Purpose

This policy serves to establish and ensure a fair and consistent method for uninsured and underinsured patients to apply and be considered for financial assistance (FA) related to emergency and other medically necessary medical care. Please note that not all medical services available at Summit Healthcare Association (SHA) qualify for FA under this policy, such as, but not limited to, cosmetic services and fertility treatments. FA involves discounted care based on household income and assets that are required to be disclosed in the application process. FA is based on a discount on the gross charge for services for those determined to be eligible.

Definitions

Applicant: Patient or other individual responsible for payment of the patient's care who seeks financial assistance.

Bad debt: The cost of providing care to persons who are able, but unwilling, to pay all or some portion of the medical bills for which they are responsible.

Financial assistance: The cost of providing discounted care to individuals who cannot afford to pay a portion of their medical bills based on the eligibility rules identified in this policy.

Gross charges: The fully established price for medical care provided to patients.

Medically necessary care: Healthcare services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice,
- Clinically appropriate in terms of type, frequency, extent, site, and duration, and
- Not primarily for the economic benefit of the health plans, purchasers or for the convenience of the patient, treating physicians, or other healthcare providers.

Self-pay balance: The amount due to a provider or hospital after services are rendered and all other payment options or reimbursement methods are exhausted.

Policy

Pursuant to 501(r) of the Internal Revenue Code policy, SHA is committed to providing access to quality healthcare for the community it serves, including patients in difficult financial circumstances, and offers FA to those with an established need to receive emergency medical care and medically necessary healthcare services.

SHA may take in the event of non-payment are described in SHA's Bad Debt policy. A free copy of this policy may be obtained by calling (928) 537-6911 or (888) 538-1491, Monday through Friday, 8:00 a.m. to 4:30 p.m.

SHA will not engage in extraordinary collection actions before it makes a reasonable effort to determine whether a patient is eligible for assistance under this policy.

I. Providers Covered Under this Policy

A list of providers covered under this policy may be furnished upon request. This list is maintained separately from this FA policy. The provider list applies only as of the date on which it was created or last updated, as specified in the provider list. The provider list may be obtained, free of charge, by calling (928)537-6911 or (888)538-1491, or online at https://summithealthcare.net/billing-information. You may also obtain a copy at the Patient Financial Services office at Summit Healthcare Regional Medical Center (SHRMC).

When obtaining tests or treatments at any Summit Healthcare facility, patients will receive separate bills from physicians who provided services during the patient encounter. Professional services provided by your physician or any other medical provider who is involved in your care may be billed separately. Examples include the emergency room physicians, radiologists, pathologists, anesthesiologists, surgeons, your attending physician and consulting physicians. Billing and collection policies for these physician services are at their discretion and not the responsibility of Summit Healthcare.

Health care practitioners who provide services in the hospital may or may not participate with the same health insurers or health maintenance organization as the hospital. Prospective patients should contact the health care practitioner who will provide services in the hospital to determine which health insurers and health maintenance organizations the practitioner participates in as a network provider or preferred provider.

II. Eligibility Criteria for FA

A. Income. To apply for FA, a patient or family member must complete an application including gross income for a minimum of 3 months (up to 12 months) prior to the date of application or date of service. Proof of income is required with the exception of patients who qualify for presumptive eligibility detailed below. Proof of income can include:

1. Tax returns and supporting schedules (previous year) for self-employment,
2. Pay stubs (most recent 3/12 months),
3. Social Security award letter, and
4. W-2 or unemployment statements.

B. Documents

1. If income below 138%- AHCCCS determination letter,
2. Bank statements (most recent 3 months, all accounts),
3. If no income, provide a statement of support.

C. Federal Poverty Guidelines (FPG)

1. FA eligibility is based upon expanded income levels of up to 300% of FPG and is prorated on a sliding scale applicable to the respective market area. Approval is based upon the number of family members, patient/spouse, and natural or adopted children under the age of 18 years. Persons over 18 years old are considered their own household.
2. The FPGs in effect on the date of service are in effect for the application process. They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS).
3. The current and historical FPGs are available at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.
4. Individuals with an income level of 200% FPG or below receive free care. Individuals with an income level from 201% to 300% FPG receive a percentage of discounted care. The specific percentage discounts for the 201% to 300% FPG income levels will be updated annually. Notwithstanding the percentages calculated, as stated above, following a determination of eligibility under this policy, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than AGB.

III. Presumptive Eligibility

A. Patients are presumed to be eligible for FA based on individual life circumstances including but not limited to patients who:
   1. Received care in the Emergency Department who are without financial resources may be eligible for FA if they are unemployed or have no permanent address. Indigent patients without access to the required application documentation may still be eligible for financial assistance,
   2. Have income below 200% FPGs and considered self-pay,
   3. Are deceased,
   4. Are eligible for state-funded prescription programs,
   5. Are homeless or received care from a homeless clinic,
   6. Are participating in Women, Infants and Children (WIC) programs,
   7. Are eligible for food stamps (SNAP),
   8. Are eligible for subsidized school lunch programs,
   9. Are eligible for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down),
   10. Are referred through a National Association of Free Clinics,
   11. Are Medicaid eligible, when the following criteria apply:
      a. Medicaid eligibility requirements are met after the service is provided,
      b. Non-covered charges occur on a Medicaid eligible encounter, and
      c. The provider is not credentialed or contracted.
   12. Low income/subsidized housing is provided as a valid address, or
   13. Other significant barriers are present.

