financial Assistance Policy will be made widely available to residents of the Hospital's primary and secondary service areas. In furtherance of the foregoing, the Hospital will utilize and widely distribute the plain-language summary attached as **Exhibit 4** to this Policy. Copies of such plain-language summary (i) will be included in patient registration materials and inpatient handbooks, (ii) will be offered to each patient as part of the intake or discharge process, and (iii) will be posted on the Hospital's website, along with this Policy and the Financial Assistance Application, in a prominent and easily accessible location. This Policy, the plain-language summary, and the Financial Assistance Application will be available in English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's primary and secondary service areas.

B. The Hospital will conspicuously post, in the Patient Admitting and Registration areas as well as the Emergency Department, signage providing information regarding the availability of financial assistance and describing the application process. Such signage will include the following statement: *You may be eligible for financial assistance under the terms and conditions the Hospital offers to qualified patients. For more information, ask your registration or patient service representative for more information.* Such signs will be in both English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's primary and secondary service areas. Such signage will be posted in other areas throughout the Hospital's facilities offering meaningful visibility.

IX. The Hospital will include information on the website of contact information to receive the Financial Assistance Application.

X. Budgeting, Recordkeeping, and Reporting:

A. The CEO will ensure that reasonable financial assistance, including both free care and discounted charges, is included in the Hospital's annual operating budget. The budgeted amount will not act as a cap in providing financial assistance, but will serve as a projection to aid in planning for the allocation of resources.

B. The Hospital will cause completed Financial Assistance Applications (along with required supporting information) to be maintained in the Business Office records. Such records will also reflect information as to whether such Applications were approved or denied.

C. Financial assistance provided by the Hospital pursuant to this Policy will be calculated and reported annually as required under applicable law. Except as otherwise specifically permitted based on context, the Hospital will report its financial assistance provided to qualifying patients under this policy using the cost of services provided (not the charges for the associated services), with cost determined by applying the total cost-to-charge ratio derived from the Hospital's Medicare cost report.

XI. Confidentiality:

The Hospital recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient's Financial Assistance Application may be released except where authorized by the patient or otherwise required by law.

EXHIBIT 1

Financial Assistance Guidelines

2015 Federal Poverty Guidelines (FPG)

Family or Household Size	100% FPG	200% FPG	250% FPG	300% FPG	350% FPG	400% FPG
	Free Care	***Free Care***	***80% Discount***	***70% Discount***	***60% Discount***	***50%** Discount***
1	$11,770	$23,540	$29,425	$35,310	$41,195	$47,080
2	15,930	31,860	39,825	47,790	55,755	63,720
3	20,090	40,180	50,225	60,270	70,315	80,360
4	24,250	48,500	60,625	72,750	84,875	97,000
5	28,410	56,820	71,025	85,230	99,435	113,640
6	32,570	65,140	81,425	97,710	113,995	130,280
7	36,730	73,460	91,825	110,190	128,555	146,920
8*	40,890	81,780	102,225	122,670	143,115	163,560

* Add $4,160 for each additional person above 8 household occupants

** The foregoing discount percentage has been established in a manner intended to comply with applicable Federal law, which provides that the Hospital may not bill a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients who have insurance covering such care. The Hospital has calculated its AGB using the look-back method set forth in applicable Treasury Regulations, considering amounts paid by Medicare and commercial payers.

Exhibit 2

Mountainview Medical Center
PO Box Q/16 W Main
White Sulphur Springs, MT 59645
(406) 547-3321

FINANCIAL ASSISTANCE APPLICATION

GUARANTOR/ACCOUNT #_____

Name: _____ Spouse: _____

SS#: ____-___-___ DOB: ___/___/___ SS#: ___-__-___ DOB: ___/___/___

Street Address: _____ Street Address: _____

Mailing Address: _____ Mailing Address: _____

City/State/Zip: _____ City/State/Zip: _____

Marital Status: Married _____ Divorced _____ Widowed _____ Single _____

Please provide the following information so we can contact you regarding this document.

Home # _____ Work # _____ Cell # _____ Message # _____

Please list the names, relationship, and age of dependents currently living in the home:

NAME	SSN	AGE	RELATIONSHIP

EMPLOYMENT HISTORY

PLEASE ATTACH A COPY OF YOUR SOCIAL SECURITY STATEMENT, THREE MOST RECENT PAY STUBS AND YOUR MOST CURRENT FEDERAL INCOME TAX RETURN FOR BOTH YOU AND YOUR SPOUSE.

