Benson Hospital

Policy Name: Financial Assistance Policy

Authority Issuing: Business Office CZ Policy El Procedure [1] Clinical Guideline

Policy/Procedure/Clinical Guideline No. F-10-01-2022 Initial Issuance: 40/

Authorized _____ _____ _____

1.0 Purpose

To further Benson Hospital's mission to the communities that it serves, Benson Hospital will provide financial assistance for medically necessary health care in a fair, consistent, respectful and objective manner to low-income patients who do not have insurance coverage or are underinsured.

2.0 Definition

a. The Community Care and Financial Assistance Policy is in keeping with Benson Hospital's commitment and mission to deliver caring, personalized, quality health care services to all patients regardless of ability to pay. True self-pay patients; those not eligible on dates of service or with non-covered benefits with the exception of elective package pricing, automatically receive a discount. When appropriate, Benson Hospital staff should determine if a patient qualifies for financial assistance.

b. Services provided to patients when payment is not anticipated because of an inability to pay - Financial assistance is available through Benson Hospital's "Financial Assistance Policy" (FAP) program. This policy is also known as our Community Care Policy. The FAP is separate and distinct from bad debts, which are accounts in which credit was extended and payment was anticipated but not received. Following the determination of FAP eligibility, an FAP-eligible individual will not be charged more for emergency or other medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care.

c. The Financial Assistance Policy applies only to charges associated with services provided by Benson Hospital. Charges for services provided by practitioners not employed by Benson Hospital may not be covered by this policy. Those providers are listed in the Appendix of this document.

d. Medically Necessary Refers to inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms, which otherwise left untreated would pose a threat to the patient's ongoing health status. Services must be clinically appropriate and within generally accepted medical practice standards, represent

the most appropriate and cost-effective supply, device or service that can be safely provided and readily available at Benson Hospital with a primary purpose other than patient or provider convenience. Expressly excluded from medically necessary services are: health care services that are cosmetic, experimental, part of a clinical research program, dental, private and/or non-Benson Hospital medical or physician professional fees, or services and/or treatments not provided at Benson Hospital.

e. The methodology used by Benson Hospital to calculate AGB is the Look-back Method. The current AGB rates are included in the Appendix to this document. Members of the public may request a description of how it is calculated by contacting Benson Hospital's Business Office at (520)720-6519 or by E-Mail at FAP@bensonhospital.org.

3.0 Policy

Consistent with its mission statement, Benson Hospital will provide available and necessary health care services, including for emergency medical conditions to patients, regardless of their disability, sexual orientation, age, sex, race, religion, creed, national origin or ability to pay.

Benson Hospital assists eligible persons without insurance coverage or who are underinsured by waiving all or part of the charges for services provided by Benson Hospital.

4.0 Application, Financial Assistance Determination and Payment

a. Completion of the Community Care application - Patients wishing to apply for financial assistance must complete a Community Care application within 30 days of discharge. Otherwise, a patient will continue to be billed. A copy of the Community Care application may be obtained on the hospital's website at http://www.bensonhospital.org or by calling Benson Hospital's Business Office at (520)720-6519. Completion includes filling out and submitting a Community Care application, along with all requested documentation of income to 450 S Ocotillo Ave, Benson, AZ 85602 or by FAX to (520)586-7283 or can be scanned and E-Mailed to FAP@bensonhospital.org. Documentation provided with the completed Community Care application must include, as applicable: Proof of residency; bank or credit union statements for the last three months; W-2s or other wage or income information such as three months of payroll stubs, Social Security checks, unemployment checks, self-employment business records, income award letters/grant of education benefits, or other documents showing income; a copy of the current IRS tax return and documents evidencing the relationships of household members, including birth or baptismal certificates, adoption papers, marriage license, divorce decree or legal separation documents. Benson Hospital may request additional documentation during its application review process. Please contact the Business Office at (520)720-6519 if you do not have the requested forms of proof, in order to ascertain which additional options are available to you.

b. Incomplete application — An incomplete Community Care application may be

denied until or unless it is completed. Benson Hospital will retain the incomplete application for six months and send a letter to the patient outlining the information needed and how to submit the necessary paperwork.

c. Confidentiality — Benson Hospital keeps confidential all Community Care applications and supporting documentation.

d. Eligibility Determinations - The Benson Hospital Business Office will review the patient applications and inform patients via mail or E-Mail of the results within 30 days of receiving a completed application and all requested documentation. Final determination for financial assistance is provided to the patient in a written notice of determination (NOD). Assignment to a collection agency for follow-up will not occur during the assistance determination process.

