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| Copper Queen Community Hospital | SECTION: | 4.23.21 |
|  | POLICY: | Financial Assistance Policy |
|  | PREPARED BY: | Business Office Manager |
|  | MANAGER’S APPROVAL: | Business Office Manager |
|  | DIRECTOR’S APPROVAL: | CFO |
|  | DATE CREATED: | 07/01/2019 |
|  | DATE APPROVED: | Not Approved Yet |
|  | LAST PERIODIC REVIEW DATE: | No Review Date |
|  | NEXT PERIODIC REVIEW DATE: | No Review Date |
|  | DATE LAST MODIFIED: | 04/16/2021 |
|  | BOARD APPROVAL DATE: |  |

# FINANCIAL ASSISTANCE POLICY

Policy Title: Financial Assistance Policy

Policy: 4.23.21

Effective Date: 07/01/2019

1. POLICY
   1. The Copper Queen Community Hospital (CQCH) is a not for profit entity committed to advancing the health and well-being of those in its communities by providing an integrated high quality and cost effective CQCH of health care services. Consistent with this mission, the CQCH recognizes its obligation to the communities it serves to provide financial assistance to persons with little to no financial means within those communities. For purposes of this Policy, the CQCH includes all Copper Queen Community Hospital rural health clinics and providers, quick care and emergency department and all providers, all referred to as “CQCH”. Services provided by community-based providers are not covered under this Policy.
   2. In furtherance of its charitable mission, the CQCH will provide
2. Emergency treatment to any person requiring such care; and
3. Essential, *non-emergent* care to patients who meet the conditions and criteria set forth in this Policy, without regard to the patients’ ability to pay for such care.
4. CQCH will in best efforts provide a billing statement for services rendered with 30 days of service date or 30 days from insurance payment/denial/correspondence. A master itemized statement of services is available upon request at any time.
   1. The CQCH will regularly review this Financial Assistance Policy to ensure that at all times it:
5. Reflects the philosophy and mission of the CQCH;
6. Explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and
7. Complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to persons of limited means to pay. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the CQCH will modify this Policy and its practices accordingly. The CQCH maintains a separate Financial Policy for Billing & Collections, a free copy of which can be obtained by contacting the Patient Advocate office at (520) 432-6458, any CQCH locations and our website at https://cqch.org. The Billing & Collections Policy sets forth the actions that may be taken in the event of non-payment of amounts determined to be patient responsibility under this Policy.

# ELIGIBILITY AND DETERMINATION OF DISCOUNT

* 1. Eligibility: A patient will be eligible for Financial Assistance if the patient:

1. Has limited or no health insurance;
2. Applies for but is deemed ineligible for government medical assistance (for example, Medicare or Medicaid); OPTIONAL
3. Cooperates with the CQCH in providing the requested information and financial documentation; and
4. Demonstrates “financial need” based on Exhibit 1. In addition, a patient may be eligible for Financial Assistance in the event the CQCH, in its discretion, deems such eligibility appropriate under a patient’s unique circumstances (including potential medical hardship). Consideration may be given to the existence of substantial medical debt, and additional documentation regarding assets and living expenses may be requested. For purposes of this Policy, the term “patient” is used with regard to the patient or the applicable payment source for the patient’s care (*e.g.*, parent, guardian or other responsible party).
   1. Financial Need: A patient will be deemed to have financial need based on the Federal Poverty Levels (FPG) in effect from time to time. The table below sets forth the income requirements and related financial assistance discount on the charges for CQCH services rendered. Income includes salaries and wages, legal judgments, unemployment compensation, worker’s compensation, dividends, interest checks and other recurrent sources of income.
   2. Calculation of Amounts to Be Billed: In no event will a patient who is eligible for financial assistance under this Policy be charged more than the amounts generally billed (AGB) by the CQCH for the emergency or medically necessary care, and for less than gross charges for all other medical care. The CQCH calculates its AGB using the “Look Back Method” based on commercial and Medicare rates. The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by
5. Calculating the gross charges for services rendered to the patient, and
6. **When total household income is less than 200% of the United States national poverty level, a 100% discount from gross hospital charges will be applied. For CQCH clinics, if the household income is 100% or less, only a $10.00 copay will be applied. Please see all other discounts based on poverty levels in exhibit 1.**
7. **To Receive the amounts generated percentage please contact the CQCH Patient Advocate at (520)432-6458.**
8. Applying the appropriate discount (as determined pursuant to the above and Exhibit 1). Notwithstanding the foregoing, however:
   * 1. Pursuant to Arizona Public Act 03-266, any Uninsured (as defined by the Act) hospital patient whose income (alone, without regard to available assets) falls below 250% of the FPGs will not be charged more than the Hospital’s cost of providing services to the patient.

# PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBIITY FOR FINANCIAL ASSISTANCE

All patients will be informed of the availability of financial assistance pursuant to this Policy. Patients with an anticipated or actual self-pay balance will be referred to the CQCH’s Patient Billing Department.

* 1. Because a patient is not eligible under this Policy until she or he has applied for and been deemed ineligible for federal and state governmental assistance programs, the CQCH’s Patient Billing Department will assist patients in enrolling in federal and state governmental assistance programs, including, but not limited to the Health Care Exchange Programs. Resources to trained financial counselors and other personnel can be provided for any assistance required in completing the Application for Financial Assistance or with any other materials required by the CQCH under this Policy.
  2. Although the CQCH will attempt to make an eligibility determination during pre-registration or prior to discharge, this may not be possible, either because the patient does not provide the necessary documentation, or the patient’s circumstances change after discharge, or in other circumstances where a given patient’s circumstances or needs are identified. A patient may request consideration at any time, and the CQCH will evaluate a patient’s eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase. Patients are encouraged to contact the CQCH’s Patient Billing Department if their circumstances change or if additional need is identified. The CQCH’s Patient Advocates will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a determination of eligibility, and will notify the patient of his/her financial obligations, if any, as set forth below.
  3. Administrative Procedure
     1. CQCH staff will immediately forward to the Hospital’s Patient Advocates a copy of the pre-admission record for any patient who has no insurance. Patient Advocates will contact the patient to schedule a financial interview as soon as is practicable but ideally before admission for a non-emergent, medically necessary service, and prior to discharge for an emergency admission. For emergency services, the CQCH will not delay screening or treatment of an emergency medical condition pending this financial interview.
     2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Financial Assistance application (Exhibit 2). The application form will be made readily available to patients through methods including (without limitation) posting on the Hospital’s website, distribution at the Hospitals’ Patient Registration and Admissions areas and the Patient Billing Department, and inclusion in the informational binders provided in patient rooms.
     3. Patients must return the application form to the Patient Billing department at CQCH within ten (10) days. Failure to timely supply required information will result in denial of a patient’s request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner. The CQCH will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the financial assistance application form. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the CQCH trained patient advocate at (520) 432-5383 or in person at our Bisbee location. Patient advocates also are available to assist patients with assessing their financial situations, gathering information requested by the CQCH, and assisting with similar tasks.
     4. As part of the financial interview process, patient advocates will request the following documentation in order to process and validate Financial Assistance applications:

|  |  |
| --- | --- |
| **Required Supporting Documentation** | **Examples of Acceptable Documentation** |
| Confirmation of Annual Income | Most Recent Federal Income Tax Return Last 4 pay stubs  Most recent W-2 or 1099 Social Security Award Letter Unemployment Statement  Workers Compensation Award Letter |
| Date of Birth | Driver’s License  State Issued Identification Card Social Security Card **(Optional)**  Birth Certificate Baptismal Certificate Military Discharge Papers School Records |
| Alternate Address or Income Support | Mortgage Statement Rental Agreement/Lease Tax Bill  Room & Board Statement Utility Bill  Written Verification from Landlord |

