

POLICY Subject: <p style="text-align: center;">Financial Assistance Policy</p>		POLICY NO.: <p style="text-align: center;">PA_03</p>
ORIGINAL DATE: <p style="text-align: center;">06/2016</p>	LAST REVIEW / REVISION: <p style="text-align: center;">03/20/2017, 8/8/2017, 1/2019. 8/20 12/21, 2/22</p>	PAGES: <p style="text-align: center;">1 of 23</p>

Key Words: Charity, Discounted Care, Presumptive Eligibility, Uninsured, Underinsured

Applies to: Inpatient: ___ Outpatient: ___ Provider: ___ All: X Video: ___.

I. POLICY:

The Methodist Hospitals, Inc. (“Methodist”) is dedicated to servicing the health care needs of its patients. To assist in meeting those needs, we have established a Financial Assistance Policy (“FAP”) to provide financial relief to those patients who first meet the following requirements:

- Seek assistance for medically necessary services, or
- Meet presumptive eligibility requirements, and
- Unable to meet their financial obligation, including low-income, uninsured, or medically indigent, and
- Reside within the Country

Methodist is committed to providing emergency and medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for care received from Methodist’s facilities and Methodist’s employed providers.

Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy’s application procedures and those of public benefit or coverage programs that may be available to cover the cost of care. Methodist will not discriminate on the basis of age, sex, race, creed, color, disability, sexual orientation, national origin, or immigration status when making financial assistance determinations. The basis of this program is the truthful and accurate provision and submission of financial information from the patient and/or responsible party(ies). Patients and/or responsible parties that intentionally misrepresent their household financial information will be disqualified from any consideration with regard to this program. Intentional misrepresentation determination is the sole right of the Methodist.

The extent of this program is predicated on the financial ability of Methodist to provide free and discounted services to patients living within United States of America, based on sound business practices and sustained fiduciary stewardship over the hospitals' limited financial resources. Internationally traveling/visiting patients who seek non-emergent treatment are not eligible for Financial Assistance.

ELIGIBILITY CRITERIA

Financial assistance will be extended to uninsured and underinsured patients, or a patient’s guarantor, who meet specified criteria, as defined below. The criteria will assure that the financial assistance policy is consistently applied across Methodist. Methodist reserves the right to revise, modify or change the policy as necessary or appropriate.

- Payment resources (insurance available through employment, Medical Assistance, Victims of Violent Crimes, Workers Compensation, Home Insurance, Auto Insurance, 3rd party liability, etc.) must be reviewed and evaluated before an account is considered for financial assistance to assure that Methodist resources are

prudently managed in providing financial assistance. If a patient appears to be eligible for other assistance, Methodist will refer the patient to the appropriate agency for assistance with completing the necessary applications and forms.

- Applicants are required to exhaust all other payment options as a condition of their approval for financial assistance.
 - Applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by Methodist as possible sources of payment for care, may be denied financial assistance.
 - Patients, or patient's guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial that was received within the previous six (6) months of applying for Methodist financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.
 - Patients or patient's guarantors who have COBRA available must pay premiums. However, if patient would otherwise be approved for Financial Assistance, Methodist may choose to pay COBRA premiums for a limited period of time.
- Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

The criteria used when evaluating a patient's eligibility for financial assistance may include:

- Family income,
- Assets, and
- Medical obligations.

Methodist's financial assistance program is available to all who meet the eligibility requirements set forth in this policy, regardless of geographic location or residency status. Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws. Financial assistance will be offered to eligible underinsured patients, providing such assistance is in accordance with insurer's contractual agreement. Financial assistance is typically not available for patient co-payment or balances after insurance in the event that a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Generally, out of network balances may be reviewed on a case by case basis. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account, will be expected to utilize account funds prior to being granted financial assistance. Methodist reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of Methodist. A patient may only receive financial relief from the financial assistance policy or Self-Pay Policy, but not both for the same patient account. If a patient participates with a given State's Medicaid, for which Methodist is not a participating provider, then Methodist may choose to disregard the patient's coverage when considering eligibility for financial assistance, some factors considered are: number of claims received from a State in a given year; a State's requirements to also enroll physicians; authorization time frame, etc.

PAYMENT BY PATIENT:

Payment in full is expected, for balances due, within 30 days of the initial patient statement. If unfeasible for a patient, or guarantor, to pay in full within this timeframe, a Payment Agreement may be extended for any balance remaining after discounts have been granted to applicants eligible for financial assistance. The term of the Payment Agreement will be based on the applicant's outstanding medical bills, family income and any extenuating circumstances. If an agreed upon Payment Plan is reached, the Payment Plan will be interest-free if paid in full within 12 months. If there are extenuating circumstances, a payment timeframe longer than 12 months may be allowed upon approval..

