## Financial Assistance

**POLICY NO.** B9045.01

### ORIGINATING DEPARTMENT

Patient Financial Services

### REPLACES PREVIOUS POLICY #

Feb. 29, 2016

### EFFECTIVE DATE

Date of Administrator’s Approval

---

**Standard Precautions**

YES | NO

**FOR USE WITH ALL BAYHEALTH POLICIES**

Effective on date of Administration’s approval

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### Responsible Party/ext (Contact Person on file with C360)

Laura Ross x6008

### Forms / Attachments

- B9045.01 Appendix A to Financial Assistance Policy
- P10195 Financial Assistance Policy form Application

### APPLICABLE STANDARDS *** (Required Information)

- **Joint Commission (JC)**
  - List Chapter, Standard & EP
  - N/A

- **National Pt. Safety Goals**
  - List Goal No. & Suffix
  - N/A

- **CMS**

### OTHER:

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### APPROVING COMMITTEES / DATES:

(Place date approved below name of committee)

<table>
<thead>
<tr>
<th>PPC Council</th>
<th>Infection Prevention</th>
<th>Med. Exec.</th>
<th>P &amp; T</th>
<th>Critical Care</th>
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Others:

~ EDUCATION REQUIRED ~

Contact the Education Department to determine if either is required. If yes, Director of Education must approve policy and their Name/Title be listed as last approver under Approval Team Members

### SKILL VALIDATION REQUIRED

<table>
<thead>
<tr>
<th>YES</th>
<th>X</th>
<th>NO</th>
</tr>
</thead>
</table>

Yes or No MUST be checked on both boxes to prevent policy being returned

### DIDACTIC/EDUCATION REQUIRED

<table>
<thead>
<tr>
<th>YES</th>
<th>X</th>
<th>NO</th>
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</thead>
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Yes or No MUST be checked on both boxes to prevent policy being returned

### APPROVAL TEAM MEMBERS

List the approval team member/proxy (with their official title) in the order in which they should be approving this policy.

David Briele, Director Patient Financial Services

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### ADMINISTRATION APPROVAL TEAM MEMBERS

Place an “X” in the box next to the Administrators included on the approval route (DO NOT ALTER OR REMOVE NAMES)

| Brad Kirkes, VP/ Ancillary and Clinical Services | Gary Siegelman, M.D., Senior VP / Chief Medical Officer |
| Mike Metzing, VP/Corporate Support Services | Michael J. Tretina, CPA, MBA, FHFMMA, FACHE, Sr. VP/CFO |
| Eric Gloss, D. O., VP / Medical Affairs | Richard Mohnk, VP/Chief Information Officer |
| Paul Lakeman, Sr. VP, Government Relations | Michael Ashton, Administrator, Milford Memorial |
| Pam Marecki, AVP Marketing Communications | John Van Gorp, Sr. VP/Strategic Planning & Business Dev. |
| Shana Ross, VP/Human Resources | | |
| Bonnie Perratto, MSN, MBA, RN, NEA-BC, FACHE, Senior VP/Chief Nursing Executive | Deborah Watson, Sr. VP,/Chief Operating Officer |
| Lindsay Rhodenbaugh, Sr. VP, Chief Development Officer for Bayhealth Foundation | Terry Murphy, President/CEO |

Policies become effective upon completion of electronic approval route for all designated Approval Team Members
Purpose / Statement:
The Financial Assistance Program (FAP) was established to provide financial relief to those who are unable to meet their obligation to Bayhealth Medical Center, regardless of age, gender, race, national origin, social or immigration status, sexual orientation or religious affiliation.

1. Policy Statement
Bayhealth Medical Center, Inc. (Kent General and Milford Memorial Hospitals, and Bayhealth Medical Group) is committed to providing Health Care Services to patients in the Kent and Sussex counties and surrounding areas regardless of their ability to pay.