* 1. Although the information above is required from patients seeking Financial Assistance, the CQCH in its discretion may choose not to require some or all documentation depending upon circumstances and the patient’s ability to obtain documentation. The CQCH may rely on documentation received from credit organizations or other outside entities, in determining a patient’s eligibility for Financial Assistance.
  2. Patients have an obligation to provide information reasonably requested by the CQCH so that the CQCH can make a determination of a patient’s eligibility for Financial Assistance. If a patient claims she or he has no means to pay but fails to provide the information reasonably requested by the CQCH, there will be no Financial Assistance extended and normal collection efforts may be pursued in the CQCH’s sole discretion.
  3. Eligibility and Notification Process:
     1. Upon receipt of a patient’s financial assistance application form, the Patient Billing department will review the patient’s application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the CQCH returns an application to a patient as incomplete, the Patient Advocate will attempt to contact that patient by telephone. If the Patient Advocate is able to reach the patient by telephone, they will offer the patient an in-person or telephonic interview to determine such patient’s eligibility for Financial Assistance. If the CQCH is unable to reach the patient by telephone, or if there is no listed telephone number available, the Patient Advocate will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the CQCH’s Patient Billing Department within ten (10) days of receiving the letter. The CQCH’s trained Patient Advocate will offer to meet with the patient to assist him/her in completing the application so that the Hospital has all of the necessary information to make a determination of the patient’s eligibility for Financial Assistance.
     2. The Patient Billing Department will complete the Financial Assistance Eligibility Determination Form attached as Exhibit 3, and will determine the amount the patient owes, if any. The Patient Billing Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within ten (10) business days of the determination.
     3. A determination of eligibility under this Policy will be effective for one
        1. year. At the end of such time period, patients continuing to require essential medical services will be expected to re-apply or update their prior applications, in order to permit the CQCH to make a new determination regarding the patient’s continuing eligibility for Financial Assistance.

# COMMUNICATION

The CQCH will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures on the CQCH’s website; In the Hospitals’ Emergency Departments; In the Patient Registration and Admissions areas; In the Patient Billing Department; In other waiting areas throughout the Hospitals’ premises (as

may be reasonably workable and appropriate); In patient informational binders included in patient rooms; and in bills and statements sent to patients.

Pertinent materials will be provided in English, and Spanish, which are the languages appropriate to the communities served by the CQCH. Other languages will be added as necessary in the event of changes to the CQCH’s patient population. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the financial assistance application form and answers to any other questions they may have about the CQCH’s Financial Assistance Program (FAP).

# DOCUMENTATION AND RECORDKEEPING

* 1. The Patient Billing Department will maintain all documentation of Financial Assistance within the Hospital’s Financial Assistance file. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following:

1. The number of applicants for free and reduced cost services;
2. The number of approved applicants;
3. The total and average charges and costs of the amount of free and reduced cost care provided;
4. Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws (including without limitation Arizona Public Act 03-266).
   1. The Chief Financial Officer will review the status of the Financial Assistance program (FAP) with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the CQCH’s policy is on Financial Assistance, the impact of this Financial Assistance Policy on CQCH operations and the level of need and benefits being conferred to the community under the CQCH’s Financial Assistance program.
   2. Information about the amount of Financial Assistance extended will be provided in accordance with federal and state laws and regulations on reporting information under the CQCH’s Financial Assistance Policy.

