

## Financial Assistance for Uninsured Patients (Discounted Care or Charity Care)

### Purpose

To provide guidelines and procedures for the identification, documentation and application for those needing financial assistance for care rendered at Children’s of Alabama (Children’s).

Children’s provides health care services to all persons who are in need of medical services regardless of their ability to pay. Financial assistance will be provided to uninsured and underinsured patients who meet the established eligibility criteria.

### Applicability of the Policy

Financial assistance will be provided to uninsured and underinsured patients who meet the established eligibility criteria.

Financial assistance shall be extended for medically necessary services ordered by a physician. These services **do not include** cosmetic, elective, experimental (including biologicals), other non-urgent treatment or medical supplies/equipment. This policy is not intended to cover services not typically covered by most major health plans. Intensive therapies are not covered by this policy as they do not meet medical necessity for most major health plans (including but not limited to Intensive Feeding, Constraint Induced, Intensive Physical Therapy).

- 1) The evaluation of the necessity for medical treatment of any patient shall be based upon clinical judgment of the patient’s personal physician; or the emergency department staff physician applying prudent layperson standards.
- 2) In cases where an emergency medical condition exists, any evaluation of possible payment alternatives shall occur only after an appropriate medical screening evaluation has occurred and necessary stabilizing services have been provided in accordance with all applicable state and federal laws and regulations.

This policy only applies to services (inpatient and outpatient) provided by Children’s of Alabama personnel at all locations including the Benjamin Russell campus, Children’s South, Children’s on 3<sup>rd</sup>, Park Place. Most professional (Physician) services rendered at any of the above named locations are generally **not** covered by this policy. See the detailed chart below of physician services and whether this policy applies to such service.

Physician Group	Financial Assistance under this Policy
Non-surgical Sub-Specialist (outpatient clinic services only)	Yes
Emergency Room Physicians	Yes
Pediatric ENT Associates	Yes
Pathologists	Yes
Primary Care Pediatricians - Children’s Employed	Yes – see separate section titled in this policy
Pediatric Surgeons – UAB	No

Psychiatrists - UAB	No
Anesthesiologists – Pediatric Anesthesia Associates	No
Radiologist – Pediatric Radiology Associates	No
Community Physicians	No

## **Eligibility**

### ***For discounted care:***

All uninsured patients are automatically eligible for and provided with discounted care.

The amount of the discount is applied to Total Gross Charges and the billing statement sent to the uninsured patient automatically reflects the discount that is in effect for the date of service.

The discount percentage is calculated annually using the “Look Back” method. The percentage discount for the year is updated and effective each year on February 14. The discount percentage is uniformly and consistently applied to all uninsured patients during the effective dates. The discount percentage is applied to Total Gross Charges to determine the amount owed by the patient. An individual will not be charged more than amounts generally billed for emergency or other medically necessary care.

The discount percentage and the applicable dates, as well as a description of how the discount percentage was calculated using the “Look Back” method are available free of charge at [www.childrensai.org](http://www.childrensai.org) or upon request from any patient registration location, financial counselor, information desk or the business office.

### ***For Additional Discounts for those who are uninsured:***

Eligibility for additional discounts are determined based on:

- 1) Ineligibility for benefits from governmental insurance programs such as Medicaid, AllKids (CHIP programs), Medicare, and/or Tricare. All applicants must apply and complete the process for all applicable government and private financial assistance programs available. Cooperation and compliance with this process is required. Verification of ineligibility for benefits must be provided before additional discounts will be given.
- 2) No other third-party insurance, financial assistance or resources including Workers’ compensation benefits, automobile or homeowner’s insurance. Verification of ineligibility of benefits must be provided before additional discounts will be given.
- 3) Resources from third-party payors are exhausted (i.e. Medicaid limited days); and
- 4) Financial need demonstrated through the completed application process relative to the Federal Poverty guidelines. (see table below)

Eligibility for additional discounts may be determined prior to, at time of, during or after a hospital stay or receipt of hospital or medical services.

### **Application Process for Determining Eligibility**

Applications for financial assistance can be obtained and initiated at any time prior to rendering services through 240 days following the first billing statement.

