



**SHENANDOAH MEDICAL CENTER
300 PERSHING AVE
SHENANDOAH, IOWA 51601**

Subject: Financial Assistance Policy

Effective Date:

Purpose: To define eligibility criteria for financial assistance

Policy:

Shenandoah Medical Center is a not for profit healthcare organization guided by a commitment to its mission and core values through compassionate service. It is both the philosophy and practice of each SMC facility and provider that medically necessary healthcare services are available to patients, and those in emergent medical need, without delay and regardless of their ability to pay.

Patients qualifying for SMC financial assistance will receive care provided at a discounted fee. The SMC financial assistance policy is intended to be compliant with applicable federal and state laws. Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy's application procedures and those of public benefit or coverage programs that may be available to cover the cost of care. Shenandoah Medical Center will not discriminate on the basis of age, sex, race, creed, color, disability, sexual orientation, national origin, or immigration status when making financial assistance determinations.

The purpose of this policy is to outline the circumstances under which financial assistance may be provided to qualifying low income patients for medically necessary healthcare services provided at facilities or by providers that are a part of the Shenandoah Medical Center.

Definitions:

The following definitions are applicable to all sections of this policy.

Amount Generally Billed: The amount generally billed is the expected payment from patients, or a patient's guarantor, eligible for financial assistance. For uninsured patients this amount will not exceed the rate of average payment received retrospectively from Medicare and private health insurers, including all patient responsibility. For patients with third party coverage, the payer will determine allowable amount and patient's financial responsibility.

Assets: Certain assets will be considered in making a determination of eligibility for financial assistance.

Discounted Care: Financial assistance that provides a percentage discount, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes 200% of the Federal Poverty Level.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd), the term "emergency medical condition" means:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

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- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions—
 - that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue

Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Assets: An applicant's family assets are the combined assets (as follows) of all adult members of the family living in the household. Assets include bank accounts, CD's, investment accounts, real estate (excluding primary residence) and miscellaneous other assets. Retirement fund assets are not considered to be part of family assets.

Family Income: An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parents and/or step-parents, or caretaker relatives.

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced [at http://aspe.hhs.gov/POVERTY/](http://aspe.hhs.gov/POVERTY/).

Financial Assistance: Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for medically necessary care provided by SMC.

Free Care: A 100% waiver of patient financial obligation resulting from eligible medical services provided by SMC for eligible uninsured and underinsured patients, or their guarantors, with annualized family incomes at or below 200% of the Federal Poverty Level.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

Gross charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.



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Medically Necessary: As defined by the State Medicaid programs in Nebraska and Iowa, as services or supplies which are medically appropriate and necessary to meet basic health needs consistent with the diagnosis of the patient's condition. Treatment should be in accordance with standards of good medical practice with demonstrated value and consistent in type, frequency and duration with scientifically based guidelines of national medical research or healthcare coverage organizations or governmental agencies. Treatment to be required to meet the medical need of the patient for reasons other than convenience of the patient or the patient's practitioner or caregiver. Treatment is to be rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service within a proper balance of safety, effectiveness and efficiency.

Payment Plan: An extended payment plan that is agreed to by both SMC and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

Qualification Period: Applicants determined eligible for financial assistance will be granted assistance for a period of six months from date of approval. Assistance will also be applied retroactively to unpaid bills incurred for eligible services that are active within SMC accounts receivable.

Uninsured Discount: Patients ineligible for financial assistance and having no third- party coverage for emergency or medically necessary services provided by SMC will be granted a discount equal to that of the average amount generally billed.

Underinsured Patient: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by SMC.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and Tricare,) Worker's Compensation, or other third party assistance to assist with meeting a patient's payment obligations.

ELIGIBLE SERVICES:

Services eligible under this financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:

- Emergency medical services provided in an emergency setting. Care provided in an emergency setting will continue until the patient's condition has been stabilized prior to any determination of payment arrangements.
- Services for a condition that, if not treated promptly, would lead to an adverse change in the health status of a patient.
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
- Other medically necessary services, for example, inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease

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or its symptoms. Also, services typically defined by Medicare or other health insurance coverage as “covered items or services.”

- Services of healthcare providers employed by MHS and delivered in MHS facilities.