# APPENDIX I

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 and there is a lack of corresponding supporting documentation. However, there is often adequate information provided by the patient or through external sources which could provide sufficient evidence to offer the patient charity care assistance. In the event there is no concrete evidence to support a patient’s eligibility for charity care, CQCH may use outside sources in determining charity care eligibility *presumptively*. Once determined, due to the inherent nature of the presumptive circumstances, the discount that will be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances including:

1. Homeless or received care from a homeless clinic
2. Deceased with no spouse and no estate
3. Approved by the court for Bankruptcy

EXHIBIT 1

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| COPPER QUEEN COMMUNITY HOSPITAL - RHC | | | | | | |  |  |
|  | | | | | | |  |  |
| 2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | | | | | | |  |  |
|  |  |  |  |  |  |  |  |  |
| Annual Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty | | | | | | |  |  |
|  |  |  |  |  |  |  |  |  |
| Copper Queen Medical Associates Sliding Fee Scale | | | | | | |  |  |
| Family Unit Size | Poverty Guideline | 20% Pay | 40% Pay | 50% Pay | 60% Pay | 75% Pay | 80% Pay |  |
| 100% | 125% | 150% | 175% | 200% | 201% | 250% |  |
| 1 | 13,590 | 16,987 | 20,385 | 23,782 | 27,180 | 27,316 | 33,975 |  |
| 2 | 18,310 | 22,887 | 27,465 | 32,042 | 36,620 | 36,803 | 45,775 |  |
| 3 | 23,030 | 28,787 | 34,545 | 40,302 | 46,060 | 46,290 | 57,575 |  |
| 4 | 27,750 | 34,687 | 41,625 | 48,562 | 55,500 | 55,777 | 69,375 |  |
| 5 | 32,470 | 40,587 | 48,705 | 56,822 | 64,940 | 65,265 | 81,175 |  |
| 6 | 37,190 | 46,487 | 55,785 | 65,082 | 74,380 | 74,752 | 92,975 |  |
| 7 | 41,910 | 52,387 | 62,865 | 73,342 | 83,820 | 84,239 | 104,775 |  |
| 8 | 46,630 | 58,287 | 69,945 | 81,602 | 93,260 | 93,726 | 116,575 |  |
|  |  |  |  |  |  |  |  |  |
| THE CO-PAYMENT FOR THOSE BELOW THE 100% OF POVERTY IS $10.00 | | | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| For family units with more than 8 members, add $4,720.00 for each additional member. | | | | | | |  |  |
| Para familias con mas de 8 miembros, agregue $4,720.00 por cada miembro addicional. | | | | | | |  |  |
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|  |  |  |  |  |  |  |  |  |
| Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services. | | | | | | |  |  |
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| --- | --- | --- | --- | --- | --- |
| COPPER QUEEN COMMUNITY HOSPITAL | | | | | |
| CHARITY CARE | | | | | |
| 2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | | | | | |
|  |  |  |  |  |  |
| Annual Income Thresholds and % of Poverty | | | | | |
|  |  |  |  |  |  |
| Financial Assistance Thresholds | | | | | |
| Family Unit Size | Poverty Guideline |  |  |  |  |
| 100% | 125% | 150% | 175% | 200% |
| 1 | 13,590 | 16,987 | 20,385 | 23,782 | 27,180 |
| 2 | 18,310 | 22,887 | 27,465 | 32,042 | 36,620 |
| 3 | 23,030 | 28,787 | 34,545 | 40,302 | 46,060 |
| 4 | 27,750 | 34,687 | 41,625 | 48,562 | 55,500 |
| 5 | 32,470 | 40,587 | 48,705 | 56,822 | 64,940 |
| 6 | 37,190 | 46,487 | 55,785 | 65,082 | 74,380 |
| 7 | 41,910 | 52,387 | 62,865 | 73,342 | 83,820 |
| 8 | 46,630 | 58,287 | 69,945 | 81,602 | 93,260 |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| For family units with more than 8 members, add $4,7200.00 for each additional member. | | | | | | |
| Para familias con mas de 8 miembros, agregue $4,720.00 por cada miembro addicional. | | | | | | |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Note: This Exhibit shall be updated from time to time to reflect the most current FPGs issued by the U.S. Department of Health and Human Services. | | | | | |
|  |  |  |  |  |  |