2. Areas Involved:
   2.1 Hospital Administration
   2.2 Patient Financial Services
   2.3 Financial Counseling
   2.4 Admissions
   2.5 Finance

3. Forms Involved:
   3.1 None

4. Procedure:
   4.1 Eligible Services: Financial Assistance applies to (1) emergency medical services provided in an emergency room setting; (2) non-elective medically necessary services to patients that meet the financial criteria set by the Medical Center using the Federal Poverty Income Guidelines.

   Bayhealth’s Financial Assistance program provides a 100% discount (full coverage) for those with incomes at or below 200% of the current Federal Poverty Levels (FPL). The uncompensated care schedule will change whenever the Federal Poverty Income Guidelines are changed which is normally annually. If services are not emergency related, but medically necessary, the Medical Center can seek input from the Physician and/or Utilization Management Director in determining the urgency of the services rendered.

   Financial Assistance approvals through the application process are effective six months from the application approval date. Patients need to reapply after the six-month period. Presumptive Financial Assistance approvals are effective for a single visit/episode of care only.

   4.2 Emergency Services: Emergency services as defined within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd); will be provided
to all patients regardless of their ability to pay. Bayhealth’s Emergency Medical Treatment and Active Labor Act (EMTALA) policy, B9000.57 contains further information on emergency services.

4.3 Basis for Calculating Amounts Charged to FAP Eligible Patients

4.3.1 All patients are charged the same based on fees established in the charge master (catalog of procedures and associated fees). Discounts are applied to the set charges to determine final patient responsibility. The Amounts Generally Billed (AGB) are calculated using the look-back methodology and ranges between 46% - 50%. Patients determined eligible for Financial Assistance will have balances written off at 100% of charges. As a result, no FAP eligible patient will be charged more than amounts generally billed.

4.4 Eligibility for Financial Assistance:

Financial Assistance will be provided for those patients who are uninsured, underinsured or who are otherwise unable to pay for care based upon a determination of financial need in accordance with this policy. The approval of Financial Assistance shall be based upon an individualized determination of financial need.

4.4.1 Financial Assistance Eligibility Determinations

Eligibility for Financial Assistance will be determined in accordance with procedures that involve an individual assessment of financial need. These procedures include:

4.4.1.1 An application process whereby the patient or patient’s guarantor provides personal, financial and other information and documentation relevant to making a determination of financial need;

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

4.4.1.3 An accounting of the patient’s available assets, and other financial resources available to the patient.

4.4.1.4 Financial Assistance approvals qualify the patient for a 100% discount on patient responsibility balances.

4.4.2 Financial Assistance Application Process

4.4.2.1 Patients may apply for Financial Assistance by completing an application form. The form is available for download at www.bayhealth.org and may also be requested by calling our Billing Support office 877-744-7081. Instructions for completion and submission of the application form are on the form itself. A referral of patients for Financial Assistance may be made by any Bayhealth staff or medical staff member. A request for Financial Assistance may be made by the patient, family member, close friend, or associate of the patient, subject to applicable privacy laws.
4.4.2.1.1 Patients may apply for Financial Assistance up to 240 days from the first statement date from the date the billed care was provided.

4.4.2.2 Patients are prescreened prior to starting the application process and may be deemed ineligible if the patient is eligible for Medicaid or other third-party reimbursement or if he/she refuses to complete the application process.

4.4.2.3 Patients are required to complete the application process and provide the supporting documentation identified below within 30 days to enable the financial need decision.

4.4.2.3.1 Proof of Income Documentation:
  4.4.2.3.1.1 A copy of the most recent tax return;
  4.4.2.3.1.2 Copies of the most recent month's pay stubs formal sources;
  4.4.2.3.1.3 Written income verification from an employer if paid in cash.

4.4.2.3.2 Family income includes earnings, unemployment compensation, worker's compensation, Social Security, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.