- 1) An application for discounted care may be obtained from a financial counselor, through the Business Office or online at [www.childrensal.org](http://www.childrensal.org).
- 2) The application must be completed in its entirety per the stated instructions on the application. The following items are required as part of the application process and must be supported by documentation:
  - a. Family - names and ages of family members residing in the same household
  - b. Family income from all sources
    - i. Most recently filed tax returns (federal and state)
    - ii. Employment – copies of 2 or more most recent pay stubs
    - iii. Proof of Alimony and/or Child support
    - iv. Proof of Pension amounts
    - v. Proof of Government Benefits (Social security, disability, unemployment, etc.)
    - vi. Investment income (dividends/interest earnings/rentals)
    - vii. All income sources not yet mentioned
  - c. Cash reserves/assets available from all sources
    - i. Checking accounts (2 most recent copies of statements)
    - ii. Savings accounts (2 most recent copies of statements)
    - iii. Other assets
  - d. Ineligibility for benefits from governmental insurance programs such as Medicaid, AllKids (SCHIP programs), Medicare, and/or Tricare
  - e. Exhaustion of benefits from governmental insurance programs such as Medicaid, AllKids (SCHIP programs), Medicare, and/or Tricare
  - f. No other benefits available from third-party insurance, financial assistance or resources including Workers' compensation benefits, automobile or homeowner's insurance.
  - g. If you are unable to work due to illness, a letter from your physician confirming your inability to work is required.
  - h. If no income is reported, information as to how daily needs are met is required. If the family is supported by relatives or friends, a **notarized** letter explaining these arrangements is required. The letter must be signed by person(s) lending assistance.
  - i. If anyone of working age (18 or older) living with you is unemployed, a **notarized** letter is required stating length of unemployment, along with the name and relationship to you. A statement of denied unemployment benefits will also be accepted.
- 3) An attestation statement must be signed by the applicant acknowledging all documents and representations are true and accurate to the best of the applicant's knowledge. Any falsification will result in nullification of any discount leaving applicant as the responsible party for the full amount owed.
- 4) Application must be submitted, either in person or mailed.

If submitting in person, applications are accepted Monday through Friday 8 AM – 4:30 PM at the Patient Relations office located on Main Street (2<sup>nd</sup> Floor) of the Benjamin Russell Hospital, 1600 Seventh Ave. South, Birmingham, AL 35233.

If mailed, send to:

Children’s of Alabama  
 Attention: Financial Counseling  
 P. O. Box 36549  
 Birmingham, AL 35236-6549

- 5) Application should be submitted no later than 120 days following the first billing statement sent to avoid the account being turned over to a collection agency.
- 6) Application will be accepted for 240 days following the first billing statement sent.

All information obtained as part of the application used to determine eligibility will be verified through the appropriate means. Such verification procedures may include inquiries of employers, banks, credit bureaus, governmental agencies, etc.

Eligibility for additional discounts are based on family income and assets and household size as verified through the application process, relative to the federal poverty guidelines (published by the federal government annually) as set forth below:

<b>Guidelines:</b>	
<b>If Family income and available assets as a % of FPL for family size is equal to:</b>	<b>Then the Additional Discount is:</b>
0 – 200% of FPL	100% discount – Free care
201% – 300% of FPL	50% discount
> 300% of FPL	No additional discount

In no circumstances will the total amount owed be greater than 15% of the total family annual income as determined by AGI.

In determining eligibility, Children’s of Alabama follows federal guidelines and definitions for determining which federal poverty guidelines to use, family income, and household size. These guidelines are used by federal government uses to determine eligibility for federal programs and are published annual in the *Federal Register* by HHS. All determinations of eligibility, applying the stated criteria, are authorized by the Revenue Cycle Director for amounts less than \$10,000, by the Revenue Cycle Division Director for amounts greater than \$10,000 but less than \$50,000, and by the Chief Financial Officer for amounts \$50,000 or greater.

Children’s of Alabama will render a determination of eligibility in writing within 30 days of receipt of the completed application. The determination letter will include the applicable dates of the determination.

If an application is deemed incomplete and a determination cannot be made, the applicant will be notified of the deficiency and given 30 days to provide the missing or incomplete information. The account will be placed on hold during the 30 day holding period.

Applications received 120 days after the first billing statement is sent will be accepted and processed and any collection efforts initiated will cease until an eligibility determination is made. The final deadline to submit an application and be considered for financial assistance is 240 days after the first billing statement is sent.