Present Employer:

Name: _____

Phone #: _____

Position: _____

Start Date: _____

Wage $: _____/hour Pay Dates: _____

Gross Monthly Income $ _____

Spouse's Present Employer:

Name: _____

Phone #: _____

Position: _____

Start Date: _____

Wage $: _____/hour Pay Dates: _____

Gross Monthly Income $ _____

ADDITIONAL INCOME

Self:		Spouse:	
Social Security Benefits	$_____	Social Security Benefits	$_____
Pension	$_____	Pension	$_____
Child Support	$_____	Child Support	$_____
Student Financial Aid	$_____	Student Financial Aid	$_____
Bonuses	$_____	Bonuses	$_____
Interest Income	$_____	Interest Income	$_____
Disability	$_____	Disability	$_____
Unemployment	$_____	Unemployment	$_____
Worker's Compensation	$_____	Worker's Compensation	$_____
Alimony	$_____	Alimony	$_____
TOTAL	$_____	TOTAL	$_____
Total Monthly Gross and Additional Income:	$_____	Total Monthly Gross and Additional Income:	$_____

BANK/CREDIT UNION INFORMATION

Self – Checking:

Spouse – Checking:

Bank Name: _____ Bank Name: _____

Checking Balance $ _____Checking Balance $ _____

Self – Savings: Spouse – Savings:

Bank Name: _____ Bank Name: _____

Savings Balance $ _____ Savings Balance $ _____

MONTHLY EXPENSES

Please provide verification where applicable

	Regular Monthly Payment	Amount Past Due
Mortgage/Rent	$ _____	$ _____
Groceries (Estimate)	$ _____	$ _____
Health/Life Insurance	$ _____	$ _____
Auto Insurance	$ _____	$ _____
Utilities (Lights, Water, etc)	$ _____	$ _____
Phone (Basic)	$ _____	$ _____
Cable	$ _____	$ _____
Child Care	$ _____	$ _____
Transportation(estimate)	$ _____	$ _____
Child Support	$ _____	$ _____
Hospital/Clinic	$ _____	$ _____
Pharmacy	$ _____	$ _____
Medicare Premium	$ _____	$ _____
Taxes (Property)	$ _____	$ _____
Alimony	$ _____	$ _____

Please bring a copy of Property Taxes

MORTGAGE INFORMATION

1ST Mortgage Company: _____

Current: Yes _____ No _____ If no, number of months behind: _____

Purchase Price $ _____ Balance $ _____ Equity $ _____ Value $ _____

2nd Mortgage Company: _____

Current: Yes _____ No _____ If no, number of months behind: _____

Purchase Price $ _____ Balance $ _____ Equity $ _____ Value $ _____

OPEN ACCOUNTS

CREDITOR	PHONE #	BALANCE	MONTHLY PAYMENT

LOANS
(Automobiles, Recreational Vehicles, ect.)

Year	Make	Model	Owner(s)	License #	Balance	Value

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

I acknowledge that the information given to Mountainview Medical Center on this financial statement is true and correct. I authorize Mountainview Medical Center to contact my employer(s) to verify my income.

Applicants Signature: _____ Date: _____

Spouses Signature: _____ Date: _____

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IF NO PROOF OF INCOME OR TAX RETURN PROVIDED, YOUR FINANCIAL ASSISTANCE APPLICATION WILL BE DENIED.

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Proof of Income includes: Social Security/Disability Benefits, Workers Compensation, Child Support Unemployment, Wage Earnings Statement (from Social Security Office), and pay stubs.

If you have any questions, please contact Patient Financial Services:

Brenda Nelson (406) 547-3323 ext124

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FOR OFFICE USE ONLY

Total Annual Gross Income $ _____

Family Size _____

Federal Poverty Level % _____

Approved _____ Denied/Reason _____

Comments

Approved By: _____ Date: _____

Exhibit 3

Section: Patient Financial Services

Topic: Covered Services

Date Adopted: _____ Reviewed:

Last Revision: 06/27/2016

Authorized by: _____

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1.0 Policy

To clarify covered services rendered for Financial Assistance.

2.0 Procedure

The Following entities/providers covered for financial assistance:

a. Mountainview Medical Center Inpatient Services

b. Mountainview Medical Outpatient Services (Lab, Radiology, Recurring, ER)

c. All professional service rendered by physicians or other professionals employed by Mountainview Medical Center

Exhibit 4

You may be eligible for Financial Assistance under the terms and conditions the Hospital offers to qualified patients. For more information, ask your registration or Patient Financial Services Representative for more information.