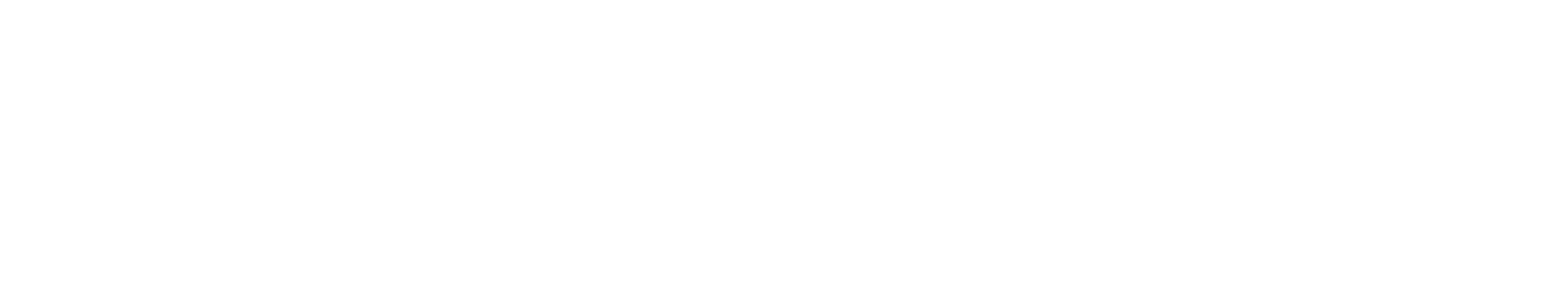
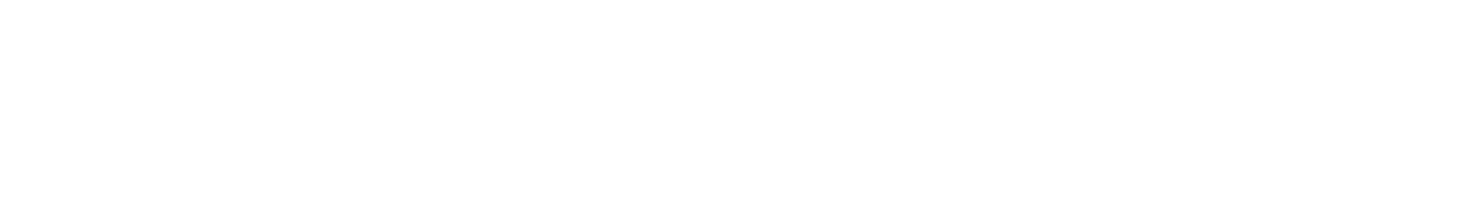
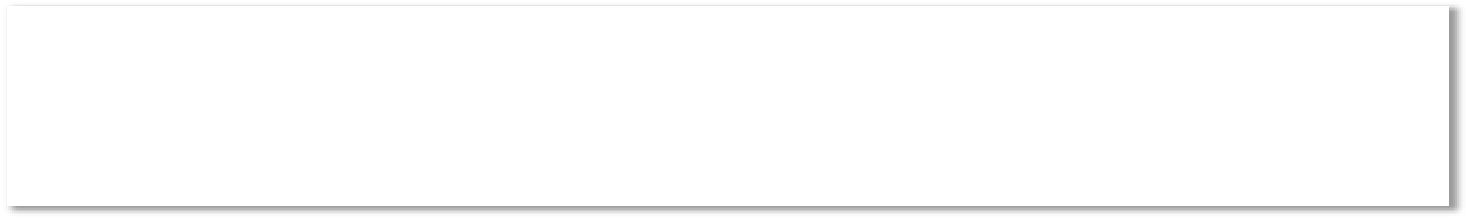
COPPER QUEEN A close-up of a logo

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FINANCIAL ASSISTANCE PROGRAM