Services not eligible for financial support include the following:

- Elective procedures not medically necessary.
- Cosmetic surgery, services or products offered through the Skin Renewal Clinic, reproductive services, bariatric procedures not covered by insurance, experimental care, or services provided under a clinical research program.
- Services of healthcare providers employed by SMC but delivered in private offices, not in SMC facilities.
- Those services received from care providers not billed by MHS. Care providers not billed by MHS may include: radiologists, anesthesiologist, surgeons, hospitalist, wound clinic physicians, neonatologist, pulmonologists, plus various physician specialists as well as ambulance transport. Patients must contact the service providers directly to inquire into assistance and make payment arrangements directly with these practitioners.

ELIGIBILITY CRITERIA:

- Financial assistance will be extended to uninsured and underinsured patients, or a patient’s guarantor, in accordance with SMC policy. Eligibility will be considered for those individuals who are unable to pay for their care; it will be based on a combination of family income, assets, and medical obligations.
- Financial assistance will be extended to patients, or a patient’s guarantor, based on financial need and in compliance with federal and state laws. Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient’s guarantors, choosing not to cooperate in applying for programs identified by SMC as possible sources of payment for care, may be denied financial assistance.
- In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations.
- Patients, or patient’s guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance. They are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.
- Financial assistance is typically not available for patient co-payment or balances after insurance when a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Financial assistance will be offered to underinsured patients providing such assistance is in accordance with insurer’s contractual obligations

FINANCIAL ASSISTANCE:

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- The type of assistance to be provided will be based on a combination of family income, family assets, and medical obligations. The federal poverty level will be used to determine an applicant's eligibility for financial assistance. Eligible applicants will receive the following assistance.

Uninsured Discount: Patients with no third-party coverage will be granted a discount on SMC bills equal to that of the amount generally billed.

Full Free Care: The full amount of SMC charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 200% of the current federal poverty level and assets are not available to pay the amount due.

Discounted Care: The SMC sliding fee scale will be used to determine the amount eligible for financial assistance for any uninsured or underinsured patient, or patient guarantor, with gross family incomes less than 200% of the current federal poverty level after all third party payment possibilities available to the applicant have been exhausted or denied and personal financial resources have been reviewed and assets are not available to pay for billed charges

Medical Hardship: Shenandoah Medical Center charges may be eligible for financial assistance for patients or guarantors with family income less than 200% of the federal poverty level when circumstances indicate severe financial hardship. Patients, or their guarantors, may be eligible for medical hardship assistance if they have incurred out-of-pocket obligations resulting from medical services provided by SMC, as well as other healthcare providers.

Payment Plans: Payment in full is expected, for balances due, within 30 days of the initial invoice. If unfeasible for a patient or guarantor to pay in full within this timeframe, a payment plan may be extended for up to three months. Arrangements for payment plans must be made with SMC Customer Service or SMC Patient Financial Counselor. If approved, the plan will be interest-free. Payment plans are developed only after Financial Assistance eligibility is determined.

Patients are responsible for communicating with customer service anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

Eligibility determinations for financial assistance will be based on the SMC policy and an assessment of the applicant's financial circumstances and need. Patients will be informed of the financial assistance policy and the process for submitting an application. Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement. Patients, or patient's guarantor, have a responsibility to cooperate in applying for financial assistance by providing information on family size and documentation of income and assets.

Shenandoah Medical Center will make reasonable effort to explain the benefits of Medicaid and other available public and private coverage programs to patients, or a patient's guarantors. The SMC will take



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steps to help patients, or a patient's guarantor, apply for programs that may assist them in obtaining and paying for healthcare services. Patients identified as potentially eligible will be expected to apply for such programs; those patients choosing not to cooperate in applying for programs may be denied financial assistance

In the case of incomplete applications, the applicant will be notified in writing of all required information or documentation to complete the application. The applicant will be informed that this information must be received within 30 days of the date the notification was postmarked. If the applicant does not respond with the information needed to complete the application within the 30 day timeframe, the request for assistance will be denied.

Information on the SMC financial assistance policy will be communicated to patients in easy-to-understand, culturally appropriate language, and in the primary language spoken by the lessor of 1,000 or 5% of the residents in communities comprising the SMC service area.

Documentation: Eligibility for financial assistance shall be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, SMC may seek additional information.

Income Documentation Includes:

1. Copy of the tax return from the most recent tax year including all schedules, W-2s, and 1099s.
2. A copy of the most recent pay stub.
3. If social security income: a copy of check or a copy of benefits letter.
4. If unemployed: verification of any compensation received. Example: unemployment compensation, workers compensation

Asset Information: Applicants will also be asked to provide information on monetary assets such as checking accounts, savings or money market accounts, certificates of deposits, non-retirement investment accounts as well as real estate other than the primary residence and other assets.