4.4.2.3.3 Family size
  4.4.2.3.3.1 Internal Revenue Service rules state if the patient claims someone as a dependent on their tax return, they may be considered a dependent for purposes of financial assistance.
  4.4.2.3.3.2 Family members visiting from abroad are not considered dependents.

4.4.2.3.4 Asset Documentation
  4.4.2.3.4.1 Bank statements from savings, checking and investment accounts for the most recent three months;
4.4.2.3.4.2 Additional information may be required as identified on the application based on an individual’s circumstances.

4.4.2.4 Bayhealth Medical Center reserves the right to check the legitimacy of the information at their discretion.

4.4.3 Appeal Process

4.4.3.1 Patients may appeal a financial assistance denial decision. To be considered for an appeal, patients must submit a written letter with copies of all medical bills to support their hardship. Additional documentation may be required to support the hardship appeal.

4.4.4 Presumptive Financial Assistance Eligibility

4.4.4.1 Effective July 1, 2014 Bayhealth has a presumptive charity care program whereby all uninsured patients will be screened for financial assistance.

4.4.4.2 Bayhealth uses an outside agency to determine estimated income amounts from an individual’s credit history for the basis of determining Financial Assistance.

4.4.4.3 Patients/Guarantors meeting the pre-defined criteria will have their balance for only that visit discounted at 100% under the Financial Assistance program.

4.4.4.4 Patients not meeting the Financial Assistance presumptive criteria are eligible to apply for Financial Assistance through the application process.

4.4.5 Migrant Workers and Homeless

4.4.5.1 Migrant workers and the Homeless often cannot be contacted to complete the Financial Assistance application process and are challenging to qualify through the Presumptive Financial Assistance process. Once Bayhealth confirms the patient is a migrant worker or homeless, the account may be written off at 100% under the Financial Assistance program.

4.4.5.1.1 Documentation to confirm migrant worker status is a letter from the farm documenting the hourly wage, frequency of payment and length of employment.

4.5 Delaware’s Adult Poverty Medicaid program does not provide retroactive coverage to the individual’s application date. Rather, qualified individuals are eligible from the approval date forward. Effective July 1, 2013 forward, patient balances incurred between Bayhealth’s Medicaid eligibility vendor application submission date and approval date for Delaware Medicaid will be deemed as Financial Assistance program qualified upon Medicaid’s approval determination.
4.6 Federally Qualified Health Centers: Bayhealth does not participate in the CHAPS program but is committed to serving the Community and will honor the Federally Qualified Health Center’s approval for diagnostic services only. Proof, in the form of a card or letter, of the Health Center’s financial assistance approval is required. Patients necessitating further services will be required to apply for Financial Assistance through Bayhealth.

4.6.1 Effective July 1, 2014 forward, patients receiving diagnostic services who are uninsured are screened through our presumptive charity process.

4.6.2 To support this decision, Federally Qualified Health Centers are required to submit a copy of their financial assistance policy, application and example redacted approvals to support their determination. Bayhealth will maintain this information on file and the Federally Qualified Health Center should provide new copies annually.

4.7 Relationship to Collection Policies

4.7.1 Bayhealth entities will comply with the Bayhealth guidelines for collection agencies and attorneys and Federal and State laws and regulation governing healthcare billing and collections. Bayhealth’s collection policies take into account the extent to which the patient qualifies for Financial Assistance and a patient’s good faith effort to comply with his or her payment plan agreements. For patients who qualify for Financial Assistance and those who are cooperating in good faith to pay their payment plans, Bayhealth will not send unpaid bills to collection agencies. Patients delinquent on their payment plans will be sent to collections.

4.7.2 No Bayhealth entity will impose extraordinary collection actions (ECAs) such as decisions to deny or defer financial assistance based on a patient’s outstanding accounts receivable and payment history, reporting adverse information to a consumer credit reporting agency or credit bureau, wage garnishments, estate claims, or other legal actions against any patient without first making reasonable efforts to determine whether that patient is eligible for assistance under this Financial Assistance policy.

