CAMERON REGIONAL MEDICAL CENTER
CORPORATE COMPLIANCE PROGRAM
POLICY AND PROCEDURE

SUBJECT: Financial Assistance Policy

POLICY: As a hospital exempt from federal taxation under Internal Revenue Code Section 501(c)(3), Cameron Regional Medical Center ("CRMC") shall comply with the requirements of IRC Section 501(r) regarding patient financial assistance. This Financial Assistance Policy shall supersede any prior policy regarding charity or financial assistance.

CRMC shall provide a discount from billed charges for emergency and other medically necessary (non-elective) treatment furnished to eligible patients based on specified criteria under this Financial Assistance Policy. CRMC will not engage in extra-ordinary collection actions before CRMC has made reasonable efforts to determine whether the individual is eligible under the Financial Assistance Policy. CRMC also shall offer a "prompt pay" discount to patients on out-of-pocket charges. CRMC may offer on a limited basis preventive services without charge or at a significant discount. This Financial Assistance Policy is intended to comply and will be construed to comply with Internal Revenue Code Section 501(r) and its implementing regulations.

PURPOSE: The purpose of this Financial Assistance Policy is to provide assistance to low-income individuals to whom CRMC provides non-elective treatment and to identify other limited circumstances in which CRMC shall reduce or waive the amount of billed charges. CRMC shall not offer discounts for the purpose of generating business payable under a federal health care program or to influence such beneficiary's selection of a particular provider, practitioner, or supplier.

PROCEDURE:

Non-Discrimination

CRMC shall provide the discounts specified herein and otherwise make other financial accommodations without respect to the patient/responsible party's race, color, religion, creed, sex, national origin, age, or disability of such person, or any other classification prohibited by law. In offering discounts, CRMC shall strive to treat similarly situated individuals in a substantially similar manner.

Publicizing this Financial Assistance Policy

1. Wide Publication. CRMC shall widely publicize this Financial Assistance Policy within CRMC's service area. A copy of this Financial Assistance Policy, a plain language Summary of the Policy, and the Application for Financial Assistance,

shall be available online at http://www.cameronregional.org/business-office. These materials shall also be available by mail and in paper copies in the public locations of the hospital, including the emergency room and the admissions areas. Further, CRMC will inform the community and patients about the Financial Assistance Policy.

2. Employee Referral to Patient Accounts Department. Employees shall refer any patient/guarantor who requests a financial accommodation or who indicates he/she is unable to pay the entire amount of his/her account balance to the Patient Accounts Department. Employees other than those persons working in the Patient Accounts Department shall not make specific representations or promises to patients/guarantors concerning whether a patient may qualify for any type or amount of financial assistance. Notwithstanding the foregoing, employees in the Emergency Department shall follow EMTALA policies and procedures in responding to inquiries from Emergency Department patients regarding charges and related financial matters.

Prompt Payment Discount

1. Account Balances Less Than $1,000. CRMC shall offer a prompt payment discount on inpatient and/or outpatient hospital charges and charges from CRMC-owned primary care clinics of Thirty Percent (30%) on balances up to $999.99, to all self-pay patients, including balance after insurance. To qualify for this discount, the patient/guarantor must pay the account in full within thirty (30) days of the first self-pay billing statement.

2. Account Balances of $1,000 or More. CRMC shall offer a prompt payment discount on inpatient and/or outpatient hospital charges and charges from CRMC-owned primary care clinics of Fifty Percent (50%) on balances in excess of $1,000, to all self-pay patients, including balance after insurance. To qualify for this discount, the patient/guarantor must pay the account in full within sixty (60) days of the first self-pay billing statement.

3. Permanent Note. If an individual avails himself/herself of the prompt payment discount, the appropriate adjustment shall be made to the account and documented in the permanent notes: "Date, Prompt Pay Discount Taken." If an individual pays his/her account in full within the timeframe described above but does not reduce the payment to reflect the prompt payment discount, CRMC shall refund the amount of the discount to the individual upon request only.

Discounts Based on Financial Need (Financial Assistance Policy)

1. Eligibility. A patient/guarantor may be eligible for financial assistance only if he/she (a) makes a good-faith effort to make payment on amounts owing CRMC, (b) cooperates fully in providing documentation requested by the Patient Accounts Department, (c) cooperates fully with efforts to qualify the patient for other sources of financial assistance (*e.g.*, COBRA benefits, Medicaid, other state and local programs), and (d) has annual income that does not exceed 300% of the current Federal Poverty Level Guidelines ("FPL"), which are available at http://aspe.hhs.gov/poverty/. (Please note: The FPL will change annually.)