A financial assistance application form must be completed and documentation provided in order to make an eligibility determination. If an application is incomplete, or there has been a request for additional information, the application will remain active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30 day timeframe, the application will be denied.

Financial assistance applications are to be submitted to the following office:

**Shenandoah Medical Center
ATTN: Financial Counselor
300 Pershing Ave**



**SHENANDOAH MEDICAL CENTER
300 PERSHING AVE
SHENANDOAH, IOWA 51601
Shenandoah, Iowa 51601
712-246-1230 or 712-246-7201**

Completed requests for financial assistance shall be promptly processed and applicants will be notified within 30 days of receipt of a completed application. If eligibility is approved, SMC will grant financial assistance for a period of six months. Financial assistance shall also be applied to unpaid bills incurred for eligible services that are within 240 days of the first post-discharge statement. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

If denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

PRESUMPTIVE ELIGIBILITY:

Shenandoah Medical Center understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by SMC to determine whether a patient's account is uncollectible and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

- homelessness or receipt of care from a homeless clinic or shelter;
- patient deceased with no known estate;
- Women, Infants and Children (WIC) program;
- SNAP benefits (Supplemental Nutritional Assistance Program, (formerly known as Food Stamps) as proof of need, and are therefore presumptively eligible).
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For patients who are non-responsive to the SMC application process, information from other sources may be used to make an informed decision on the financial need of non-responsive patients. The purpose of using this information is to make the best estimate available in the absence of information provided directly by the patient.

The SMC utilizes a presumptive eligibility analytics solution that examines historical data combined with household economic information. It evaluates accounts based on the following standards: available household income, household size, capacity to make payment, and over-extension compared to federal poverty guidelines. The analytics solution uses socioeconomic data from numerous sources including Census data. Using this presumptive eligibility approach, a score is assigned at the individual patient



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level. The score enables Patient Financial Services to meet internal processing requirements while providing a community benefit through forgiving account balances for those in need.

This approach enables SMC to evaluate accounts for financial assistance equally, regardless of the patient's ability to complete an application for assistance.

When the presumptive eligibility solution is the basis for determining eligibility, a full free care discount will be granted for eligible services for retrospective dates of service only. These accounts will not be sent to collection and will not be included in bad debt expense.

In the event a patient does not qualify under the presumptive rule set, the patient may still be considered under the traditional financial assistance application process.

APPEALS AND DISPUTE RESOLUTION:

Applicants denied financial assistance may appeal the determination in writing by providing information on the reason for the appeal and any relevant information. An appeal letter must be received within 30 days of the date of the determination letter.

Disputes and appeals may be filed by contacting:

**Shenandoah Medical Center
ATTN: Financial Counselor
300 Pershing Ave
Shenandoah, Iowa 51601
712-246-1230 or 712-246-7201**

The appeal will be reviewed and a written decision provided to the patient within 30 days of receiving a completed, written appeal.

NOTIFICATION OF FINANCIAL ASSISTANCE:

Information on financial assistance will be available to patients and the community served by SMC. The SMC financial assistance policy, application and a plain language summary of the policy will be available on the system's website.

Financial assistance information will also be provided in the patient admission information package. Information on the SMC financial assistance policy and instructions on how to contact SMC for assistance and further information will be posted in hospital and physician clinic admitting and registration locations, as well as the hospital(s) emergency departments. Financial assistance information will also be included in patient statements.



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Information on financial assistance, and the notice posted in hospital and physician clinic locations will be in English, Spanish and in any other language that is the primary language spoken by the lessor of 1,000 or 5% of the residents in the service area.

A request for financial assistance may be made by the patient, a patient's guarantor, a family member, close friend, or associate of the patient, subject to applicable privacy laws. The SMC will respond to oral or written requests for more information on the financial assistance policy made by a patient or any interested party. Any SMC staff member may make a referral of a patient to a financial counselor to examine eligibility for financial assistance.

The SMC will distribute informational materials on the financial assistance policy to agencies and non-profit organizations serving the low-income population in the particular hospital or clinic service area.

REGULATORY REQUIREMENTS:

Shenandoah Medical Center will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that SMC track financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

RECORD KEEPING:

Shenandoah Medical Center will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.