Policy

TITLE: Financial Assistance

NUMBER: SBPH.REV.042

I. Purpose

This policy provides guidance on Financial Assistance guidelines for the provision of free or discounted, eligible Medically Necessary services to patients who meet certain eligibility criteria and demonstrate an inability to pay in accordance with 26 U.S. Code § 501r and other applicable regulations.

II. Scope

This policy applies to all patients who are residents of Alabama, Louisiana or Mississippi and receive either Professional Services or Technical Services at this Organization, as listed on Attachment D, that are Medically Necessary and who meet certain eligibility criteria.

III. Definitions

A. Organization - Hospital Service District of the Parish of St. Bernard, State of Louisiana d/b/a St. Bernard Parish Hospital.

B. Emergency Medical Condition – As defined within the Social Security Act §1867.

C. Elective Services- Services, which could include Medically Necessary Services, that are not considered Urgent Services.

D. Expected Payments - All claims allowed by insurers.

E. Family Income – As defined by the Census Bureau to include earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources on a pre-tax basis. The following are excluded from calculation as Family Income by the Census Bureau:

1. Noncash benefits (such as food stamps and housing subsidies);
2. Capital gains or losses; and
3. Tax credits.

F. Federal Poverty Level (FPL) – The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities and varies by family size as set forth by the Department of Health and Human Services.

G. Financial Assistance – refers to healthcare services provided by this Organization without charge or at a discount to qualifying patients.

H. Gross Charges – Total charges at the facility's full established rates for the provision of patient care services before deductions from revenue are applied.

I. Medically Necessary – Services that are reasonable or necessary for the diagnosis or treatment of an illness or injury. Medical Necessity will be determined by the examining physician.

J. Patient Portion - The amount of medical charges the patient is financially responsible for after insurance has been applied to the bill for the services rendered.

K. Professional Services - services provided by a physician or clinical professional.

L. Self-Pay Discount – Discount applied to amounts due from patients for uninsured services.

M. Technical Services - medical or technical equipment, supplies or services.

N. Underinsured – Patient has some form of third-party assistance but still has out-of-pocket expenses that exceed his/her ability to pay.

O. Uninsured – Patient has no form of third-party assistance to assist with financial responsibility for medical services.

P. Urgent Services – Services that if not performed timely would endanger life, significantly worsen the patient's condition, or result in loss of limb or irreversible loss of function.

IV. Policy Statement

A. This Organization is committed to providing Financial Assistance for Medically Necessary Care to persons who are Uninsured, Underinsured, ineligible for a government program, or otherwise unable to pay, and who are determined to be eligible for Financial Assistance in accordance with this policy. This Organization shall provide, without discrimination, care of Emergency Medical Conditions to individuals regardless of their eligibility for Financial Assistance or for government assistance.

V. Policy Implementation

A. Eligibility for Financial Assistance

1. The granting of Financial Assistance shall be based on an individualized determination of financial need and will not take into account age, gender, race, social or immigration status, sexual orientation, or religious affiliation.

2. Patients are expected to cooperate with Organization procedures for obtaining Financial Assistance or other forms of payment, and to contribute to the costs of their care based on their individual ability to pay.

    a. Failure to comply with the Organization's Financial Assistance screening process, including but not limited to, Medicaid coverage determinations, will exclude patients from Financial Assistance eligibility.

3. Financial Assistance applies to patient liability only, including but not limited to, deductibles, co-payments, and co-insurances and is available to residents of Louisiana and Mississippi. Eligibility for Financial Assistance is determined based on the patient's Family Income, assets, and family size.