DATE:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | DOB: | | | |  | |
| Primary Phone #: | Race: | | | Primary Language: | | | * Male * Female | Status: ☐ Single ☐ Married   * Divorced ☐ Widowed | | |
|  |  | | |
| Home Address:  *Street address 1* | |  | Mailing Address:  *Street address 1* | | | Employer: | | | | Work Phone #: |
| Annual Household Income: | | | | |
| *Street address 2* | | *Street address 2* | | |
| Number of Household  Dependents: (including self) | | | | |
| *City:* | | *City:* | | |
|  | | | | |
| *State: ZIP:* | | *State: ZIP:* | | |
| Email address: | | | | | |



Documentation Required for Determination:

* ✔ Driver’s license, photo ID with home address, or utility bill
* ✔ Proof of Income (Paycheck stub, signed and stated statement from patient, or guardian stating income)
* A Denial letter from the State AHCCCS Program (Optional)

I understand that if my income is over 200% of the Federal Poverty Level, I may not qualify for this program. Therefore, I will be responsible for 20% of the full charges if am uninsured or the full patient responsibility amount if I am insured. I also verify that all of the above information is true to the best for my knowledge and I agree to immediately notify the staff at Copper Queen Community Hospital if there is any change in the information above.

I also understand this application does not cover charges billed to me from third party organizations to include but not limited to (pathology charges, radiology professional charges, etc.)

Patient/Guardian Signature Date Staff Witness Signature Date

List all MRN’s in household:

Notes:

MM/DD/YYYY

MM/DD/YYYY

Reviewed by: Date:

Approved by: Date: Charity approval timeframe: / / through / /

* Dis-Approved

*To be completed by the Business Office* ☐ Approved

Are all required documents included? ☐ Yes ☐ No Is the patient over 200% FPL? ☐ Yes ☐ No

Initial amount to be adjusted? $

A close-up of a logo

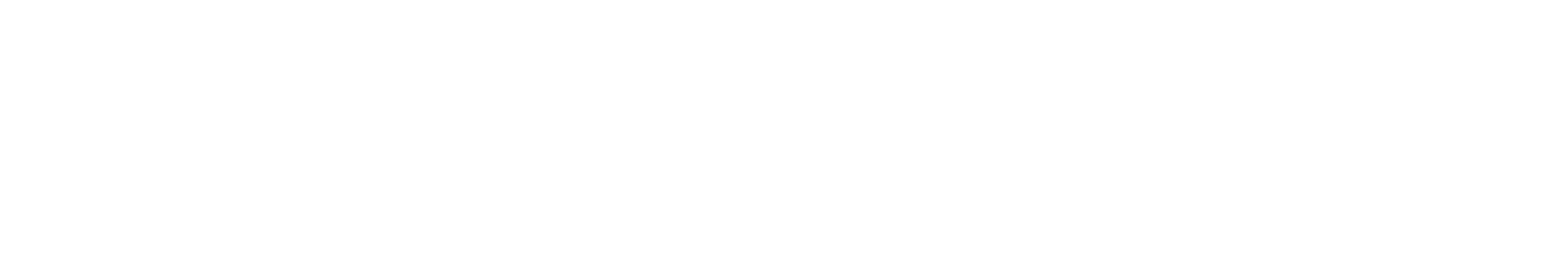
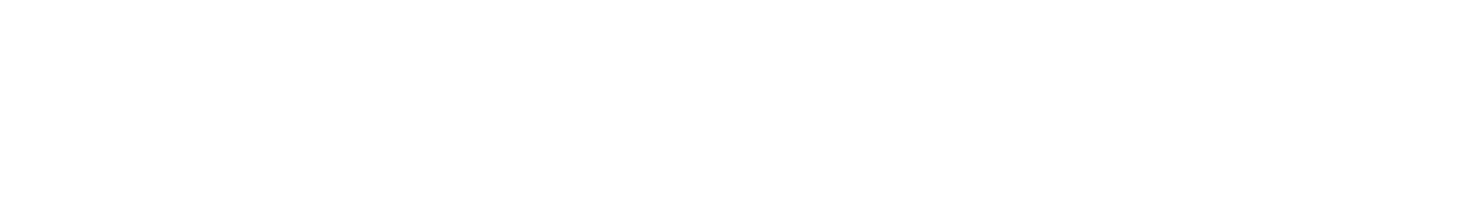
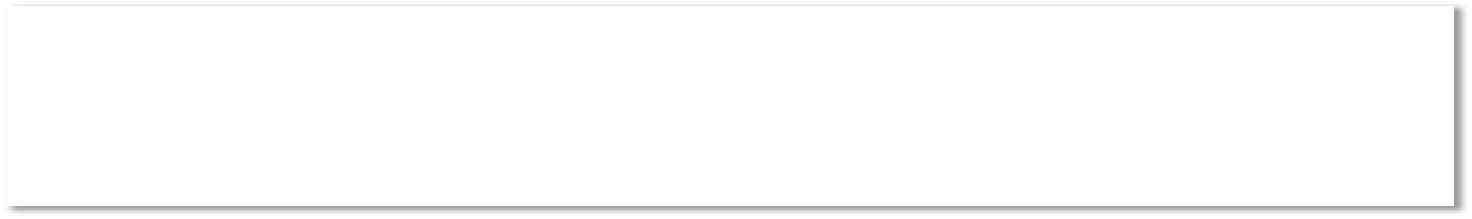
Description automatically generated with medium confidenceCOPPER QUEEN COMMUNITY HOSPITAL