Patients are responsible for communicating with Methodist anytime an agreed upon Payment Agreement cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency or legal action. If a patient is on a Payment Agreement and then qualifies for financial assistance or additional financial assistance, the Payment Agreement will be adjusted accordingly. In the event a patient fails to pay or does not pay the full amount he/she owes, then Methodist may pursue patient for payment or refer to a third party to pursue payment—see

PRESUMPTIVE ELIGIBILITY

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

- Patient or guarantor has declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off.
- Patient or guarantor are deceased with no estate in probate.
- Patient or guarantor determined to be homeless.
- Patient or guarantor determined by Methodist to be an illegal alien, with no evidence of income or assets as determined by communication with patient or guarantor, credit reports or any other appropriate means.
- Accounts returned by the collection agency as uncollectible due to any of the above reasons.
- Patient or guarantor who qualify for State Medicaid programs, will be eligible for assistance for any cost-sharing obligations associated with the program or uncovered services, unless prohibited by State law.

Methodist understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by Methodist to determine whether a patient's account is uncollectible and will be used to determine presumptive eligibility.

Methodist may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for Methodist financial assistance under the traditional application process.

The electronic technology, when utilized, will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows Methodist to screen uninsured patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

FULL CHARITY

When electronic enrollment is used as the basis for presumptive eligibility, patient financial services will conduct a presumptive charity care screening. Patients will be screened to determine if 100% Financial Assistance adjustment will be provided, and if applicable, will be provided retrospectively for unpaid eligible balances, including balances in Bad Debt, with the exception of balances in legal process or judicial process. Patient accounts granted 100% financial assistance under Presumptive Eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their electronic eligibility qualification, and will not be included in the hospital's bad debt expense.

PARTIAL CHARITY

For patients who cannot be qualified for 100% financial assistance under Presumptive Eligibility, they may still be considered under the traditional financial assistance application process for increased financial assistance. Methodist will provide a written notice informing the patients that increased financial assistance may be available. This notice will include a plain language summary of the financial assistance policy and actions that may be initiated if a financial assistance application is not submitted or the outstanding balance not paid. The following patients who were screened under the Presumptive Eligibility process will be sent a written notice: (a) patients who qualified for partial financial assistance; (b) patients who were denied financial assistance; and (c) patients for where there was not sufficient information available to determine approval or denial.

NON-RESPONSIVE PATIENT:

Methodist understands that certain patients may be non-responsive to Methodist's application process. Under these circumstances, Methodist may utilize other sources of information to make an individual assessment of financial need.

APPLYING FOR FINANCIAL ASSISTANCE

Financial assistance will be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. However, patients that are currently receiving financial assistance by Trustee, County, State and/or Federal assistance, with appropriate proof of such, will not need to provide the hospital with other income information, and municipalities that qualify patients for income assistance and healthcare assistance are recognized as qualifying agencies and no further income information will be necessary as well with appropriate proof of such.

Documentation for income and assets (when applicable) should be included for all patients applying for financial assistance, where such information is available and accessible to the patient. During the screening process the patient's signature will signify the patient's request for financial assistance. Reliable evidence to support the need for financial assistance is required. Income will be determined on a before-tax basis. The following income documentation is required from patients, or their guarantors, to determine eligibility:

- Copy of the Federal tax return with all schedules, from the most recent tax year
- Current proof of income (copy of most recent pay stubs or other documentation)
- Proof of other income (includes earnings, unemployment compensation, workers' 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 stipends, alimony, regular support from family members not living in the household, insurance and annuity payments, etc.)
- Current Bank Statements
- Other documents that may be required to prove income

Noncash benefits (such as food stamps and housing subsidies) and capital losses are excluded from income and asset calculation.

CATASTROPHIC CARE

While the FAP program is primarily income based, for a patient that does not qualify for financial assistance under the income based may qualify for Catastrophic Care Assistance. Under Catastrophic Care Assistance, assets will be valued and added to the household or family unit's total income to determine the amount of financial assistance. Patient or guarantor will need to provide the following documentation and other information requested regarding assets, in order to determine eligibility:

- Checking accounts
- Savings accounts
- Money market accounts
- Certificates of deposit
- Annuities
- Non-retirement investment accounts
- Retirement accounts, including pensions
- Real estate
- Settlements or potential Settlements
- Other assets

SUBMISSION AND REVIEW OF FINANCIAL ASSISTANCE APPLICATIONS

Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement.

