



Shepherd Center

Origination:	06/1988
Effective:	06/2019
Last Approved:	06/2019
Last Revised:	06/2019
Next Review:	06/2022
Owner:	<i>Jennifer Dennard</i>
Area:	<i>Patient Financial Services</i>
References:	<i>All Center</i>

Financial Assistance to Patients (Revised to Include Financial Arrangements, AC.FS.01.11, 1/2011), AC.FS.01.03

Purpose

Shepherd Center requires that financial arrangements for charges for all services be made prior to or at the time of admission/registration. Assignment of benefits for all verified insurance is accepted towards payment of hospital charges for services rendered. Financial assistance for indigent/charity patients may be available through a systematic and consistent process for the collection of information sufficient to provide determination of eligibility for financial assistance for amounts owed that are the patient or guarantor's responsibility. Due to the changing nature of coverage for Shepherd Center services, all patients will be asked to complete a financial screening form, (as deemed appropriate) at the time of admission or registration regardless of expected insurance coverage.

General Statement:

It is Shepherd Center's (SC) policy to extend its services to as many patients as it can within the financial resources that are available. Those who do not have financial resources to pay for their care at SC will be considered for financial assistance. Patients that will be approved for financial assistance are limited by the funds available for this purpose, unless approved by Chief Financial Officer. It is critical to safeguard funds available for this purpose by assuring that this assistance program is the "payer" of last resort and is only provided to those who have proven an inability to pay.

Procedure

Inpatient and Day Patient Procedure

1. Admission of patients with third party insurance coverage:
 - a. Pre-admitted patients:
 1. All patients scheduled for admission more than 24 hours in advance are pre-admitted.
 2. Insurance benefits or third party coverage is verified prior to admission.
 3. All known deductible, non-covered, and estimated co-pay amounts for which the patient is responsible are due upon admission.

4. Prior to admission, the patient is notified of the amount of deposit due on admission.
5. Deposit is required when the patient is admitted.
6. Amounts due from the patient in excess of the admission deposit payment will be billed to the patient after insurance payments have been collected. Patient liability amounts are due within thirty days from bill date, unless arrangements are made according to section titled Payment/ Credit Arrangements.

b. Emergency or Urgent Admission:

1. Insurance benefits are verified within the first business day on or after admission.
2. Deductible, non-covered, and estimated co-pay amounts due from patient are calculated after admission benefits are verified.
3. Patients or guarantors are notified by the financial counselor or case manager representative, as soon as reasonably possible, the amount that is estimated to be patient liability.
4. Patients whose self-pay responsibility is expected to be less than \$100 may be discharged without definite financial arrangements.
5. Estimated self-pay amounts greater than \$100 are due prior to or on discharge unless other financial arrangements have been approved in advance by the financial counselor or the manager, Patient Financial Services.
6. Amounts due from the patient, not collected at or before discharge, will be due thirty days after billing unless other financial arrangements have been made according to section titled Payment/ Credit Arrangements.

2. Admission of patients with no third party insurance coverage:

a. Routine Admissions:

1. All patients scheduled for routine admission more than 24 hours in advance are pre-admitted.
2. Total estimated payments due from patients (and/or the guarantor) are calculated prior to admission. This amount typically changes given the patient's unique situation as they move through the continuum of care. An initial deposit is collected, preferably for 100% of the estimated discounted amount due. If the full amount is not able to be collected, other arrangements may be made on a case-by-case basis with approval by either the Patient Financial Services Manager or Chief Financial Officer. The case is then monitored on an ongoing basis by the financial counselor to determine when deposits are exhausted. As the deposit amount approaches zero, the financial counselor will contact the case manager to determine the expected discharge date. At that time, additional payments may be calculated and additional deposits may be required prior to the continuation of the patient stay. The approved self pay discount will be afforded to all patients when the patient has no insurance coverage for their hospital stay. The current expected payment for Inpatient and Outpatient services amount. The current expected payment amount is 55% of charges, representing a 45% discount on charges. The current expected payment for Day Program (SCI and ABI) patients are \$550.00, per day. This discount is set slightly higher than our actual estimated cost and at rates far lower than our average managed care contracted rate, reflecting our purposeful philosophical decision to not profit disproportionately from self-pay patients. This percentage may be recalculated from time-to-time as conditions dictate.
3. Financial Assistance in the form of charity care will be considered if financial resources do not