FINANCIAL ASSISTANCE PROGRAM

Fecha:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nombre del Paciente: | | | | | | Fecha de nacimiento: | | | |  | |
| # de Teléfono: | Raza: | | | Lenguaje primario: | | | | * Masculino * Femenino | Estado: ☐ Soltero ☐ Casado   * Divorcio ☐ Viudo | | |
|  |  | | |
| Direccion de casa:  Direccion 1 | | Direccion de envio:  Direccion 1    Direccion 2 | | | | | Empleador: | | | | # de Teléfono trabajo): |
| Ingreso Annual: | | | | |
| Direccion 2 | |
| # de Dependientes Inmediatos  ( incluir a uno mismo) | | | | |
| Ciudad: | |  | Ciudad: | | | |
|  | | | | |
| Estado: Codigo postal | | Estado: | | Codigo postal | |
| Email: | | | | | | |

Entiendo que si mis ingresos superan el 200% del Nivel Federal de Pobreza, es posible que no me califiquen para este programa. Por lo tanto, seré responsable del 50% de los cargos totals si no tengo seguro o el monto total de la responsabilidad del paciente si estoy asegurado. También verifico que toda la información antedicha es verdad al mejor de mi conocimiento y acepto notificar inmediatamente al personal del Copper Queen Community Hospital si hay cualquier cambio en la información arriba.



Documentación Requerida para la Determinacion:

* ✔ Licencia de conducir, identificación con domicilio, o factura de servicios públicos
* ✔ Prueba de ingreso (talón de cheque o declaración firmada y declarada del paciente o guardián indicando ingresos)
* Una carta de negación del Programa Estatal AHCCCS (Opcional)

Tambien entiendo que esta solicitud no cubre los cargos facturados por otra organización que incluyen, entre otros, cargos de patología, cargos profesionales de radiología, etc.

Firma del Paciente / Guardián Fecha Firma del Testigo del Personal Fecha

List all MRN’s in household:

Notes:

MM/DD/YYYY

MM/DD/YYYY

Reviewed by: Date:

Approved by: Date:

Charity approval timeframe: / / through / /

* Dis-Approved

*To be completed by the Business Office* ☐ Approved

Are all required documents included? ☐ Yes ☐ No Is the patient over 200% FPL? ☐ Yes ☐ No

Initial amount to be adjusted? $