If an application is incomplete, or there has been a request for additional information, the application will remain active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30 day timeframe, the application will be denied.

During the period in which the fully completed Financial Assistance Application (FAA) is being reviewed, there will be a stay of all collection proceedings. The FAA will be documented in the patient record or scanned and the account will be noted. The normal billing process is to continue while the FAA is reviewed and considered. If a complete, conforming FAA is approved by the appropriate Methodist representative, this will be noted in the patient's file and the account balance will be adjusted accordingly using the appropriate code. **Financial assistance applications are to be submitted to one of the following offices:**

The Methodist Hospitals, Inc.
Attn: Financial Services
600 Grant Street
Gary, Indiana 46402
Fax: 219-886-6930

The Methodist Hospitals, Inc.
Attn: Financial Services
8701 Broadway
Merrillville, Indiana 46410
Fax: 219-738-6606

If denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

For an Uninsured/Underinsured patient or a patient meeting Catastrophic Care Assistance who qualifies for financial assistance under this policy, the amount billed to the patient or guarantor will not exceed the Amount Generally Billed Percentage ("AGB Percentage") multiplied by total billed charges. Therefore, any patient balance determined by Partial Charity or a Catastrophic Balance, will be adjusted to comply with the upper limited as set by AGB.

The Look Back Method will be based on amounts allowed under Medicare Fee-For-Services. The claims to be included in the AGB calculation will be claims discharged in the prior calendar year that were adjudicated by Medicare Fee-For-Service at the time the AGB calculation was completed. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-For-Service payment. The gross charges for said claims will be included in the denominator. The AGB will be calculated annually by the 45th day following the close of the prior calendar year, and implemented by the 120th day following the close of the calendar year.

Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under Methodist financial assistance policy.

ELIGIBILITY DETERMINATIONS, APPEALS AND DISPUTE RESOLUTION

Patients must be notified of the decision in writing regarding their FAA within thirty (30) days of submitting a completed application. An applicant determined eligible for financial assistance will be refunded payments in excess of the amount determined owed by the patient or guarantor on the unpaid accounts for which they have been granted assistance under the Methodist financial assistance policy. Refunds apply to excess payments of \$5 or more. In accordance with this policy, financial assistance is generally not extended for co-payments or balances after insurance when a patient fails to obtain

proper referrals or authorizations, or if such assistance is not in accordance with insurer's contractual agreement, therefore such payments received will not be refunded. Patients may appeal this decision in writing within 30 days of receiving notification to:

The Methodist Hospitals, Inc.
Attn: Financial Services
600 Grant Street
Gary, Indiana 46402
Fax: 219-886-6930

Appeals must be filed within 30 days of the date of the original decision. The Financial Assistance Committee will review the appeal for further consideration. Decisions of the Financial Assistance Committee will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, Methodist will grant financial assistance for a period of six months from the date of approval, and financial assistance will also be applied retroactively to all unpaid balances for eligible accounts including accounts in Bad Debt, with the exception of accounts in legal process or judicial process.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on the Methodist financial assistance policy will be posted in hospital and clinic registration and admitting locations, in the hospital emergency department, and on patient statements. This information may also be obtained from financial counselors throughout the organization.

The Methodist Financial Assistance Policy, application, Plain Language Summary, Billing and Collections Policy; and Self-Pay Policy will be available on the system's website at www.methodisthospitals.org/billing_info/obtaining-financial-assistance/. This information is also available free of charge. If you need help in completing the financial assistance application, you may call (219) 886-4584 or (219) 738-5508 to speak with a financial counselor.

Information on the Methodist financial assistance policy will be communicated to patients in culturally appropriate language. Information on financial assistance, and the notice posted in hospital and clinic locations will be translated and in any language that is the primary language spoken by the lessor 1,000 or 5% of the residents in the service area.

REGULATORY REQUIREMENTS

Methodist will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that Methodist track financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

EMERGENCY MEDICAL SERVICES

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance; payment information; or debt collection prior to the rendering of services for an Emergency Medical Condition. Methodist will not discriminate on the basis of age, sex, race, creed, color, disability, sexual orientation, national origin, immigration status or FAP eligibility in providing services for an Emergency Medical Condition. Methodist may request a patient to make payment; or pay outstanding debts; or pay cost sharing obligations (i.e. copayments, coinsurance, and deductibles) after services for an Emergency Medical Condition were rendered. No request for payment or debt collection activities will be permitted that may cause a delay in necessary care for an identified Emergency Medical Condition occurring anywhere or at any time at Methodist.