appear to be available. The patient or guarantor will be asked to complete a 'Patient Financial Evaluation' form, (also known as FAP, 'financial assistance program' form), to obtain additional information that will further assist us to assess their eligibility for charity assistance. (Note: If patient is at least 18 years old they will be qualified to apply for assistance based on their own income and assets rather than their parents.) The patient or guarantor will be required to complete the application in full and provide supporting evidence to substantiate income. Minimum supporting evidence for income would include:

Pay stubs representing current income of household.

Anything that provides proof of income, i.e., W2's, Prior Year Income Tax forms, letters from employers etc.

If no income, letter from person providing room & board to patient is required.

(Note: Explanations regarding omission of information due to extenuating circumstances must accompany the FAP form & be documented in Lotus notes, otherwise failure to provide appropriate information necessary to determine eligibility for financial assistance will result in rejection of the application).

Once the FAP form is complete the Financial Counselor will review to assure that supporting documentation is attached, provide all the calculations required on the FAP, and provide a preliminary assessment of eligibility. Eligibility will be based on the criteria established by Shepherd Center as follows:

1. Current Income must not exceed 250% of the Federal Poverty Guidelines for the current year.
2. If income exceeds 250% of the Federal Poverty Guidelines, additional information may be required from the patient or guarantor to determine if assistance can be granted based on a 'medically needy' situation resulting from the catastrophic event necessitating admission to Shepherd Center.
3. For inpatients and day patients, the patient will need to meet asset requirements. Expectation would be that assets other than those listed below and disposable income after reasonable living expenses would be used to satisfy a portion or all of the financial requirements of the patient's care. Assets that may be excluded from consideration are Patient's home with no more than 25% or \$25,000 equity, whichever is less. The requirements to use home equity can be waived if the patient is unable to make payments on additional debt. If the patient has applied for Georgia Medicaid, the FAP form should be completed and if such charges are ultimately not covered or uncollectible the patient is deemed eligible for financial assistance.

If the patient still does not meet criteria, the Financial Counselor will establish deposit requirements based on the expected length of stay and will offer the patient payment options including, payment by Wire Transfer, MasterCard, Visa, Discover, American Express or a payment plan as appropriate.

If the preliminary assessment is to approve the patient for financial assistance, the Financial Counselor will present the packet to the Manager of Patient Financial Services for review and qualification approval.

All financial and other mitigating circumstances are reviewed by the Manager of Patient Financial Services who then makes the final decision regarding eligibility. If assistance is not approved the

Financial Counselor will coordinate the notification to the patient. Payment arrangements will be completed as listed above and based on the Financial Arrangements Policy.

If approved for full assistance or assistance for patient liability over insurance amounts, the Financial Counselor will notify the patient. The covered amount will be written off pursuant to established policy after discharge or insurance is finalized.

b. Emergency or Urgent Admissions

1. Total estimated charges are requested on admission or as soon as it is prudent to approach the patient or guarantor. Nursing staff, and/or the case manager, will be consulted by the financial counselor prior to any contact with the patient or family regarding financial arrangements.
2. Patients who are unable to meet deposit requirements will be assessed by the financial counselor for eligibility of financial assistance following the guidelines under step A3 above or will initiate other payment arrangements.
3. Amounts due in excess of the estimated charges/deposits collected will be billed to the patient and are due within thirty days of bill date unless other financial arrangements are made according to section titled Payment/Credit Arrangements.

