Financial Assistance Program

Neosho Memorial Regional Medical Center, its employed physicians, owned clinics, home health, hospice, ambulance and ancillary services, (hereinafter referred to as NMRMC), are committed to providing Financial Assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government programs, or otherwise unable to pay for medically necessary care based on their individual financial situation.

NMRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. NMRMC will provide without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance. If any individual presents with an emergency medical condition, NMRMC will provide further medical examination and treatment as required to stabilize the medical condition and/or transfer of the individual to another medical facility without regard to ability to pay within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd).

This written policy:

- Includes eligibility criteria for financial assistance: full or partially discounted care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how NMRMC will publicize the policy within the community served by the hospital
- Limits amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to amount generally billed to commercially insured or Medicare insured patients.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with NMRMC's procedures for obtaining financial assistance or other forms of payment and to contribute to the cost of their care based on their individual ability to pay.

Individuals with 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.

In order to manage its resources responsibly and to allow NMRMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Trustees established and approved the following guidelines for the provision of the Financial Assistance Program.

FAP DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

Financial Assistance: Discounted care provided to patients who are uninsured for the relevant medically necessary service, ineligible for government or other charity care benefit, and unable to pay. NMRMC maintains two types of Financial Assistance, Financially Indigent and Medically Indigent.

Financially indigent: The patient is uninsured and their yearly household income is less than or equal to 250% of the Federal Poverty Guidelines (FPG) based on the number of person(s) in their household.

Medically Indigent: The patient's medical or hospital bills from NMRMC and related providers, after payment by all third parties, exceeds 25% of his or her yearly household income, whose yearly household income is greater than 250% but less than 400% percent of the federal poverty guideline (FPG), and patient is unable to pay the outstanding patient account balance.

Household: One or more people who reside together is considered a household. If the patient claims someone as a dependent on their income tax return, they may be considered a dependent (or part of the household) for purposes of the provision of financial assistance.

Gross Household Income: Gross Household Income is income before taxes are deducted and is determined by Federal poverty guidelines and includes the following: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veteran's benefits/payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, annuities, commissions, bonus', income from estates, trusts, educational assistance, alimony, child support, personal allowance, household expenses (rent, utilities, etc) in exchange for any type of services, self-employment records, and other miscellaneous sources.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions; Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: The definition of Medically Necessary is services or items reasonable and necessary for the diagnosis or treatment of illness or injury. Medically necessary services does not include cosmetic surgery or procedures, fertility treatments, and infertility treatments (tubal ligation, vasectomy).

Eligibility Criteria and Amounts Charged to Patients

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity may be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Services eligible under this Policy may be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Guidelines in effect at the time of the determination. Once a patient has been determined by Hospital to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts Hospital will charge patients qualifying for financial assistance is as follows, but not limited to:

1. Patients who are uninsured and whose family income is at or below 250% of the FPG are eligible to receive care at a fully discounted rate.

2. Patients who are uninsured or underinsured and whose family income is above 250% but not more than 400% of the FPG are eligible to receive services at discounted rates no greater than the amounts generally billed to commercially insured or Medicare patients.

3. Patient who are uninsured or underinsured and whose family income exceeds 400% of the FPG may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Hospital. The discounted rates may not be greater than the amounts generally billed to (receive by the hospital for) commercially insured or Medicare patients for the patients deemed eligible.

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, Hospital could use outside agencies in determining estimate of income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include, but are not limited to:

1. State-funded prescription programs

2. Homeless or received care from a homeless clinic

3. Participation in Women, Infants and Children programs (WIC)
4. Food stamp eligibility
5. Subsidized school lunch program eligibility
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
7. Low income/subsidized housing is provided as a valid address
8. Patient is deceased with no known estate
9. Medicaid Program participants where coverage is denied for maximum confinement, or non-covered services
10. Bankruptcy declared and confirmed within the prior (12) months of hospital services being rendered
11. Any uninsured account returned from a collection agency as uncollectable
12. Participation in Temporary Assistance for Needy Families (TANF) Program
13. Participation in Children's Health Insurance Program (CHIP)
14. Participation in Free lunch program at children's respective school
15. Participation in County Indigent Health Care programs
16. Hospital services provided with no history of payments
17. Patient has stated that he/she does not have the resources to pay
18. Patient has been given an indigent or charity care application but has not returned the application or the necessary documentation
19. The address on file is no longer a good address
20. Other factors that are useful in formation an expectation of payment

Patients who provide false information or who do not cooperate will not be eligible for charity care or discounted care assistance.

APPLICATION PROCESS

Application: The attached application will be used by patients to apply for Financial Assistance from NMRMC. Patients must fully complete and submit the application for financial assistance along with all required personal information, financial information, and any other information and documentation required and/or requested, to make a determination of financial need. The need for financial assistance shall be re-evaluated at each subsequent time of service and application updated. Additionally, patients are screened and counseled again for all possible payment sources. If the patient does not submit relevant information that could affect eligibility status within the 240-day eligibility period, this may result in denial of financial services depending on the nature of the information.