e. Payment arrangements after financial assistance determination - Benson Hospital will continue to work with patients to resolve the remainder of their balance after a financial assistance determination has been made. Patients are responsible to make mutually acceptable payment plan arrangements with Benson Hospital within 30 days of their NOD (See payment plans).

f. Patient default notification of transfer to a collection agency after payment plan arrangements - Benson Hospital will send a minimum of two monthly statements to patients who have failed to make payment arrangements after NOD or who do not comply with mutually agreed upon payment plans. The notice will alert the patient of the balance and, if the patient's financial situation has changed, the patient may have the opportunity for a new payment plan. The notice will also alert the patient that the matter may be sent to a collection agency if it is not resolved. This communication will take place prior to transfer to a collection agency.

g. Collection activities - Patients who have completed an application and are under review will have collection activity put on hold pending the decision.

h. Late completion of an application - Patients may apply for financial assistance at any time.

5.0 Collection Practices for Community Care Patients

a. Benson Hospital will continue to bill the patient for at least 120 days if the patient does not make payment arrangements or fails to initiate the financial assistance process. Collection activities, including transferring to a collection agency, will begin on accounts older than 120 days. Benson Hospital will send a minimum of three statements every 30-45 days prior to transferring an account to a collection agency. Benson Hospital will make two phone calls on accounts with returned mail in an attempt to contact the patient at the address and phone numbers provided by the patient. If there is no response, the account will be transferred to a collection agency. Statement and communications will inform the patient of the amount due, the opportunity to complete an FAP application, and that the completion of the application may qualify the patient for free or reduced-cost care.

b. Accounts older than 241 days that have been referred to a collection agency may be reported to a credit bureau agency.

c. Agencies contracted with Benson Hospital will provide patients the Benson Hospital phone number where patients may call to request financial assistance, if financial assistance is requested by the patient while in collections.

d. Patients whose accounts have been transferred to a collection agency may request Benson Hospital financial assistance, submit a Community Care application with requested documentation and be considered for reduction of their bill. These patients will be subject to a stay-of-collection activities described in the preceding paragraph.

6.0 Eligibility Criteria for Patient Financial Assistance under the FAP

a. The Community Care policy provides a discount that takes into consideration a patient's household income.

b. Eligible patients are uninsured or underinsured persons who receive inpatient or outpatient medically necessary services from Benson Hospital and both of the following apply:

i. They are not eligible for coverage that would otherwise pay for these services (whether through employer-based coverage, commercial insurance, government-sponsored coverage or third-party liability coverage).

ii. They have household incomes (as defined below) below 400 percent of the Federal Poverty Level (See FPL Grid) at the date of services.

c. Financial assistance determinations will be consistent among patients regardless of their age, sex, race, religion, creed, disability, sexual orientation, national origin or immigration status.

d. Financial assistance is generally secondary to all other financial resources available to the patient including insurance, government programs, third-party liability and qualified assets.

e. Financial assistance may be provided to uninsured or underinsured patients who do not qualify under the Community Care Policy. In addition, a prompt pay discount may also be provided for payments made at the time of service by uninsured patients (see Appendix for current rate).

f. Individuals with access to health insurance, third-party reimbursement for health services or governmental assistance who refuse to enroll, fail to take advantage of, or fail to maintain eligibility for such coverage may be excluded from receiving financial assistance.

g. Hospital Community Care application information may be used for a period of six months for qualification. After six months, a new application may be required to qualify new services for community care.

h. Community Care applications will be reviewed and approved within the limits stated, as follows:

Business Office Manager/Delegate	$0 - $5,000
CFO	$5,000.01 - $25,000
CEO	$25,000.01 and over

7.0 Eligibility Criteria for Patient Financial Assistance under the FAP

a. The qualifying level of assistance for patients eligible for Community Care will be based on Benson Hospital's billed charges. Patients that qualify under the Community Care policy will not be charged more than the amounts billed (AGB) for services rendered. In order to obtain financial assistance, the patient must establish (through completion of an FAP application and submission of required documentation) that the patient's household income is below 400 percent of the FPL.
b. Allowances may be made for extenuating circumstances based on each person's unique life situation and mitigating factors. The amount of assistance provided by Benson Hospital may be more than outlined in the Benson Hospital FPL Grid for the current year, but not less.
c. Documents used for income and assets verification for the household include but are not limited to: copies of the most recent 90 days of payroll stubs, Social Security checks or unemployment checks; copy of the current IRS tax return filed; current bank, trust fund statements, mortgage statements and annual property tax statements. In the absence of income, a letter of support from individuals providing for the patient's basic living needs may be provided. Upon request, Benson Hospital may require additional verification of income.