Outpatient Deposit Requirements

1. Regular Outpatient Services

- a. Insurance assignment in lieu of payment will be accepted if the patient presents a current insurance card indicating coverage by any of the following:
 - Medicare
 - Georgia Medicaid
 - Blue Cross
 - Champus/Tricare
 - HMO, PPO, etc. (refer to managed care contract database)
 - Verified Worker's Compensation
 - Commercial insurance through an employer
- b. For all outpatient services, payment in full for all charges is due at the time of service. If insurance assignment is accepted in lieu of payment, the patient will be billed known co-pays or deductibles at the time of service, including Shepherd Center employed physician co-pays. In the event the patient is willing to pay for their known co-pays or deductibles, the registration staff will collect at the time of service. Charges are calculated based on the current charge(s) in the hospital charge master for each procedure or treatment scheduled for the patient at the time of registration.
- c. Additional charges for procedures or treatments provided which were not scheduled prior to registration will be billed to the patient and due within 30 days of bill date.
- d. Balances of patient co-pays or deductibles not identified at the time of registration will be billed to the patient after insurance payment is collected and will be due 30 days from the bill date.
- e. Patients who are unable to meet deposit requirements are referred to the Outpatient financial counselor who will assess eligibility for financial assistance or make financial arrangements for payment according to section titled Payment/Credit Arrangements.
- f. All uninsured patients will be asked to complete a financial screening form at the time of registration. If patient is approved for assistance based on the financial data supplied, any patient balances will

be applied to a charity allowance in the same manner as inpatient or day patient accounts.

Payment/Credit Arrangements

1. Patients are requested to pay with check, cash or credit card. Shepherd Center accepts Mastercard, Visa, Discover Card and American Express.
2. Patients who are unable to pay the full amount due are referred to the financial counselor to make appropriate payment arrangements.
3. If the patient demonstrates eligibility based on the financial screening or patient financial evaluation form, using the hospital policy, patient liability balances over insurance, or the full charges would be written off to charity care.
4. Short-term payment arrangements below are accepted based on approval by financial counselor and/or manager, Patient Financial Services.
 - a. Payment Schedule:
 1. Payments must be made monthly.
 2. Payments will be calculated so the entire balance is paid as quickly as possible. The maximum allowable payment periods are:
 - i. Six months for balances greater than \$ 1,000.
 - ii. Three months for balances less than \$1,000.
 - iii. Twelve months, twenty-four (24) and thirty-six (36) month payment plans are available with completion of financial application and approval of the Chief Financial Officer.
 - b. Minimum allowable payment is \$50 per month.
 - c. Previous balances must be combined with the current charges to establish a payment schedule.
 - d. A patient's financial status may be re-evaluated for any changes in circumstances that could require new arrangements.
 - e. Collection actions will be completed using monthly statements with messages requesting payment and referring patient to contact the appropriate financial counselor if assistance is needed. In addition the financial counselor will attempt to contact the patient by phone or other letters as necessary as well as schedule to meet with the patient at the time of any future visits. After a period of 120 days of patient statements, the account will be reviewed for collectability. If it is determined that the patient has not responded the account will be written off as a 'bad debt' and no further collection action will take place. Because of the limited income for many of our Shepherd disabled population, we do not file suits against the patient or report non-payment to credit agencies. We will however coordinate with outside attorneys representing our patients in settlements. We may at our discretion occasionally place a patient on a no-treat list for non-payment of previous balances.

Clarifications:

1. The amount of financial assistance available for all patients will be monitored by the CFO during the year to ensure that funds will be available throughout the year if possible.
2. As a payment source, of last resort, all possible financial resources to the patient will be pursued prior to and subsequent to approval of the patient for financial assistance. Retroactive approval for payment by any third payer or liability settlement will result in funds used for that patient being restored to amounts

available for other patients.