RECORD KEEPING

Methodist will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

PROGRAM LIMITATIONS

The Methodist Hospitals, Inc. is committed to serving the underprivileged within our community to the fullest extent our limited financial resources permit. To ensure prudent management of limited resources, Methodist shall review these programs on a regular, periodic basis and institute adjustments based on our limited financial resources to ensure our longevity and commitment to future services to those in need.

II. DEFINITIONS:

- A. **Amount Generally Billed (“AGB”):** The amount generally billed is the expected payment for emergency or medically necessary services from patients, and/or a patient’s guarantor. For qualifying patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method described in §1.501(r)-5(b) (3) of the Internal Revenue Code.. Prospectively, Methodist may change the method of calculation and/or the AGB Percentage at any time upon update to this policy.
- B. **Amount Generally Billed Percentage (“AGB Percentage”):** The Look Back Method will be based on amounts allowed under Medicare Fee-For-Services. The claims to be included in the AGB calculation will be claims discharged in the prior calendar year that were adjudicated by Medicare Fee-For-Service at the time the AGB calculation was completed. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-For-Service. The gross charges for said claims will be included in the denominator. The AGB Percentage will be calculated annually by the 45th day following the close of the prior calendar year, and implemented by the 120th day following the close of the calendar year..
- C. **Application Period:** The period during which applications will be accepted and processed for financial assistance. The application period will be at a minimum from the date the care is provided and not less than the 240th day after the date that the first post-service billing statement is provided.
- D. **Assets:** Personal property and items of value including checking accounts, savings accounts, money market accounts, certificates of deposit, annuities, on-retirement investments, real estate, settlements or proposed settlements owned by the patient and/or responsible party. Retirement funds (however, distributions and payments from pension or retirement plans will be included in income), the principal residence and ordinary automobiles are excluded from consideration when evaluating the patient’s income and ability to pay unless they are determined to be an extraordinary asset. Extraordinary assets are those items over and above the basic needs of housing and transportation required for self-sufficiency. Examples of extraordinary assets would be: savings accounts with value in excess of estimated annual expenses; personal property considered recreational, such as vacation homes; non-Income generating land; and multiple vehicles per adult in the family
- E. **Catastrophic Care Assistance:** Financial assistance provided to (a) eligible patients with annualized family incomes in excess of 400% of the Federal Poverty Level, and financial obligations over a 12 month period resulting from medical services provided by Methodist in excess of 25% of the family income or (b) upon approval of Chief Financial Officer for patients with extenuating circumstances.
- F. **ELIGIBLE SERVICES:** Services eligible under the Methodist financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:
 - 1. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a patient’s condition.
 - 2. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.
 - 3. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as “covered items or services.”

4. Services of providers employed by Methodist are covered under this policy. Please see Appendix three for a full listing of providers included.
 5. Services not eligible for financial assistance (unless specifically indicated otherwise, such as to address a Community Needs Assessment objective) include the following:
 6. Elective procedures not medically necessary, as well as services typically not covered by Medicare or defined by Medicare or other health insurance coverage as not medically necessary.
 7. Lasik Surgery, Chiropractic Care, Fertility Services, Contacts/Glasses, Cosmetic Surgery/Plastic Services (however, plastic surgery required to correct a disfigurement caused by injury or illness or congenital defect or deformity will be considered Medically Necessary), Hearing Aides, Orthodontics, Dental Services, Optometry.
 8. Services received from care providers not billed under Methodist tax identification number (e.g. private and/or non – Methodist medical or physician professionals, ambulance transport, etc.) Patients are encouraged to contact these providers directly to inquire into any available assistance and to make payment arrangements. See Appendix 3 for a listing of providers not covered under this policy.
 9. Deductibles and coinsurance associated with medically necessary services provided to patient's out-of-network as defined by their insurers.
- G. **Emergency Medical Condition:** As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 2. Serious impairment to bodily functions, or
 3. Serious dysfunction of any bodily organ or part;
 4. With respect to a pregnant woman who is having contractions:
 - i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or That transfer may pose a threat to the health or safety of the woman or the unborn child..
- H. **Family/Household Size and Composition:** Family/Household size is calculated to include the patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their Income Tax Return, they may be considered a dependent for purposes of the provision of financial assistance.
- I. **Family/Household Income:** An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, Family/Household income includes that of the parent or parents and/or step-parents, or caretaker relatives. Family/Household income is determined using (a) the Census Bureau definition, which include the following income when computing federal poverty guidelines and (b) Liquid Assets in excess of \$10,000:
1. Includes earnings, unemployment compensation, workers' 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 stipends, alimony, capital gains, regular support from outside the household, insurance and annuity payments, income from rents, royalties, etc.
 2. Noncash benefits (such as food stamps and housing subsidies) are excluded
 3. Determined on a before-tax basis;
 4. Excludes capital losses
- J. **Federal Poverty Level:** The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.
- K. **Full Charity:** Household income that is equal to or less than 200% of Federal Poverty Guidelines (FPG). (Qualifying applications will receive 100% relief from their hospital obligations.)
- L. **Guarantor:** An individual other than the patient who is responsible for payment of the patient's bill.
- M. **Gross Charges:** Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