8.0 Appeals of Assistance Determination

Patients or their representatives may appeal a financial assistance determination by providing additional information demonstrating eligibility, such as income verification or an explanation of extenuating circumstances, to the business office within 30 days of receiving the NOD. The Patient Advocate and Business Office Manager will review all appeals. The responsible party will be notified of the outcome.

9.0 Accounting for Community Care

a. A separate file will be maintained for accounts written off as community care and retained in the Business Office for a minimum of two years.
b. Staff will use the "Approval of Application for Community Care" form when the receivable is approved for write-off.

10.0 Communications to Patients

a. Benson Hospital is committed to making the people in the communities that it services aware of the availability of financial assistance through its Community Care Policy. Benson Hospital will provide financial counseling to patients upon request and help those who are eligible through the Community Care application process.
b. Benson Hospital communicates the availability of financial assistance in appropriate acute-care settings such as the Emergency department, registration areas and on the hospital website.
c. All billing statements and statements of services will inform patients that financial assistance is available.
d. Signs are posted in hospital registration areas informing patients that financial assistance is available for qualifying patients who complete an assistance

application. These signs inform patients that free or reduced-cost care may be available to qualifying patients who complete an application.

e. Materials describing the Community Care Policy, including cards and brochures, are available in English and Spanish on the hospital website, in Admitting and at the Business Office 450 S Ocotillo Ave Benson, AZ 85602
f. Financial counseling and Business Office personnel are available at the hospital or at the Business Office to assist patients in understanding and applying for local, state and federal health care programs and the Benson Hospital Community Care Program.
g. Reasonable efforts are made to ensure that all Benson Hospital employees are informed about how to refer patients to apply for Benson Hospital's Community Care Program. Annual staff education programs are provided to all Business Office and Admitting Staff.
h. Patients can request financial assistance information or a copy of this policy or the Community Care application by calling the Business Office at (520)720-6519 or by E-Mail at FAP@bensonhospital.org. Voicemail is available and calls will be followed up within two working days.
i. Patients are provided information regarding the availability of financial assistance upon registration or admission to Benson Hospital's acute care areas.
j. This policy and the Community Care application for assistance in the form of the Benson Hospital FAP are available on the hospital website at http://www.bensonhospital.org, in acute care inpatient registration areas or via mail or E-Mail from the Business Office. The Community Care application documents include instructions on how to complete the application form and the kinds of supporting documentation that are needed to complete the application process. Instructions for return of the form are also provided.
k. Individuals other than the patient, such as the patient's physician, family members, community or religious groups, social services or hospital personnel may make requests for financial assistance on a patient's behalf.

APPENDIX

AGB 45% automatic discount.

Governance: Medical Staff
Executive Staff: Department

Included Providers:

- Hospitalist
- Clinic Providers
- Ed Physicians

Not Included:

- Radiologist
- Pathologist
- Specialists.

BENSON HOSPITAL PATIENT FINANCIAL ASSISTANCE — PLAIN LANGUAGE SUMMARY

To further Benson Hospital's mission to the communities that it serves, Benson Hospital is pleased to provide financial assistance for medically necessary care in a fair, consistent, respectful and objective manner for low-income patients who do not have insurance coverage or are underinsured.

The term ***medically necessary*** refers to inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms that if left untreated would pose a threat to the patient's ongoing health. Services not considered medically necessary are services that are cosmetic, experimental, dental or part of a clinical research program.

APPLICATION PROCESS

A financial assistance application should be completed within 30 days after discharge. Documentation necessary for income and monthly expense verification for the household includes, but is not limited to:

• Most current W-2s and tax forms	• Rent receipt or lease/mortgage statement
• Last three (3) payroll statements	• Room and board/Support letter
• Social Security award letter for current year	• Utility bills
• Unemployment Compensation benefit letter	• Divorce decree
• Bank and/or credit union statements for the last three (3) months	• Copy of death certificate

Incomplete applications will be denied until they are fully completed. A letter will be sent to the patient outlining the information needed with instructions on how to submit the necessary documents. Applications will remain on file for 180 days. If the required documents are not received or no payment arrangements have been made, the account will be submitted for bad debt review.

ELIGIBILITY DETERMINATION

The Benson Hospital Business Office has 30 days from the date when the completed application is received to authorize financial assistance and to notify the patient. Final determination for financial assistance will be provided in writing. Assignment to a collection agency will not occur during the assistance-determination process.

Determining factors for approval include:

- No third party is responsible for payment
- Household Income is at or below 400 percent of the Federal Poverty Level

Patients have the right to appeal the financial assistance determination by submitting an explanation of extenuating circumstances to the Benson Hospital Business Office within 30 days of receiving the notification of determination.