If an additional discount is determined, all collection efforts will be ceased for all outstanding accounts until the eligibility is no longer valid.

If an additional discount is determined, any excess payments received by the hospital will be returned.

Eligibility must be re-evaluated when one of the following occur:

- a. Subsequent rendering of services more than one year from the date of the most recent determination;
- b. Family size change;
- c. Family income change
- d. Qualification for insurance or other assistance during this period; or
- e. Any change that would affect the eligibility determination including discovery of an erroneous decision or falsification of information.

Confirmation of continued eligibility must be determined each year from the date of the most recent eligibility determination for patients with ongoing medical services needed.

In the event insufficient information is provided by the patient/family to determine eligibility, a family refuses to cooperate with the application process and/or all collection attempts have resulted in non-payment, or government benefits are exhausted or not covered, management may, at its discretion, grant additional discounts on an individual account. If such determination is made, collection efforts on said account will be ceased. Management will periodically review unpaid accounts and if additional discounts are determined, collection efforts will cease.

### **Failure to Pay**

In the event payment for services is not received, efforts will be made to contact the patient/family to notify them of the availability, eligibility and application process for additional discounts.

When no payment is received for an account and/or there is failure to qualify for additional discounts, the account will be turned over to a collection agency. Prior to an account being turned over to a collection agency, the billing statement will contain a notice that such action is forthcoming in 30 days if payment is not received. The collection agency may contact the patient/family for payment and may report the non-payment of the account to the credit bureaus.

Extraordinary collection actions such as liens, lawsuits or garnishments are **not** used by Children's of Alabama for the non-payment of accounts.

### **Availability and Notification of the policy**

Children's of Alabama makes many efforts to educate and publicize its financial assistance program for additional discounts including:

- 1) Referring all uninsured patients to a financial counselor at the time of registration to assist with obtaining and completing applications for additional discounts as well as determining whether governmental, private or other assistance is available to the family.
- 2) Providing all inpatients a copy of the plain language summary of the financial assistance policy prior to discharge.
- 3) Prominently publishing the policy, the plain language summary and the application on the Hospital's web site, in English and Spanish;
- 4) Posting the availability of financial assistance in registration areas throughout the hospital and indicating where to find information;
- 5) Notifying patients throughout the billing process of the availability of additional discounts by providing copies of the plain language summary with the billings statements and communications during phone calls;
- 6) Providing paper copies of the policy, the plain language summary, the application, and the Discount Percentage and Look Back method calculation methodology upon request, in person or by mail without charge, in both English and Spanish. Any of these documents can be requested through any patient registration location, financial counselor, information desk or the business office.

Notification of the financial assistance policy begins at the initiation of healthcare services and continues until 120 days after the first bill is sent to the patient.

### **Uninsured patients receiving care in a Primary Care Location:**

For those who receive care in a Children's Primary Care location, discounted care may be available based on financial need. However, anyone needing financial assistance must apply as there are no automatic discounts for primary care. The same application form and process for submission as outlined above is used for determining eligibility for a Primary Care discount.

The amount of the discount is applied to Total Gross Charges. The discount percentage is calculated annually using the "Look Back" method based on calendar year data for the rendering primary care location only. The percentage discount for the year is updated and effective each year on February 14. The discount percentage is uniformly and consistently applied to all patients approved for financial assistance for Primary Care during the effective dates. The discount percentage is applied to Total Gross

Charges to determine the amount owed by the patient. An individual will not be charged more than amounts generally billed for medically necessary care in a Primary Care location.

<b>Guidelines:</b>	
<b>If Family income and available assets as a % of FPL for family size is equal to:</b>	<b>Then the patient charges are:</b>
0 – 200% of FPL	Amounts generally billed as calculated annually

**Financial Assistance for Insured Patients with High Deductibles, Co-pays or Limited Coverage**

Financial assistance will be provided to underinsured patients who meet the established eligibility criteria. See the separate policy titled “**Financial Assistance for Insured Patients with High Deductibles, Co-pays or Limited Coverage**” for the eligibility criteria and application process.

**Related Documents:**

- Plain Language Summary
- Financial Assistance Application and Instructions
- Understanding Discount Percentages for Financial Assistance

**Related Policies:**

- Financial Assistance for Insured Patients with High Deductibles, Co-pays or Limited Coverage