- N. **Homeless:** As defined by the Federal government, and published in the Federal Register on December 5, 2011 by HUD: An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.
- O. **Income:** See definition of Family/Household Income
- P. **Income verification:** Patients that are currently receiving financial assistance by Trustee, County, State and/or Federal assistance, with appropriate proof of such, need not provide the hospital with other income information. Municipalities that qualify patients for income assistance and healthcare assistance are recognized as qualifying agencies and no further income information will be necessary.
- Q. **Liquid Assets:** Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, real estate (other than primary residence) or other property immediately convertible to cash. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non-qualified deferred compensation plans. Any resources excluded in determining financial eligibility under the Medical Assistance Program under Social Security Act shall not be considered as assets convertible to cash.
- R. **Medically Necessary:** As defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.
- S. **Medicare Fee-For-Service (FFS):** Health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 USC 1395c – 1395w-5).
- T. **Partial Charity:** A sliding scale reduction in billed charges in accordance to gross (pre-tax) income evaluation for patients who do not qualify for any other financial assistance, who ask for assistance and cooperate fully with the financial need determination process or meet Presumptive Eligibility requirements. Patients/guarantors whose income is between 201 - 400% of the Federal Poverty Guidelines will qualify for one of the following assistance plans:
1. Financial Assistance Plan I (HH90) 201-250% FPG = 90% patient balance due
 2. Financial Assistance Plan 2 (HH70) 251-300% FPG = 70% patient balance due
 3. Financial Assistance Plan 3 (HH50) 301-350% FPG = 50% patient balance due
 4. Financial Assistance Plan 4 (HH45) 351-400% FPG = 45% patient balance due
- Note: Any patient balance determined by Partial Charity, will be adjusted to comply with the upper limited as set by AGB.
- U. **Payment Agreement:** A Payment Agreement is a Payment Plan.
- V. **Payment Plan:** A payment plan that is agreed to by both Methodist and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.
- W. **Payment Plan Options:** Up to a 12 Month Payment Plan at no interest - with a minimum payment of \$25.00. The balance must be paid in 12 months or require approval for extension.
- X. **Presumptive Eligibility:** Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need.
- Y. **Private Health Insurer:** Any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.
- Z. **Qualification Period:** The time frame described in this document for which financial assistance will be granted.
- AA. **Uninsured Discount/Underinsured Discount:** Patients with no third-party coverage, as permitted under this policy, will be provided an uninsured discount for eligible services provided by Methodist, at the time that the undiscounted charges are rendered
- BB. **Underinsured Patient:** An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by Methodist.

CC.Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance available to cover the cost of a patient's healthcare expenses.

III. REFERENCE:

EMTALA Policy
Self-Pay Billing & Collection Policy
Federal Poverty Guidelines, US Department of Health and Human Services
IRS Notice 2015-46 and 29 CFR §§1.501(r) (4) – (6)
26 CFR 250 (31 Dec 2014) p78954-79016
Appendix 1: Financial Assistance Application Form
Appendix 2: FPL
Appendix 3: Covered providers and departments
Appendix 4: Amounts Generally Billed (AGB) Percentage
Appendix 5: Public Access to documents
Appendix 6: Plain Language Summary

IV. DOCUMENT INFORMATION:

A. Prepared by

Dept. & Title

Director, Revenue Cycle

B. Review and Renewal Requirements

This policy will be reviewed annually and as required by change of law, practice or standard.

C. Review / Revision History

Reviewed on: 3/19/18

Revised on: 3/20/17, 8/2017, 1/2019, 8/20, 6/21 12/21 2/22

D. Approvals

- 1. This Policy has been reviewed and approved by the Department Director & Vice President(s) of the Service Group(s):**

Department Director

Revenue Cycle

Date

12/2021

Vice President(s)

CFO

Date

12/2021

- 2. This Policy has been reviewed and/or approved by the following committee(s):**

Committee(s)

Board of Directors

Date

12/2021

Financial Assistance Policy

Appendix 1

See following pages for Financial Assistance Application

***Financial Assistance Program
Documentation Checklist***

Please see the Financial Assistance Policy for eligibility requirements. Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as we can't return any documents sent with the application. If any of the documents are missing, it will delay the processing of your application.