4. This Organization shall provide a 100% Financial Assistance discount for eligible services to patients whose Family Income is at 200% of the FPL Guidelines or less.
5. Patients whose Family Incomeexceeds 200% of the FPL may be eligible to receive discounted rates based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Organization. For exceptions, documentation may be required to qualify for Financial Assistance. Exceptions include, but are not limited to:
    a. Expensive medications and hospital/physician bills;
    b. Terminal illness; or
    c. Multiple hospitalizations.
6. Failure to comply with the Organization's Medicaid coverage and Financial Assistance screening process will exclude patients from Financial Assistance eligibility.
7. Modifications to previously awarded discounts shall be made if subsequent information indicates the information provided to the Organization was inaccurate.
8. Patients who are determined eligible for Financial Assistance shall not be deferred for Medically Necessary care.

B. Services Available Under this Policy
    1. Financial Assistance is available for all Professional Services and Technical Services, except for the following:
        a. Pre-paid, fixed price services;
        b. Transplant services;
        c. Elective Services; and
        d. Fees for Professional Services rendered by the providers as listed on Attachment A.
    2. This Organization reserves the discretion to offer Financial Assistance for excluded services on a case-by-case basis.

C. Methods by Which Patients May Apply for Financial Assistance
    1. Financial Assistance requests can be made by contacting the Patient Account Customer Service department via telephone, email, fax, or written correspondence or by visiting the Patient Financial Services Department located at Organization facilities.
    2. Financial need will be determined by an individual assessment of financial need and may:
        a. Include an application process ("Attachment B"), in which the patient or the patient's guarantor, is required to cooperate and provide personal, financial, and other information and documentation relevant to making a determination of financial need;

i. The Financial Assistance application is required to provide additional information to allow for a more in-depth review of borderline approvals, hardship cases, and large balances.

b. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (e.g., credit scoring);

c. Use a third-party tool when there is insufficient information provided by the patient, which may be used as the sole documentation source to make a Financial Assistance determination.

d. Include reasonable efforts by the Organization to explore appropriate alternative sources of payment and coverage from public and private payment programs and to assist patients to apply for such programs; or

e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

3. Approvals for financial assistance are considered valid for 90 days and future balances within 90 days will be auto adjusted. A patient has 240 days from the date of the first post-discharge bill for an episode of care to apply for Financial Assistance for that episode of care.

D. Amounts Charged to Patients

1. Patients who receive Financial Assistance may not be charged more for the same services generally billed to insured patients. The Financial Assistance discounts are separately calculated for each facility and represent the average payor yield by reviewing Medicare and commercial actual and Expected Payments (including the Patient Portion) over the prior twelve-month period as demonstrated more fully on Attachment C.

2. Uninsured patients who are not eligible for financial assistance still qualify for an uninsured discount that is calculated for each facility (attachment C) and represents the average payor yield by reviewing Medicare and commercial actual and expected payments (including the Patient Portion) over the prior twelve-month period.

E. Presumptive Financial Assistance Eligibility

1. In addition to the formal Financial Assistance application process, Uninsured patients may also be presumed to be eligible for Financial Assistance for charges on Technical and Professional Services based on evidence provided via use of a third party screening tool, which may be utilized as the sole documentation source to make a Financial Assistance determination.

2. Technical and Professional Services will be reviewed separately under the presumptive process.

3. Medically Necessary charges not covered by Medicaid or indigent care programs may be presumed eligible for Financial Assistance.

4. Technical and Professional account balances with previously made payments may be considered for Financial Assistance if requested through Patient Financial

Services or Patient Accounts Customer Service; however, they shall not be considered through the presumptive Financial Assistance process.

5. Approvals granted under presumptive Financial Assistance are valid for the encounter under review only and not valid for 90 days.

F. Billing and Collection Efforts

1. The Billing and Collections policy and translated copies can be obtained:
   a. online at https://www.ochsner.org/patients-visitors/billing-and-financial-services/financial-assistance/ or
   b. upon written request at Ochsner Health System Patient Financial Services 1514 Jefferson Highway, New Orleans, LA 70121.
2. This Organization will not impose against any patient extraordinary collection efforts such as wage garnishment, liens on primary residences or take other legal actions.

