TITLE: Financial Assistance		POLICY: PA 7.11.18	
AUTHOR:	Karen Schneider	APPLICABLE TO:	Patient Financial Services
SUPERSEDES:		ISSUED BY:	Patient Financial Services
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CFNI	Community Hospital	St. Catherine Hospital	St. Mary Medical Center	PHRC
☒ Munster, IN	☒ Munster, IN	☒ East Chicago, IN	☒ Hobart, IN	☒ Crown Point, IN

POLICY STATEMENT/PURPOSE:

Powers Health is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Powers Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Powers Health will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance -- free and discounted (partial charity) care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to Amount Generally Billed (AGB) received by the hospital for Medicare patients. AGB calculation can be found in Appendix A.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Powers Health procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibly and to allow Powers Health to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity.

I. Definitions

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, 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.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

Includes pre-tax earnings, unemployment compensation, workers' compensation, rental income, disability income, public assistance, veterans' payments, survivor benefits, pension or retirement income, social security, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;

Noncash benefits (such as food stamps and housing subsidies) do not count;

Determined on a before-tax basis;

Excludes capital gains or losses.

If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Assets: Total liquid assets exceeding $ 10,000 would disqualify patient for charity. Exceptions may apply for catastrophic medical situations. Retirement accounts such as 401K and IRA are not considered liquid assets. These assets are reviewed on a case-by-case basis, if retirement account is less than $ 100,000.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross Charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: Defined by Medicare and includes services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Non-covered services: Defined as services considered to be excluded from coverage by Medicaid, Medicare or other insurances or indigent care programs. Non-covered services can be different under each payor's medical coverage policies. This includes exhausted benefits.

Application: The process of applying under this policy, including either (a) by completing the Powers Health Helping Hand Financial Assistance Application in person, online or over the phone with a Financial Counselor or (b) by mailing or delivering a completed paper copy of the Powers Health Application to Powers Health. Financial Counselors are available at each hospital and at Patient Financial Services office, 541 Otis Bowen Drive Munster, IN. Information can be obtained from Patient Financial Services at (219) 934-8888 or toll free at (800) 210-9776.

Documents Needed for Application Consideration:

- Most recent federal tax return with supporting schedules and W-2. Return must be signed.
- Current pay stubs for the last 30 days.
- Most recent bank statement for all bank accounts. Include all pages.
- Proof of assets listed on application.
- If Self Employed, most recent quarterly business profit/loss statement.
- Proof of non-wage income (i.e. unemployment, child support, alimony, trust, pension, social security, interest).

- Proof of Patient Insurance Information, if applicable.
- If not employed, a letter showing means of support signed by person supporting you.
- Award Letter for Food Stamps.
- If you applied for government or state assistance, provide proof of approval or denial.
- Proof of separation.

Community Healthcare System may use all or a portion of the above documents to approve charity care eligibility.

II. Procedures

A. Services Eligible Under this Policy. For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by Powers Health without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at Powers Health discretion.

B. Eligibility for Charity. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, Medicaid, Medicare or other insurance non-covered services and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Amounts eligible for charity can include:

- Uninsured charges
- Uninsured discounts (See separate Self Pay Discount Policy)
- Charges for patients with coverage from an entity that does not have a contractual relationship with Powers Health
- Coinsurance, deductible, and copayment amounts related to insured patients
- Charges for otherwise insured patients with non-covered services
- Charges for otherwise insured patients that have exhausted their benefits
- Charges for patients that have exceeded the length of stay for Medicaid or other indigent care programs

C. Method by Which Patients May Apply for Charity Care.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need and may include:

   An application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;

   The use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

Reasonable efforts by Powers Health to explore appropriate alternative sources of payment and coverage from public and private payment programs and to assist patients to apply for such programs;

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergency medically necessary services. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. Powers Health values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and Powers Health shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

4. A patient seeking income-based financial assistance at any time in the scheduling or billing process may complete the Financial Assistance Application and will be asked to provide information on Annual Family Income for the 30-day period immediately preceding the date of eligibility review. Third party income verification services may be used as evidence of Annual family Income. The Financial Assistance Application may be found in our Emergency departments and Admissions areas, on the back of your printed statement from Powers Health, or from a Financial Counselor at our facilities or online at https://www.comhs.org/about-us/patient-resources/financial-assistance-program or by calling Patient Financial Services at (219) 934-8888 or toll free at (800) 210-9776.