Attach a copy of Patient and/or Guarantor's Driver license; State Identification Card, Visa or other proof of Identity and Residency

If Your Household Has Income:

- Wages, salaries, tips
- Business income
- Social security income
- Pension or retirement income
- Dividends and interest
- Rent and royalties
- Unemployment compensation
- Legal judgments
- Alimony and/or child support
- Workers' compensation income

Attach proof of your household income, which may include:

- >Social Security benefit payments and/or pension/retirement distributions
- >Award letters for Food Stamps (SNAP) or TANF or Township
- >Unemployment or workers' compensation award letters
- >Pay stubs for the last 30 days (pay stubs and/or 1099 forms)
- >Most recent IRS Form 1040 with schedules or equivalent of Form 1040 for residences of other countries
- >If you are self-employed, you must include a full tax return with Schedule C and/or profit and loss statement
- >Dividends and Interest shown on bank statements, mutual fund statements, money market accounts, COD's, bonds, stocks, etc.
- > Other income, such as trust funds, charitable foundations, etc. (statement from this month or last month)
- >Liquid Assets – Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, real estate (other than primary residence) or other property immediately convertible to cash.

If You Have No Income:

If you have no income, send us a letter of support. The person who provides your support must sign the letter and have letter notarized.

Letter of Denial of Medical Assistance

You need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application.

Your Completed and Signed Financial Assistance Application Form

Please complete all the parts of the form that apply to you. Note that a separate application must be completed for each individual patient who is requesting financial assistance.

If you do not qualify for Financial Assistance based on Income, please talk with a financial counselor about Catastrophic Care Assistance.



Financial Assistance Program

To help us determine if you are qualified to receive financial assistance, complete and return the application to the one of the addresses below. Please attached all requested documents.

If you have any questions or need help completing the application please contact Financial Services

Southlake Campus
Financial Services
Methodist Hospital
8701 Broadway Ave
Merrillville, IN 46410
219-738-5508

Northlake Campus
Financial Services
Methodist Hospital
600 Grant Street
Gary, IN 46402
219-886-4584

Account Number(s): _____

Name of Patient:	
Patient's Date of Birth (mm/dd/yyyy):	
Patient's Address:	
Patient's City, State, and Zip Code:	
Patient's Cell Phone:	Patient's Daytime Phone:
Patient's Employer's Name:	Patient's Employer's Phone Number:
Patient's Social Security Number: _____ . Note: Social Security Number is required for some public health programs, including Medicaid. Providing your Social Security Number will help us know if you can qualify for any public health programs.	

If Guarantor is the Patient – skip this section	
Name of Guarantor	
Guarantor's relationship to Patient:	
Guarantor's Address:	
Guarantor's City, State and Zip Code:	
Guarantor's Cell Phone:	Guarantor's Daytime Phone:
Guarantor Employer's Name:	Guarantor's Employer's Number:

Guarantor Spouse – skip if no Spouse	
Name of Guarantor's Spouse:	
Guarantor's Spouse's Address:	
Guarantor's Spouse's City, State and Zip:	
Guarantor's Spouse's phone number:	

Does Patient have health insurance? Yes No	If have insurance, what is name of insurer?
--------------------------------------------	---------------------------------------------

Did you apply for Medical Assistance in the past 6 months? Yes No
If yes, please enclose a copy of the Letter of Denial.
Do you have a lawsuit, settlement, personal injury or liability claim pending for this date(s) of service/treatment of care? Yes No If Yes, provide details

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040. If you are now divorced or separated, please provide proof. If pregnant, count as two members.		
Name	Relation to Patient	Age
Total number of household members (including the patient):		

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your proof of income and asset documents (see documentation checklist).		
Monthly Gross Income	Self	Spouse and/or Other Household Members
Wages/self-employment	\$	\$
Social Security	\$	\$
Pension or retirement income	\$	\$
Dividends and interest	\$	\$
Rents and royalties	\$	\$
Unemployment	\$	\$
Workers' compensation	\$	\$
Alimony and child support	\$	\$
Legal judgments	\$	\$
Business Income	\$	\$
Other Income	\$	\$
Liquid Assets (see checklist) -- if less than \$10,000, enter \$0. If greater than \$10,000, list dollar amount that exceeds \$10,000	\$	\$
Total Monthly Family Income used to determine eligibility for assistance	\$	\$

Additional Comments:

Notice: This application is intended to serve as a statement of policy and not as a contract or agreement with any patient or guarantor. This application does not entitle any person to financial assistance. This application does not create and is not intended to create any third party beneficiaries nor is it intended to create any legal

rights with regard to any person or entity. The Information provided by patient/guarantor will be used only to determine financial responsibility for charges from Methodist (medical care, including hospital and applicable provider services) and will be kept confidential. The information provided to prove income and assets will not be returned. The submitted information concerning annual household income and household size is subject to verification by Methodist including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. **Only emergency and medically necessary healthcare services are eligible for free or discounted service.**

Certification: My signature authorizes Methodist to verify all information provided on this form, including authorization to check credit history, employment status, and other third party information sources to determine eligibility, for federal, state, and private medical programs. I certify that the above information is true and accurate to the best of my knowledge. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges. I understand a determination for financial assistance is made solely at the discretion of Methodist.