G. Communication of the Financial Assistance Program to Patients and Within the Community

1. Information about the Financial Assistance program can be found:
   a. On patient billing statements,
   b. Online via the Organization's web site,
   c. By visiting Patient Financial Services located at Organization facilities, or
   d. On the patient discharge summary.

VI. Enforcement

Failure to comply with this policy may result in progressive discipline up to and including termination of employment for employees or termination of contract or service for third-party personnel, students or volunteers.

VII. Attachments

Attachment A Professional Services Not Covered by Financial Assistance Policy
Attachment B Financial Assistance Application
Attachment C Amounts Generally Billed Discounts
Attachment D Facilities Covered under Financial Assistance Policy

VIII. References

Patient Billing and Collection Process

HFMA 501(c)(3) Hospital Charity Care Policy and Procedure

Census Bureau Measure of Poverty

42.U.S.C. 1395dd
26 U.S.C 501, see also 26 CFR Parts 1, 53 and 602, Additional Requirements for Charitable Hospitals; Final Rule

https://www.census.gov/topics/income-poverty.html

IX. Policy History

OHS.REV.042 Financial Assistance (July 2014)

Attachment B Financial Assistance Application

Financial Assistance
Process & Application

The Ochsner Health System ("OHS") is committed to providing financial assistance for patients with a demonstrated financial need or hardship, who have received medically necessary healthcare services provided by OHS. Medically necessary services are services that are reasonable or necessary for the diagnosis or treatment of an illness or injury. Medical necessity will be determined by the examining physician. This application does not serve as a guarantee of financial assistance or reduction in outstanding liability.

Application must include:

- All required documents for you and your co-applicant if applicable.
- Proof of Dependents for anyone listed on application.
- Completed Ochsner Financial Assistance Application
- Signed & Dated Patient Attestation Form
- Proof of LA or MS Residency

Please include all applicable documents listed below:

A. Proof of Income (Please provide 1 of the following):
   a. Copy of tax return (Form 1040) for current tax year or
   b. Copy of three (3) most recent pay stubs.
   c. If unemployed, please provide letter from last employer OR copy of unemployment award letter OR letter certifying denial of unemployment benefits from applicable state department of labor
   d. If no income can be provided, please complete and sign the No Income Verification/Statement of Support (view attachment)
   e. If separated, please submit a copy of tax return (Form 1040) for current tax year.
   f. Copy of Social Security Administration monthly award letter
   g. Copy of Disability monthly award letter

B. Copy of Healthcare Insurance card/information (If applicable)

C. Proof of Residency (Please provide 1 of the following):
   a. Valid Louisiana Driver's License/Identification Card
   b. Current Utility Bill (shows name and address of applicant)
   c. Lease Agreement (shows name and address of applicant)
   d. Voter Registration

D. All other income: (Please provide 1 of the following):
   a. Spousal/Child Support (Copy of letter stating monthly award amount)
   b. Rental Property
   c. Investment Income

E. Proof of Dependents (Please provide 1 of the following):
   a. Copy of tax return (Form 1040) for current tax year
   b. School records or statements
   c. Health provider statements

Please Mail Completed Info to:
Ochsner Health System
Attn: _____
1514 Jefferson Hwy
New Orleans, LA 70121

Applications can also be emailed or faxed to:
Fax- (504)-842-0322
Email- OchsnerFADocs@ochsner.org

Financial Assistance Application

MRN: _____

Income Information: Please complete the income information below. *If married, please include spouse income information under the Co-Applicant fields.*				
Income Sources	**Applicant**	**Monthly Gross Income**	**Co-Applicant**	**Monthly Gross Income**
Employment	$		$	
Social Security	$		$	
Disability	$		$	
Unemployment	$		$	
Rental Property	$		$	
Investment Income	$		$	
Spousal Support	$		$	
Child Support	$		$	
			Total Combined Income	$

Applicant(s) Information

Applicant/Guarantor Information

Relationship to patient:

[ ] Self [ ] Spouse [ ] Parent

Marital Status (*):

[ ] Single [ ] Married [ ] Divorced [ ] Separated

Last Name	**First Name**	**Middle Initial**	**Social Security Number**

Date of Birth	**Number of Dependents**	**Age of Dependents**	**Current Telephone Number**

Street Address	**City**	**State**	**ZIP**

Current Employer	**Position**

If you are not working, how long have you been unemployed?