2. Method for Applying for Financial Assistance. Any individual wishing to apply for financial assistance for emergency or other medically necessary care shall contact a Patient Accounts Representative at: (**816) 649-3326**. Upon request from a patient for financial assistance, the Patient Accounts Department shall provide the individual with the Application for Financial Assistance and answer questions regarding completion of the application. The application is also available at: http://www.cameronregional.org/wp-content/uploads/2013/10/business-financial_policy.pdf.

   Upon receipt of a completed application, the Patient Accounts Department shall verify the patient's information and request and obtain from the patient sufficient documentation to verify his/her family income and net worth, employment status, other sources of income, other financial obligations, and amount and frequency of bills for medical care. Such documentation may include financial statements, income tax returns, bank statements, paycheck stubs, medical bills, and documentation demonstrating eligibility for public assistance. The Patient Accounts Department shall determine the appropriate documentation necessary for verification purposes on a case-by-case basis, and shall interview the patient/responsible party to obtain any necessary additional information. Failure on the part of the individual to provide necessary information shall render him/her ineligible for any discount.

3. Available Discounts. Using the information provided by the individual as well as information obtained from a credit reporting agency (if available), the Patient Accounts Department shall make an initial determination of the percentage discount available on the balance owing by the individual (the amount the individual is actual responsible for paying, *i.e.,* self-pay, co-insurance, deductible) based on the following chart:

Available Discount

Income Level	Account Balance						
0 – 100% of FPL	**<$1,000**	**$1,001 - $2,500**	**$2,501 - $5,000**	**$5,001- $10,000**	**$10,001 - $25,000**	**$25,001 - $50,000**	**>$50,000**
101 – 150% of FPL	60%	65%	70%	75%	80%	85%	90%
151 – 200% of FPL	50%	55%	60%	65%	70%	75%	80%
201 – 250% of FPL	40%	45%	50%	55%	60%	65%	70%
251 – 300% of FPL	30%	35%	40%	45%	50%	55%	60%

The Administrator/CEO may approve a higher percentage discount for an individual based on documentation of individual or family net worth (*e.g.*, unavailability of liquid assets to pay medical and other expenses), employment status (*e.g.*, recent job loss), amount and frequency of bills for health care services (*e.g.*, individual's or family member's need for future services), and other financial obligations (*e.g.*, extraordinary expenses resulting from unique family situations) or special situations that may be a factor for an individual in the payment of medical bills at CRMC.

4. Limitations on Charges. With respect to an individual who qualifies for financial assistance under this policy, for emergency or other medically necessary care, CRMC shall not require such individual to pay more than amounts generally billed individuals who have insurance coverage for such care ("AGB"), with AGB to be determined as follows:

> CRMC shall use the billing and coding process it would use if the FAP-eligible individual were a Medicare fee-for-service beneficiary and shall set AGB for the care at the amount CRMC determines would be the amount Medicare and the beneficiary together would be expected to pay for the care.

For all medical care that is not emergency or medically necessary care, an individual who qualifies for financial assistance under this policy shall be required to pay an amount that is less than gross charges.

5. Payment Plan. For an individual who does not qualify for a discount but reports difficulty paying bills, the Patient Accounts Department will work with the individual to establish an appropriate payment plan based on the amount due and the individual's financial status. The terms of any payment plan (after appropriate

approval) shall be documented in CRMC's billing system and reflected in billing statements provided to the patient. Such document shall include the following provisions: (a) if an individual fails to make minimum monthly payments, the full amount of the balance shall be immediately due and owing unless the individual demonstrates good cause for his/her failure to make such payments in a timely manner; and (b) if the terms of the payment plan extend beyond one (1) year, the individual may be required to submit updated financial information, and the terms of the plan may be adjusted based on a significant change in the individual's financial situation. After three (3) years of consistent payments, the Administrator/CEO may forgive up to fifty percent (50%) of the remaining balance due as an administrative adjustment.

6. Approval and Notification. All proposed discounts and payment plans shall be reviewed and approved by the Administrator/CEO prior to being offered to any person. If approved, the individual shall be notified in writing. In the case of a payment plan, the individual may be required to sign documentation. The appropriate adjustment shall be made to the account and documented in the permanent notes: "Date, Charity/Hardship Discount Taken." Appropriate documentation for all discounts and payment plans extended to individuals based on financial need (including completed applications and documentation of family income) shall be maintained for a period of five (5) years following resolution.

   CRMC shall promptly notify an individual if his/her request for a discount or payment plan is denied, and shall afford such individual an opportunity to appeal such decision, including the submission of additional documents.

7. Discounts Based on Other Considerations. In addition to discounts based on financial need, the Administrator/CEO may approve an adjustment to a patient account balance based on the following:

   > Good will, public relations, or risk management concerns, so long as there is no intention to influence patient referrals or induce any federal health care program beneficiary to receive services from CRMC.