B. Patients determined to have presumptive financial assistance eligibility will be provided with 100% financial assistance.

C. Patients determined to have presumptive financial assistance eligibility will not be required to meet income criteria, asset eligibility criteria, or fill out a financial assistance application.

D. SHA shall utilize available resources (e.g., technology solutions, service organizations, etc.) to obtain such information as credit scores to assist in determining whether a patient is presumed eligible for financial assistance.

IV. Catastrophic Situations

Patients whose patient responsibility after all eligible discounts is greater than 25% of the gross annual family income may be eligible for catastrophic financial assistance and awarded 100% on open balances not currently in bad debt.

V. Cooperation

A. Patients/guarantors shall cooperate in supplying all third-party information including motor vehicle or other accident information, requests for coordination of benefits, pre-existing information, or other information necessary to adjudicate claims, etc.

B. While the application is being processed, SHA will request that patients who may be Medicaid-eligible apply for Medicaid. To receive FA, the patient must apply for Medicaid and be denied for any reason other than the following:

   1. Did not apply,
   2. Did not follow through with the application process, or
   3. Did not provide requested verifications.

C. Accuracy of Application

   SHA reserves the right to reverse financial assistance and pursue appropriate reimbursement or collections as a result of newly discovered information, including insurance coverage or payment to the applicant or pursuit of a personal injury claim related to the services in question. All payments received after financial assistance is awarded will result in the reversal of the adjusted amounts to resolve the remaining self-pay balance without creating a balance due or a credit balance.

VI. Application Process for FA

A. Application forms are made available in Pre-Admission, Admission/Registration, and several alternative registration sites to facilitate early identification and initiation of the application process. Application forms may also be obtained by contacting SHA as indicated in the contact list at the end of this policy.

B. SHA may accept verbal clarifications of income, family size or any information that may be unclear on an application.

C. Providing FA does not obligate SHA to provide continuing care; however, at SHA's sole discretion, services and support that are medically necessary and unavailable elsewhere may be provided on a continuing basis. Patients are required to re-apply for FA at least every 180 days (six months), or sooner should new financial situations arise. Care for a period of the prior 240 days (eight months), may be eligible for assistance.

VII. Method of Applying for FA

FA is offered through either an application process or based on eligibility for medical assistance or other governmental need-based assistance, including AHCCCS.

A. Application Process

1. Applicants who want to apply for FA may apply by either requesting the application form from a financial counselor through our Patient Financial Services office, or downloading and printing the financial assistance application form, at no charge from our website at: https://summithealthcare.net/billing-information. SHA reserves the right to deny any application not received within the application period of 240 days from the first statement date.
    a. Applications are available by written request at:
    Summit Healthcare Regional Medical Center
    Patient Financial Services
    2200 E. Show Low Lake Rd.
    Show Low, Arizona 85901
    b. Applications are available by phone at:
    Customer Service at (928)537-6911 or (888)538-1491
2. SHA Patient Financial Services staff will review the application and will make a determination of financial assistance that may be offered. Once a decision has been made regarding the eligibility status of financial assistance, a letter will be sent to the applicant advising of the decision.

VIII. Basis for Calculating Amounts charged to Patients

All patients are billed according to gross charged amounts; however, the self-pay balance for patients eligible for financial assistance is limited to the Amount Generally Billed (AGB) to

those who have insurance covering such care. SHA uses a look-back method to calculate the AGB by dividing the amounts allowed by Medicare fee for service and commercial and private health insurers by the gross charges submitted. The amount that a patient is expected to pay out of pocket is limited to the AGB percentage of the gross charge if that patient is deemed eligible for financial assistance. The combination of insurance payments and patient or applicant payments may exceed the AGB.

IX. Emergency Services

SHA provides medical screening examinations and emergency care to stabilize patients, regardless of their ability to pay and in compliance with the Emergency Medical Treatment and Labor Act (EMTALA). SHA prohibits any actions that would discourage individuals from seeking emergency medical care and does not perform debt collection activity in the Emergency Department.

X. Equal Opportunity

SHA is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state or local laws.

I. Confidentiality

SHA will uphold the confidentiality and individual dignity of each patient and will adhere to Health Insurance Portability and Accountability Act (HIPAA) and other applicable state and federal privacy and security requirements for handling personal medical, health and financial information. SHA and its affiliates may share patient FA across SHA facilities for the benefit and ease of administering FA to patients seen in multiple locations. No information will be shared outside of SHA, unless authorized or required by law.