Guarantor's Signature: _____

Date: _____

Guarantor's Spouse's Signature: _____

Date: _____

Letter of support

Patient medical record number/account number

Supporter's name

Relationship to patient/applicant

Supporter's address

To Methodist Hospitals,:

This letter is to advise that (patient's name) receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter _____ Date _____

Notorized by the below:

Appendix 2
(Effective March 1, 2022)

Income & Asset Thresholds: The following figures are the 2022 Health and Human Services poverty guidelines which were published in the Federal Register on January 21, 2022.

Number of Person(s) in Family/Household	100%	200%	250%	300%	400%	Asset Threshold (100% of pverty x 6)
1	\$13,590.00	\$27,180.00	\$33,975.00	\$40,770.00	\$54,360.00	\$81,540.00
2	\$18,310.00	\$36,620.00	\$45,775.00	\$54,930.00	\$73,240.00	\$109,860.00
3	\$23,030.00	\$46,060.00	\$57,575.00	\$69,090.00	\$92,120.00	\$138,180.00
4	\$27,750.00	\$55,500.00	\$69,375.00	\$83,250.00	\$111,000.00	\$166,500.00
5	\$32,470.00	\$64,940.00	\$81,175.00	\$97,410.00	\$129,880.00	\$194,820.00
6	\$37,190.00	\$74,380.00	\$92,975.00	\$111,570.00	\$148,760.00	\$223,140.00
7	\$41,910.00	\$83,820.00	\$104,775.00	\$125,730.00	\$167,640.00	\$251,460.00
8	\$46,630.00	\$93,260.00	\$116,575.00	\$139,890.00	\$186,520.00	\$279,780.00
For families/households of more than 8 people, add the appropriate amount for each additional person	\$4,720.00	\$9,440.00	\$11,800.00	\$14,160.00	\$18,880.00	\$28,320.00

Financial Assistance Policy
Appendix 3
Covered Providers and Departments

- 1) The Methodist Hospitals, Inc. (Hospital): All locations
- 2) Physician and physician extenders bill under Methodist's tax identification number, which are as follows: Methodist Physician Group; Indiana Surgical Associates at The Methodist Hospitals, Inc. Northwest Indiana Gastroenterology Center at Methodist

Note: Services must be covered by Financial Assistance Policy and provided by the above Covered Providers and Departments to qualify for financial assistance.

Providers NOT Covered by Financial Assistance Policy

- 1) Emergency Department Physicians/Physician Extenders
- 2) Radiologists/ Physician Extenders
- 3) Pathologists/Physician Extenders
- 4) Anesthesiologists/Physician Extenders
- 5) Hospitalists/Physician Extenders
- 6) All other physician and physician extenders not billed under Methodist's tax identification number

Financial Assistance Policy
Appendix 4
Amounts Generally Billed (AGB) Percentage

Methodist utilizes the “Look-Back” Method. Prospectively, Methodist may change the method of calculation and/or the AGB Billed Percentage at any time upon update to this policy.

AGB Percentage for March 1, 2015 (2014)	27.7% (72.3% Discount from charges. Based on Medicare claims discharged in 2014)
AGB Percentage for March 1, 2016 (2015)	25.1%. (74.9% Discount from charges. Based on Medicare claims discharged in 2015)
AGB Percentage for March 1, 2017 (2016)	23.3%. (76.7% Discount from charges. Based on Medicare claims discharged in 2016)
AGB Percentage for March 1, 2018 (2017)	22%. (78% Discount from charges. Based on Medicare claims discharged in 2017)
AGB Percentage for March 1, 2019 (2018)	21.2%. (78.8% Discount from charges. Based on Medicare claims discharged in 2018)
AGB Percentage for March 1, 2020 (in 2019 with zero balance as of Feb 2020)	20.80%. (79.2% Discount from charges. Based on Medicare claims discharged in 2019 with zero balance as of Feb 2020)
AGB Percentage for March 1, 2021 (discharged in 2020, as of Feb 10, 2021)	20.80%. (79.2% Discount from charges. Based on Medicare paid claims discharged in 2020, as of Feb 10, 2021)
AGB Percentage for March 1, 2022 (discharged in 2021, as of Feb 10, 2022)	20.04%. (79.96% Discount from charges. Based on Medicare paid claims discharged in 2021, as of Feb 10, 2022)

Financial Assistance Policy
Appendix 5
Public Access to Policy

Information on the Methodist Financial Assistance Policy, and the Methodist Self-pay Billing and Collection Policy will be made available to patients and the community served by Methodist through a variety of sources.

1. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via mail at:

The Methodist Hospitals, Inc.
Attn: Financial Services
600 Grant Street
Gary, Indiana 46402

2. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via phone at (219) 886-4584 or (219) 738-5508.
3. Patients and guarantors may download copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via www.methodisthospitals.org/billing_info/obtaining-financial-assistance/.
4. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary in person at the following locations:

Methodist Hospitals
600 Grant Street
Gary, Indiana 46402

Methodist Hospitals
8701 Broadway
Merrillville, Indiana 46410

**Financial Assistance Policy
Appendix 6
Plain Language Summary
The Methodist Hospitals, Inc.**

**The Methodist Hospitals, Inc.
FINANCIAL ASSISTANCE POLICY SUMMARY**

The Methodist Hospitals, Inc. (“Methodist”) is dedicated to servicing the health care needs of its patients. To assist in meeting those needs, we have established a “Financial Assistance Policy” to provide financial relief to those patients who ask for assistance for medically necessary services and who are unable to meet their financial obligation. The Financial Assistance Policy applies to all Methodist’s locations, employed physicians and physician extenders.

Applicants should have...

- Residence in the U.S.
- Limited or no health insurance (underinsured or uninsured)
- A household income at or below 400% of the current year’s Federal Poverty Guidelines or incur a financially catastrophic balance

To uninsured patients, we offer emergency and other medically necessary services in our hospital at no charge to you if your income is at or below 200% of the Federal Poverty Guidelines (the “FPG”). Patients whose income is between 201 – 400% of FPG are eligible for sliding-scale financial relief. All applicants will be screened for other sources of payment to determine what level of financial assistance may be granted. All applicants must comply with the application process or meet presumptive charity requirements in order to receive financial assistance. If you are uninsured and are not eligible for financial assistance, you may still qualify for a discount under our Self-Pay Policy. Please request to speak with a financial counselor regarding the Self-Pay Policy.

If you have insurance, you may still qualify for financial assistance on your patient balance. The patient balance (when allowed for by the private insurer/employer plan) for emergency and other medically necessary services will be fully adjusted off if your income is at or below 200% of the Federal Poverty Guidelines (the “FPG”). Patients whose income is between 201 – 400% of FPG are eligible for sliding-scale financial relief. All applicants will be screened for other sources of income to determine what level of financial assistance may be granted. All applicants must comply with the application process in order to receive financial assistance.

If you have a Catastrophic Balance, which is defined as a balance due to Methodist which is greater than 25% of your annual family income as determined over a 12 month period, you may be eligible for financial assistance. Please ask to speak to a financial counselor for more details.

Under the financial assistance policy, you will not be billed more for emergency or other medically necessary care than the amount of the average payment percentage we are paid by Medicare.

You may apply for financial assistance at any time, even after services have been rendered; however, there are time limitations, as well as limitations to which services/accounts qualify for financial assistance—please see the full Financial Assistance Policy and/or request to speak to a financial counselor. You may obtain a free copy of the financial assistance policy and the financial assistance application form by the following methods: (1) on the Methodist Hospital website at www.methodisthospitals.org/billing_info/obtaining-financial-assistance/ or (2) at our Northlake or Southlake campus in our admissions areas or emergency departments; or (3) by calling Financial Services at **219-886-4584 or 219-738-5508** to request that a free copy of our financial assistance policy and application form be mailed to you. You also have the option to set up an appointment with one of our financial counselors. Our financial counselors are here to assist you in completing the application—please reach out to them.

The financial assistance policy applies only to Methodist and for physician and physician extenders’ services billed under Methodist’s tax identification number. This policy does not apply to non-employed physicians and physician extenders who also treat patients at Methodist. A list of providers which are and are not covered by this policy is located in Appendix 3 of the Financial Assistance Policy.

Hay disponibles versiones en español de este documento, de la Política de Asistencia Financiera y de la Solicitud de asistencia financiera. Solicite copias gratuitas o visite www.methodisthospitals.org/billing_info/obtaining-financial-assistance/.