Requests for Financial Assistance must be submitted within 30 days from the receipt of the application and shall be processed promptly by NMRMC. NMRMC will notify the patient or applicant in writing of the approval or denial.

Patients who do not have insurance may qualify for Financial Assistance based on their gross monthly or annual income and their family size. Patients having insurance may also be eligible based on their gross monthly or annual household income and their family size for the portion of their bill that is not covered by insurance, including deductibles, coinsurance, and non-covered services.

NMRMC staff will provide upon request, application assistance and/or translation services per Case Management Policy # 709.032 titled INTERPRETERS.

NMRMC shall provide anyone who requests information regarding the Financial Assistance Program a plain language summary, application form, (and copy of the FAP policy if requested). Additionally, the application and policy can be obtained in any of the following manners: NMRMC website (www.NMRMC.com), mail request, in person at Registration and/or ER Registration. See section 8.1 for additional methods of obtaining financial assistance information.

The notification period starts with the date care is provided and ends 120 days after the date of the first statement. NMRMC will not engage in Extraordinary Collection Activities (ECA) until the end of the notification period, which is 120 days after the date of the first statement and UNLESS FAP eligibility has been determined. During the notification period, NMRMC will send three statements detailing FAP availability and a "final notice" which provides at least 30 days for the patient to respond and apply for financial assistance. Extraordinary Collection Activity (ECA) will start at the 121st day IF FAP application is not received. ECA is defined as anything that requires a legal or judicial process (including wage garnishment, liens, lawsuits, etc.); reporting adverse information to credit bureaus; and selling a debt. NMRMC will cease ECA if the patient chooses to apply within 240 days from date of the first statement for accounts where the patient has not applied yet for financial assistance.

APPLICATION REVIEW PROCESS

Financial Assistance Review: Once the completed application and documentation are received, NMRMC will:

1. Initiate a screening for 3rd party and/or any possible payment coverage based on information within the application completed by patient(s). Patient will be contacted if

another possible type of payment coverage is determined and will be required to apply for it.

2. If patient is not eligible for 3rd party or other payment coverage, the application and required documentation will be analyzed (per procedure) to make a determination of financial assistance eligibility.

3. Eligibility Criteria for NMRMC is based on Household size and Gross Total Household Income. Services eligible under this policy will be made available to the patient at a rate up to 100% and decreasing on a sliding fee scale based on following percentage in relation to the poverty guidelines.

HHS Poverty Guidelines	Percentage Adjustment
At or below 250%	100%
Between 251% and 275%	85%
Between 276% and 300%	70%
Between 301% and 325%	55%
Between 326% and 350%	40%
Between 351% and 375%	25%
Between 376% and 400%	10%
Over 400%	0%

Financial Information: NMRMC retains the right to offer financial assistance only if the patient completes a financial assistance application and supplies other information requested and required by NMRMC. A variety of information may be requested by NMRMC to substantiate financial circumstances, such as paycheck stubs, W-2 forms, income tax returns, unemployment, child support documentation, disability statements, employment verification from the patient's employer, etc. If those items are unavailable, a letter of support from individuals providing for the patient's basic living needs might be accepted.

Timing: Processing for the application time is 240 days starting with the day patient bill is submitted to the individual or responsible party. If the patient is not mailed a bill due to NMRMC administrative reasons, the 240-day processing will start immediately after insurance pays or if the patient doesn't have insurance, it will start the date of the patient's discharge. NMRMC will continue processing the application throughout this time period until it is complete.

Approval: Approval and authorization of individual Financial Assistance write-off will require two signatures and NMRMC's decision will be made by the following individuals:

- Amount to be approved and written off in Financial Assistance Category <$1,500.00 = Patient Financial Services Director

- Amount to be written off in Financial Assistance Category ≥$1,500.00 = CFO/CEO

Approval Notification: The patient shall be notified in writing within ten (10) working days after receipt of the Financial Assistance application and any supporting materials as to whether the patient qualifies for the Financial Assistance Program. When the patient is notified that s/he is eligible for Financial Assistance, the patient shall receive a letter that states Financial Assistance has been approved.

Denial & Appeal: If a patient is denied Financial Assistance, the patient will be informed in writing within a reasonable amount of time of the denial. All reason(s) for denial shall be provided at that time and the patient shall be informed of the appeal process.
Each patient denied Financial Assistance may petition NMRMC within thirty (30) days for reconsideration based on extenuating circumstances. The patient will be notified of the appeal process in the correspondence informing the patient of the Financial Assistance denial.

Communication of the Charity Program to Patients and Within the Community

Notification about charity care available from NMRMC shall be disseminated by NMRMC by various means, which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the Conditions of Admission form, at admitting and registration departments, and patient financial services offices that are located on the NMRMC's campuses, and at other public places as NMRMC may elect. NMRMC may also provide a summary of this charity care policy on facility websites, in brochures available in-patient access sites and at other places within the community served by the hospital as NMRMC may elect. Such notices and summary information shall be provided in the primary languages

spoken by the population serviced by NMRMC. Referral of patients for charity may be made by any member of the NMRMC's staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. The patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws, may make a request for charity.