3. Funds available for endowment funds will be considered when setting the level of uncompensated services available but will not be the sole criteria. Other factors would include the profitability level of SC as a whole and the competing uses of the resources available.
4. While 100% of the uncompensated balance will be written off the patient's account, SC will only release donated funds in an amount equal to the estimated cost of providing care, as determined by using the immediately preceding year's overall hospital ratio of costs to charges (RCC) from the filed Medicare Cost Report.
5. Inpatient admission to SC should not be denied pending final resolution of a FAP. However a patient and/or family's lack of cooperation in providing information necessary to assess ability to pay could delay admission to SC.
6. All patients will be asked to complete the Financial Screening form regardless of service location or patient type. The screening forms will allow patients who would not otherwise request assistance to be provided equal access to financial assistance based on the information they provide. It will be up to the judgment and discretion of the Manager of Patient Financial Services to make the determination based on individual cases and circumstances for any patient balance using only the prescreening information without requiring a FAP application. This will be based on guidelines established jointly with the Chief Financial Officer.

Attachments:

[Patient Financial Evaluation](#)

COPY

SHEPHERD CENTER- PATIENT FINANCIAL EVALUATION

Patient's Name _____ DOB _____
 Guarantor Name (if not patient) _____ Date of Application _____
 Address _____ City, State, Zip _____
 Guarantor Employer _____
 Number you claim on income taxes _____ (for dependents under the age of 18 or dependents in college under the age of 26)
 Single Married: If married, how many people in household you pay at least half of their living expenses: _____
 (This will include guarantor, spouse and dependent children)

CURRENT INCOME: Per Month/Year (Gross)

Patient Employment Income: \$ _____ ****Proof of income must be attached**
 Spouse or Guarantor Emp Income: \$ _____ ****Proof of income must be attached**
 Other Income: (List Source) Examples, Social Security, Disability, Worker's Comp etc.
 1. _____ \$ _____ ****Proof of income must be attached**
 2. _____ \$ _____
****Proof of income can be paystubs, bank statement, letter from employer, disability determination letter.**

Total Monthly Income \$ _____ ****If zero and there is no spouse income, must provide room & board letter from person providing basic living expenses to patient.**

PRIOR to INJURY INCOME (No proof required)

Patient \$ _____
 Spouse or Guarantor \$ _____

RESOURCES:

Do you own your home? No Yes (If yes) Estimated Value of Home: \$ _____
 Outstanding Loan Amt: \$ _____
 Checking Account Balance: \$ _____ Savings Account Balance \$ _____
 Investments/Dividends/Interest, etc. \$ _____
CURRENT DEBT: Total Amount of Debt other than home mortgage: \$ _____

FOR SHEPHERD EMPLOYEE TO COMPLETE:

Shepherd Center Employee's Name: _____ Date: _____
Level of Care: Services requested Reason
SCI ___ **ABI** ___
 Inpt.: _____
 Day Pt: _____
 Outpt: _____
 Other: _____
 Has patient applied for GA Medicaid? Yes No Is patient covered by COBRA? Yes No
 Is patient eligible for OOS Medicaid? Yes No If yes, what state? _____

APPROVALS from Program Director & PFS Manager

<125% FPG >125%-250% FPG >250% FPG+ Expenses
 Use of Funds Approved by: _____ Date: _____
 Qualification Approved by: _____ Date: _____

Patient Agreement:

I understand that the information I have provided will be utilized to assess my ability to pay for services rendered at Shepherd Center and/or to determine my eligibility for financial consideration/assistance. I affirm the above information is true & correct. If requested, I will provide additional information and documentation to further assist in the evaluation of my request for assistance. I agree to cooperate with Shepherd Center with regard to identification and assistance with collection of any other payment sources. I agree that misrepresentation of information on this form will result in forfeiture of financial assistance. (Completion of this agreement does not guarantee approval for financial assistance.)

Signature & Date: _____ Witness & Date: _____