D. Presumptive Financial Assistance Eligibility. The following individuals are presumed to be eligible for 100% financial assistance related to their patient responsibility (including non-covered charges), with no application required. If any items listed below are used as a basis for determining the financial assistance discount, documentation should be retained on file for audit purposes. At hospital's discretion, final eligibility for charity can be made with a subset of charity documents.

- Powers Health may use a third party to conduct an electronic review of public record databases to estimate a patient's family income and otherwise to assess financial need. This predictive model incorporates public record data to calculate a socioeconomic 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 financial assistance under the traditional application process. The hospital uses this information to assess whether a patient is presumptively eligible for financial assistance.
- Death certificate and/or estate search showing no estate
- Patients/guarantors for whom legal notice of bankruptcy is received
- Eligible for other state or local assistance programs for indigent patients
- Homelessness
- Incarcerated patients (hospital personnel should attempt to verify incarceration) may be deemed to be presumptively eligible, but only if their medical expenses are not covered by the governmental entity incarcerating them (i.e. the Federal Government, the State or a County is responsible for the care)
- Medicaid eligible patients who have exhausted benefits or are receiving non-covered services
- Patients with Medicaid or other state or local indigent program in the immediately prior or subsequent six months to the date of service under review
- Patients with limited Medicaid coverage including ER or Pregnancy only
- Charges not covered under Medicaid as part of the Medicaid patient's share of cost

- Out of State Medicaid where the hospital is not currently set up as a billing Provider and the expense of enrolling the hospital is not cost effective
- Non-Credentialed referring physicians with Indiana Medicaid, Out of State Medicaid or Medicare
- Patients referred from community organizations which have agreements with individual hospitals to provide specific services to identified patients with no charge to the patient (i.e. community free clinics).
- Food stamp eligibility
- Subsidized school lunch program eligibility
- Family or friends of the patient that have provided information for establishing a patient's inability to pay. Additional factors may be reviewed before attesting to the patient's indigence.
- Low-income/subsidized housing eligibility
- Information from other external sources that support the patient's eligibility for financial assistance.
- Balances the hospital is not allowed to bill to the patient due to the No Surprise Act.
- Medicare self-administered drugs statutorily excluded by Medicare.

The following individuals are presumed to be eligible for 80% financial assistance related to their patient responsibility (including non-covered charges), with no application required.

- Patients who have children on Package C Medicaid

E. Eligibility Criteria and Amounts Charged to Patients. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. A determination of charity care will be effective for a period of up to 90 days including subsequent emergent or medically necessary care from the date the application was approved and all outstanding receivables unless a payment has been applied on the account. A change in financial situation or the addition of third party payer eligibility may alter the approval period and require further review. If Powers Health has received payments during the application period Powers Health will refund excess payments unless amount is less than five dollars ($5.00). Once a patient has been determined by Powers Health to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges. The basis for the amounts Powers Health will charge patients qualifying for financial assistance is as follows:

Patients whose family income is at or below 200% of the FPL are eligible to receive free care;

Patients whose family income is above 200% but not more than 300% of the FPL are eligible to receive services at amounts no greater than the amounts generally billed to (received by the hospital for) Medicare patients*;* and

Patients whose family income exceeds 300% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Powers Health; however the discounted rates shall not be greater than the amounts generally billed to (that is, received by the hospital for) Medicare patients.

See Appendix B for Charity Sliding Scale.

F. Communication of the Charity Program to Patients and Within the Community. Notification about charity available from Powers Health, which shall include a contact number, shall be disseminated by Powers Health by various means, which may include, but are not limited to, the publication of notices in patient bills and the posting of notices in emergency rooms, in the Conditions of Admission form, at immediate care centers, admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as Powers Health may elect. Powers Health also shall publish and widely publicize a summary of this

charity care policy on facility websites, in brochures available in patient access sites and at other places within the community served by the hospital as Community Healthcare System may elect. Such notices and summary information shall be provided in the primary languages spoken by the population serviced by Community Healthcare System. Referral of patients for charity may be made by any member of the Community Healthcare System staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

G. Relationship to Collection Policies. Community Healthcare System management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from Community Healthcare System, and a patient's good faith effort to comply with his or her payment agreements with Community Healthcare System. For patients who qualify for charity and who are cooperating in good faith to resolve their discounted hospital bills, Community Healthcare System may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. Community Healthcare System will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by the hospital;

2. Documentation that Community Healthcare System has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements;

3. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

See Community Healthcare System website for list of providers who follow our policy.