Co-applicant Information
** If married, please include spouse information and income*

Relationship to patient:

[ ] Self [ ] Spouse [ ] Parent

Last Name	First Name	Middle Initial	Social Security Number

Date of Birth	Number of Dependents	Age of Dependents	Current Telephone Number

Street Address	City	State	ZIP

Current Employer	Position

If you are not working, how long have you been unemployed?

Attachment(s)
Attestation
No Income Verification

Attestation

- I have complied with the **Ochsner Medical Cost Assistance Program ("MCAP")** screening process to determine if I may be eligible for alternate resources (COBRA, Social Security, Medicaid, and Victim of Crime).

- I understand that until I have complied with the MCAP eligibility process, or applicable application process, I will not be eligible for financial assistance.

- I understand that balances due to non-medically necessary services, such as purely elective or cosmetic services are not eligible for financial assistance. I also understand that balances over 240 days from the date of the first post discharge bill for an episode of care will not be included in this request.

- If I have included balances due to purely elective or cosmetic services, they will not be adjusted. If they are adjusted in error, they will be reinstated.

- If applicable, I have provided my most recent/current Insurance card with appropriate information to submit past, present, and future claims.

- I have provided all requested documentation from page 1 of this application. I attest that all information provided on this application, as well as all supporting documents are accurate and truthful to the best of my knowledge and ability.

Printed Name	**Signature**
Date of Application	**Phone/Contact**

Address (Street Address, City, State, Zip)

No Income Verification/Statement of Support

_____ & _____
(Applicant) **(Co-applicant) if applicable**

is applying for financial assistance with the Ochsner Health The applicant has stated they do not receive any monthly/yearly income. The applicant has listed you as their sole means of support. To the best of my knowledge, the applicant has no income and I certify this to be true. I am either providing the applicant with food and shelter and/or providing the applicant with financial support as specified below _____
(Relationship to the applicant-for example: Shelter, Mother, Father, Other)

I am providing:

- Food and Shelter **$**_____ Approximate monthly total
- Financial Support **$**_____ Approximate monthly total
- Other **$**_____ Approximate monthly total

_____ _____
Printed Name (of supporter) **Signature** (of supporter)

_____ _____
Date **Phone/Contact**

_____
Address (Street Address, City, State, Zip)

******If you are not receiving income from any source please sign here******

I, _____ am not receiving income or financial support from any sources currently**.**

Signature_____**Date**_____
Applicant/Co-Applicant (*if applicable*)

Please Mail Completed Info to:
Ochsner Health
Attn: _____

1514 Jefferson Hwy
New Orleans, LA 70121

Applications can also be emailed or faxed to:
Fax- (504)-842-0322
Email- OchsnerFADocs@ochsner.org

Attachment C Amounts Generally Billed Discounts Financial Assistance Policy

Policy Number	OHS.REV.042
Date of Issue	01/2021, 01/2021
Review Dates	01/2022, 01/2022
Revision Dates	01/2023, 01/2023
Policy Owner(s)	Patient Financial Services

Facility Charge	Calculated Discount Rate
St Bernard Parish Hospital	70%

Attachment D Facilities Covered by Financial Assistance Policy

Policy Number	OHS.REV.042
Date of Issue	01/2021, 01/2021
Review Dates	01/2021, 01/2021
Revision Dates	01/2023, 01/2023
Policy Owner(s)	Patient Financial Services

OHS.REV.042 applies to the following hospital facilities and the associated provider-based departments of each:

St. Bernard Parish Hospital