FINANCIAL ASSISTANCE POLICY

POLICY:

Patients are expected to pay for services rendered. Franklin Medical Center will assist patients who indicate they are unable to meet their financial obligations. Patients may be determined as eligible for partial to full discounts utilizing the current poverty guidelines issued by appropriate government agencies or by the amount of medical bills relative to earnings.

FMC will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or ability to pay.

This written policy describes:

A. Eligibility criteria for services and patients that may qualify to receive financial assistance;
B. Basis for calculating amounts charged to patients eligible for financial assistance;
C. The method by which patients may apply for financial assistance;
D. Actions that may be taken by the hospital for non-payment;
E. How the hospital will publicize the policy within the community served by the hospital; and
F. The keeping of records on financial assistance applications.

A. SERVICES AND PATIENTS THAT MAY QUALIFY FOR A PATIENT TO RECEIVE FINANCIAL ASSISTANCE

Only emergency or medically urgent services may qualify for financial assistance. Such services shall include:

- services provided in an emergency room setting,
- services for a condition which, if not promptly treated would lead to an adverse change in health status of the patient,
- services provided in response to life-threatening circumstances in a non-emergency room setting; and
- Medically necessary services.

Services that DO NOT qualify for a patient to receive financial assistance

Non-medically necessary, elective or cosmetic services, fertility treatment and infertility treatment (including tubal ligation and vasectomy).

Patients who MAY qualify for financial assistance

Patients who supply requested information and fall within guidelines outlined below;
Presumptive eligibility can be based on the patient's current status with federal or state agencies;

Patients who DO NOT qualify for financial assistance

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with CRMC's policy and procedures for obtaining financial assistance or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Patients who appear to qualify for State, Federal or other benefits that would cover all or part of their care must cooperate with the appropriate application process to be considered for financial assistance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services, for their overall personal health and for the protection of their individual assets.

ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE

Patients may qualify for financial assistance one of two ways:

1) meeting certain income criteria based on the Federal Poverty Guidelines or
2) incurring medical expenses that meet certain percentages of annual income.

Income Criteria

If the patient's financial need is permanent instead of circumstantial the patient then may apply to qualify for charity care. Prior to being approved for charity care, an eligible patient/guarantor must have exhausted all other possibilities for third-party payer reimbursement, including applying for Medicaid. Requested documentation by Franklin Medical Center should be submitted to justify the determination and deemed necessary as part of the Charity Care program application. Staff will determine eligibility for the program based on federal poverty guidelines, sliding scale eligibility, financial documentation and verification of income. An adjustment code will be assigned to each level of discount. The granting of the discount will be noted in the patient's account.

Adjustments to charges will be calculated as follows:

% of Federal Poverty Guidelines	Percent Discount
201-300%	20%
201-250%	40%
151-200%	60%
101-150%	80%
<100%	100%

The granting of the adjustment will be noted in the patient's account. Approved applications will be valid for a period of 6 months from the date of determination, after which time the patient will need to re-apply. The patient's account status will never be permanently designated as financial hardship. The patient's status will be reviewed periodically.

Medical Expense Guidelines

Franklin Medical Center recognizes the need to serve all individuals with medical care regardless of financial ability. Therefore, the FMC Charity Care program is available for those clients seeking care, but who are unable to pay for a portion or all of services rendered due to a patient's financial need that is permanent such as disability or fixed income. The Charity Care program establishes a consistent process for determination of eligibility. Note: FMC outpatient Clinics are excluded from this Charity Care policy.

The need for charity care is addressed as soon as the individual indicates a need. If the patient's financial need is permanent instead of circumstantial the patient then may apply to qualify for charity care. Prior to being approved for charity care, an eligible patient/guarantor must have exhausted all other possibilities for third-party payer reimbursement, including applying for Medicaid. Requested documentation by Franklin Medical Center should be submitted to justify the determination and deemed necessary as part of the Charity Care program application. Staff will determine eligibility for the program based on federal poverty guidelines, sliding scale eligibility, financial documentation and verification of income. An adjustment code will be assigned to each level of discount. The granting of the discount will be noted in the patient's account.

Patients with documented income below 300% of the Federal Poverty Guidelines may apply for assistance due to excessive medical bills relative to income. The financial assistance application process must be followed and medical bills must be documented. Patients will only be responsible for a portion of their FMC bills as follows:

Medical Expense % of Annual Income	**Discount on Patient Responsibility**
0-50%	20%
51-100%	40%
101-150%	60%

151-200%	80%
201-300%	100%

B. Basis for Calculating Amounts Charged to Patients, or Amount Generally Billed (AGB)
Patients who are uninsured or under-insured must be charged less than gross charges for any care they receive and no more than the amount generally billed (AGB) to insured patients for emergency or medically necessary care. FMC utilizes the look-back method for the prior fiscal year activity to calculate AGB. The look-back method which is based on actual claims paid by Medicare fee-for-service and Medicare beneficiaries, or by Medicare fee-for-service plus all private health insurers and their beneficiaries. Patients that apply for financial assistance will be eligible for the AGB discounts.

C. The Method for applying for financial assistance
Need to describe and include application form.

D. Actions that may be taken by the hospital for non-payment
Patients who are deemed eligible for Charity Care and qualify for reductions in patient responsibility will be required to meet a payment obligation for the remainder of the balance, if any. The terms will be agreed upon at the time eligibility is established. If the terms are not met in the timeframe allotted the Charity Care discount will not be applied and the patient will be responsible for the total amount billed.

E. How the hospital will publicize the policy within the community served by the hospital
FMC will make this Financial Assistance Policy known to the public using various means which may include flyers posted in Admitting areas, publication in local and area newspapers, flyers posted in physician offices, communication with local healthcare providers including Home Health, Hospice case managers and social workers, and communication with local service organizations as the opportunities arise.

F. Recordkeeping
Applications will be logged and given a central control number. Completed applications will be kept on file for five (5) years. Accounts with approved applications will receive a write-off that will be recorded using the direct write-off method. Separate adjustment codes will be assigned for each type and level of adjustment.

NHSC-Approved Sites

Offers a sliding scale fee discount program. The amount owed for services by eligible patients are adjusted based on income and family size.

- Available to all individuals and families with annual incomes at or below 200 percent of the most current federal poverty guidelines.
- To qualify for 100% full discount an individual or family shall have an annual income at or below 100% of the most current federal poverty guidelines.
- Fees will be adjusted based on the family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of federal poverty guidelines.
- Patients of NHSC-Approved Sites are made aware of the sliding scale program.
- Sliding scale eligibility requirements for discounts at NHSC-Approved Sites is based on income and family size and no other factors.
  https://www.fmc-cares.com/services/financial-counseling/
  https://www.fmc-cares.com/non-discrimination/