   Any such discount and the reasons for the discount shall be properly documented in the patient's record and entered in the permanent note as: "Date/Reason for Discount."

Non-Payment

1. Limitation on extraordinary collections. CRMC shall not engage in extraordinary collections actions against a patient (including referral to a collection agency, report to a credit agency, termination of the provider-patient relationship for non-payment) before CRMC has made a reasonable effort to determine whether the patient is eligible under the Financial Assistance Policy.

2. Billing and Collections Policy. CRMC shall adhere to those procedures set forth in the CRMC Billing and Collections Policy in collecting that portion of the bill that is the patient's responsibility. A free copy of this policy is available by calling a Patient Account Representative at (816) 649-3326.

Preventive Services

CRMC may offer certain preventive services to the community at discounted rates or free of charge for a limited period of time, *e.g*., health fair, school physicals. CRMC shall structure such offers so as not to violate any "most-favored nation" or "usual and customary charges" clause in any insurance contract. CRMC shall not condition the offer of any free or discounted preventive services on the provision of any other health care goods or services to the individual.

List of Providers

A list of providers who deliver emergency or other medically necessary care at CRMC is maintained in a separate document and is attached to this Financial Assistance Policy as "Appendix A." The list of providers identifies which providers are covered by this Financial Assistance Policy. The list is also reviewed and updated quarterly.

Appendix A

List of Providers as of September __, 2020

Provider/Specialty	Covered by CRMC Financial Assistance Policy
Cardiology	No
Child Psychiatry	Yes
Cardiovascular/ Thoracic Surgery	No
Dermatology	Yes
Ear, Nose, Throat/ Otolaryngology	Yes
Emergency Medicine	Yes
Endocrinology	No
Family Medicine	Yes
Gastroenterology	No
General Surgery	Yes
Gerontology	Yes
Gynecology	Yes
Hematology	No
Hospitalist	Yes
Internal Medicine	Amin and Azmat – Yes; all others - No
Interventional Radiology	No
Nephrology	Yes
Neurology	No
Neurosurgery	No
Obstetrics	Yes
Oncology	Yes
Orthopedic Surgery	Yes for self-pay, Medicaid, and Tri-Care patients only
Pain Management	Yes for self-pay only.
Physiatry	No
Podiatry	No
Psychiatry	No

Provider/Specialty	Covered by CRMC Financial Assistance Policy
Pulmonary Medicine	No
Rheumatology	No
Sleep Medicine	No
Urology	Yes

If you would like to be considered for Charity Care, please complete this financial assistance form. Below are the guidelines that you must follow in order to qualify for charity write-off:

1) Please complete the entire charity form.

2) Please send a copy of your state and federal income tax returns. If you do not file taxes, proof of income is necessary, whether it be a copy of your most recent W-2 or an alternative form that provides your most recent proof of income.

3) Please start making payments on the account. There needs to be at least six months or more of documented effort to pay.

4) Please make sure all family dependents living with you are listed, including social security numbers and dates of birth.

5) Any accounts turned to a collection agency will not qualify for financial assistance, as there has been no effort to make payments toward the balances owed CRMC.

If you need assistance with this application, please call the number shown below.

Thank you,
Patient Account Representative
(816) 649-3326

CAMERON REGIONAL MEDICAL CENTER DATE:_____

APPLICATION FOR FINANCIAL ASSISTANCE

THE INFORMATION REQUESTED ON THIS APPLICATION WILL BE USED TO ASSIST IN DETERMINING ELIGIBILITY. APPLICANT WILL BE REQUIRED TO SHOW PROOF OF INCOME AND EXPENSES. APPLICATION MUST BE COMPLETE. DEPENDENTS ARE CHILDREN AND OTHER DEPENDENTS WHO ARE LIVING WITH THE APPLICANT AND ARE CLAIMED AS DEPENDENTS ON FEDERAL AND STATE INCOME TAX FILINGS.

PATIENT: _____ ACCOUNT NO. _____ AGE _____ DATE OF ADMISSION _____

RESPONSIBLE PARTY OR APPLICANT	AGE	SOCIAL SECURITY #	SPOUSE	CHILDREN OR DEPENDENTS No. and Ages	

FAMILY MEMBERS LIVING IN YOUR HOME	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS _____ HOW LONG @ ADDRESS _____ TELEPHONE NUMBER _____

	EMPLOYER	POSITION	HOW LONG THERE FROM	TO	MONTHLY GROSS INCOME	TAKE HOME EACH CK	TAKE HOME MONTHLY
1.							
2.							