H. Determination of Eligibility for Financial Assistance Prior to Action for Non-Payment.
Billing and Reasonable Efforts to Determine Eligibility of Financial Assistance. Community Healthcare System seeks to determine whether a patient is eligible for assistance under this Policy prior to or at the time of admission or service. If a patient has not been determined eligible for financial assistance prior to discharge or service, Community Healthcare System will bill for care. If the patient is insured, Community Healthcare System will bill the patient's insurer on record for the charges incurred. Upon final payment from the patient's insurer, any remaining patient liability will be billed directly to the patient. If the patient is uninsured, Community Healthcare System will bill the patient directly for the charges incurred. Patients will receive a series of up to four billing statements over a 120 day period beginning after the patient has been discharged delivered to the address on record for the patient Only patients with an unpaid balance will receive a billing statement. Billing statements include the financial assistance application. Community Healthcare System will also proactively seek to identify patients who are eligible for income-based financial assistance under this Policy through use of third party verification databases. Patients who are identified as presumptively eligible for income-based assistance will be notified and may apply for additional assistance.

I. Incomplete or Missing Applications. Patient will be notified of information missing from the Financial Assistance Application and given a reasonable opportunity to supply it. If missing information is not supplied, Community Healthcare System will close the application and notify the patient by letter that the application has been closed until requested information is supplied.

J. Regulatory Requirements. In implementing this Policy, Community Healthcare System shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

Appendix A

Community Healthcare System Financial Assistance Policy

Basis for Calculating Amounts Charged to Patients

Community Healthcare System utilizes the “look-back” method to determine the “amounts generally billed” (AGB) to individuals who have insurance covering Emergency or other Medically Necessary Care. The AGB is calculated annually and is based on the annual average reimbursement received from all commercial and private health insurers that pay claims to Community Healthcare System and Medicare fee-for-service, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The AGB percentage applicable as of 07/01/2023 at each of our facilities is 24% resulting in a discount of 76% applied to gross charges. Community Healthcare System will begin applying its AGB percentages by the 120th day after the end of the 12-month period used in calculating the AGB percentage.

The percentage was calculated using all claims allowed by Medicare for both inpatient and outpatient services having discharge dates from July 1, 2023 to June 30, 2024. Total expected payment from allowed claims was divided by total billed charges for such claims.

AGB was calculated using this Medicare approach for each of the Community Healthcare System hospital facilities. We have chosen to apply the facility rate most favorable to patients to all of our facilities in 2025.

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Appendix B

Community Healthcare System
Helping Hand Program Discount Matrix
Sliding Scale
Based on Federal Poverty Guidelines for 2025

Effective Date: 02.10.25
***Percent of Federal Poverty Guidelines:**

Powers Health
Helping Hand Program Discount Matrix
Sliding Scale
Based on Federal Poverty Guidelines for 2025

Effective Date: 02.10.25

***Percent of Federal Poverty Guidelines:**

	Up to 200%	201% - 250%	251% - 300%	Over 300%
No. in Family	Annual Income Up To			
1	31,300	39,125	46,950	46,951
2	42,300	52,875	63,450	63,451
3	53,300	66,625	79,950	79,951
4	64,300	80,375	96,450	96,451
5	75,300	94,125	112,950	112,951
6	86,300	107,875	129,450	129,451
7	97,300	121,625	145,950	145,951
8	108,300	135,375	162,450	162,451
9	119,300	149,125	178,950	178,951
10	130,300	162,875	195,450	195,451
11	141,300	176,625	211,950	211,951
*For Family Units with more than eleven members, please see your supervisor.				
Helping Hand Discount Applies at this Rate	100%	80%	74%	0% For Charity (Follow Self Pay Discount)