A copy of the financial assistance application and the complete financial assistance policy is available from the Hospital website at fap@bensonhospital.org, calling the Benson Hospital Business Office at (520)720-6519, or at Benson Hospital- 450 S. Ocotillo Ave, Benson, AZ 85602. If you have any questions about the Financial Assistance Program, please contact the Benson Hospital Business Office.

THE UNDERSIGNED VERIFIES RECEIPT OF THIS INFORMATION ABOUT THE BENSON HOSPITAL PATIENT FINANCIAL ASSISTANCE PROGRAM

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

BENSON HOSPITAL- PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

Benson Hospital recognizes that certain patients may require financial assistance in paying for health care services. The Patient Financial Assistance Program has been designed by the hospital in response to the needs of these patients.

Attached is the Patient Financial Assistance Application for you to complete and return to us. The information requested on the form will assist us in determining if you qualify for assistance. Please fill out the attached form as completely as possible and return with copies of the items that are checked below.

- ❑ **Most current W-2s and tax forms**
- ❑ **Last three (3) paycheck stubs from employment**
- ❑ **Social Security Award Letter for current year**
- ❑ **Unemployment Compensation Benefit Letter**
- ❑ **Copy of Checking/Savings Account Statement(s)**
- ❑ **Rent Receipt/Lease/Mortgage Statement**
- ❑ **Room and Board/Support Letter**
- ❑ **Utility Bills**
- ❑ **Divorce Decree**

An incomplete application will be denied until it is fully completed.

If you have any questions regarding the financial application or documents needed, please contact the Business Office at (520)586-1873 or by E-Mail at FAP@bensonhospital.org.

BENSON HOSPITAL BUSINESS

OFFICE Enc.: Application

BENSON HOSPITAL - PATIENT FINANCIAL ASSISTANCE PROGRAM
APPLICATION

PATIENT'S NAME			SEX	PATIENT ACCOUNT NUMBER	
GUARANTOR'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE
SPOUSE'S FIRST NAME	MI	LAST NAME	SEX	DOB	SOCIAL SECURITY #
ADDRESS OR PO BOX		CITY	STATE	ZIP	PHONE
# IN HOUSEHOLD				PATIENT LIVES IN HOUSEHOLD	YES 0 NO ❑
# OF CHILDREN UNDER 18 IN THE HOUSEHOLD				# OF DEPENDENT CHILDREN OVER 18	
# OF DEPENDENT CHILDREN OVER 18 THAT ARE FULL-TIME STUDENTS				# OF DEPENDENT CHILDREN THAT ARE DISABLED	
	HOME OWN RENT		L_1 ❑	HOW LONG AT PRESENT ADDRESS	

MONTHLY INCOME SOURCES	SPOUSE #1	SPOUSE 42	CHILDREN	TOTAL
Employment				
Social Security				
Industrial Comp				
Unemployment				
Penslon/Retirement/Annuities				
ADC,GA,Food Stamps				
Other (rental income, child support, spousal, etc.)				
TOTAL GROSS INCOME				

MONTHLY EXPENSES

HOME (RENT/MORTGAGE)	CAR		CAR
ELECTRIC BILL	GAS BILL		WATER BILL
PHONE BILL	TRASH BILL		CABLE BILL
CELL PHONE BILL	GROCERY		OTHER
CHECKING. Circle One YES NO	5 TOTAL AMOUNT		BANK NAME
SAVING. Circle One YES NO	S TOTAL AMOUNT		BANK NAME

I CERTIFY THAT THE INFORMATION GIVEN HEREIN IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT DELIBERATE FALSIFICATION CAN LEAD TO DENIAL OF CONSIDERATION. I HEREBY AUTHORIZE THE HOSPITAL TO MAKE ANY NECESSARY INQUIRIES TO VERIFY AND TO OBTAIN ANY ADDITIONAL INFORMATION REQUIRED BY THE FACILITY,

GUARANTOR SIGNATURE		DATE
SPOUSE SIGNATURE		DATE

- RELATIONSHIP OF HOUSEHOLD MEMBERS: Divorce Decree or Copy of Death CertIfIcal
- PROOF OF RESIDENCY: Rent Receipt/Lease/Mortgage Statement or Room and Board/Support Letter;UtIlity Bills
- ASSETS: Bank and credit union statements for the last three (3) months
- INCOME FOR ALL HOUSEHOLD MEMBERS: Last three (3) paycheck stubs/employer's statement listing gross wages, Social Security Award Letter for current year or Unemployment Compensation Benefit Letter
- Most current W-2's and tax forms