LIST SOURCES OF OTHER INCOME

IF RESPONSIBLE PARTY OR SPOUSE IS EMPLOYED, HOW LONG EMPLOYED? WHO WAS PREVIOUS EMPLOYER? OCCUPATION?

1. _____
2. _____

MONTHLY INCOME BEFORE TAXES $_____ MONTHLY TAKE HOME PAY $_____ NAME OF BANK_____

POSSIBLE SOURCES OF OTHER INCOME

Alimony	Retirement
Annuity Payments	Social Security
Child Support	Trusts
Dividends	Workman's Comp
Interest	Public Assistance
Rent	

POSSIBLE SOURCES OF PAYMENT

County Indigent Funds
Auto Medical Insurance
Settlement of Liability Claims

Checking _____
Savings _____

A. MONTHLY INCOME BEFORE TAXES $_____gross X 12 $_____ No. in family_____

B. MONTHLY TAKE HOME PAY $_____net x 12 $_____

A. Hill Burton Guidelines $_____

B. Per Capita Income Guidelines $_____

IF APPLICANT QUALIFIES FOR CHARITY BASED ON INCOME GUIDELINES
ADDITIONAL INFORMATION NOT REQUIRED EXCEPT FOR APPLICANTS SIGNATURE
TRANSFER REQUIRED INFORMATION TO SUMMARY.

FOOD (Monthly Cost)	$_____	UTILITIES (Monthly Cost)		BUYING/OWN_____	APARTMENT_____
Grocery Store	$_____	Electric	$_____	RENT_____	MOBILE HOME____
Lunches - work	$_____	Gas	$_____	_____Furnished	HOUSE_____
Lunches - school	$_____	Water	$_____	_____Unfurnished	
Restaurant Meals	$_____	Phone	$_____	Rent.Mtg Payment of $_____	____%of take home pay
% of Take Home Pay Total	$_____	Total	$_____	Paid To _____	

TRANSFER REQUIRED INFORMATION TO SUMMARY

I UNDERSTAND THAT THE INFORMATION SUBMITTED IS SUBJECT TO VERIFICATION BY THIS HOSPITAL. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ANY INFORMATION I HAVE GIVEN PROVES TO BE UNTRUE, I UNDERSTAND THAT THE HOSPITAL MAY RE-EVALUATE MY FINANCIAL STATUS AND TAKE WHATEVER ACTION BECOMES NECESSARY.

_____ _____ _____
SIGNATURE OF APPLICANT DATE SIGNATURE OF WITNESS

PROVISIONAL DIAGNOSIS

	MONTHLY PMTS	PAID TO	DATE DEBT INCURRED	ITEM PURCHASED
auto year/make				
auto year/make				

LIST ANY MONTHLY PAYMENTS TO THE RIGHT

INSURANCE BENEFITS

REMINDERS
CREDITORS

CREDIT CARDS
BANKS
HOSPITALS
FINANCE COMPANY
DOCTORS
DEPT STORES
CREDIT UNION

← total pmts_____% of take home pay total →

balance

SUMMARY

		Percent of Take Home Pay
Take Home Pay	$_____	
Rent/Mtg	$_____	_____%
Utilities	$_____	_____%
Food	$_____	_____%
Monthly Pmts	$_____	_____%
Balance of take home pay left for: Auto repairs, gas & oil, clothing, medical, personal, education, entertainment, misc	$_____	_____%
		_____% TOTAL

CIRCUMSTANCES FOR CONSIDERATION
PLEASE GIVE A BRIEF REASON WHY YOU NEED ASSISTANCE

	ANNUAL FAMILY INCOME	NO. IN FAMILY	INCOME GUIDELINES
A.	$_____		
B.	$_____		

DATE **SIGNATURE OF PERSON TAKING APPLICATION**

OFFICE USE ONLY

EMPLOYMENT STATUS_____
INFORMATION
VERIFIED NO_____ YES_____ HOW? _____
CREDIT REPORT NO_____ YES____

REASON FOR APPROVAL
____ 95020 INCOME GUIDELINES MET
____ 95021 UNEMPLOYED
____ 95022 DEBT OVERLOAD
____ 95023 CATASTROPHIC MEDICAL BILLS
____ 95024 EXPIRE, NO ESTATE
____ 95025 40/48 BALANCE
____ 95026 OTHER _____

REASON FOR DENIAL
_____ INCOMPLETE INFORMATION
_____ LACK OF COOPERATION
_____ SUFFICIENT INCOME APPARENT
OTHER

BILLED CHARGES ____
THIRD PARTY PAYMENTS ____
PAID BY RESPONSIBLE PARTY ____
BALANCE ____
APPROVED FOR CHARITY ____

_____ DATE _____ APPROVED

_____ DATE _____ APPROVED