Reasonable efforts shall include:

4.7.2.1 Multiple invoices to the patient, from both Bayhealth and Bayhealth’s external collection agencies;

4.7.2.2 Attempts to contact non-responsive patients via telephone or other means of communication to inform the patient of the amount owed and discuss payment options, including eligibility for Financial Assistance;

4.7.2.3 Documentation that Bayhealth has or has attempted to offer the patient the opportunity to apply for Financial
4.7 Assistance pursuant to this policy and that the patient has not complied with the Bayhealth application requirements;

4.7.2.4 Documentation that the patient does not qualify for Financial Assistance on a presumptive basis;

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

4.7.3 Estimated ECA Timeframes

4.7.3.1 Accounts placed in collections between 120 – 150 days from the date of first statement.

4.7.3.2 Unpaid debt is reported to the credit bureau no less than 30 days post placement with collection agency.

4.7.3.3 Legal action is recommended by our collection agency after they have exhausted their collection efforts. Collection agencies use publicly available data from the credit bureaus to identify patients who may have a means to pay before recommending legal action. Bayhealth reviews each recommended legal action to confirm patients have not subsequently qualified for Medicaid or our Financial Assistance Program as legal action is not pursued on those patients. Legal actions may result in wage garnishments.

4.8 Provider List: Bayhealth contracts with several physician groups to provide physician and/or supervisor and interpretation services within Bayhealth entities. Please see Appendix A for a list of contracted physicians/physician groups who provide service at Bayhealth.

4.8.1 The provider list can be obtained by calling the Billing Support office at 877-744-7081.

4.9 Limited English Proficiency (LEP) Translation Services

4.9.1 Patients with LEP may come to our office at one of the addresses below and Bayhealth will call the Language Line (800-481-3289) with the patient to have an interpreter assist in communication.

4.9.1.1 Kent General: 522 South State St, Dover, DE 19901

4.9.1.2 Milford Memorial: 21 West Clarke Ave, Milford, DE 19963

5. Communication:

5.1 Policy Communication Methods:

5.1.1 Policy is available on Bayhealth’s website.

5.1.2 Patient Access refers patients to a Financial Counselor if the patient is uninsured or expresses concern over the cost of services.
5.1.3 All clinical departments performing registration functions have the "Guide to Bayhealth Billing" pamphlet which provides information on the financial assistance policy and how to apply for assistance.

5.1.4 Patient statements include information on how patients can apply for and contact information for financial counselors.

5.1.5 We attempt to contact self-pay/balance after insurance patients via the telephone and certified mail as appropriate, prior to placing the account in Bad Debt. If the patient indicates they are unable to pay, we advise them of our policy and screen them for financial assistance.

Attachment: Appendix A (list of contracted physicians/physician groups)
Patients must meet both the income and assets criteria

**INCOME CRITERIA**

Patient Pays 0% of Charges

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Poverty Line Factor 200%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$23,760 or below</td>
</tr>
<tr>
<td>2</td>
<td>$32,040 or below</td>
</tr>
<tr>
<td>3</td>
<td>$40,320 or below</td>
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<tr>
<td>4</td>
<td>$48,600 or below</td>
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<tr>
<td>5</td>
<td>$56,880 or below</td>
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<tr>
<td>6</td>
<td>$65,160 or below</td>
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<tr>
<td>7</td>
<td>$73,460 or below</td>
</tr>
<tr>
<td>8</td>
<td>$81,780 or below</td>
</tr>
<tr>
<td>9</td>
<td>$90,100 or below</td>
</tr>
<tr>
<td>10</td>
<td>$98,420 or below</td>
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</table>

**ASSETS CRITERIA**

Individual assets cannot exceed $40,400 for a single and $80,800 for a family. Assets greater than the limits are to be paid towards the outstanding balance prior to applying the uncompensated credit.
Dear __________________________

Your application for Bayhealth Medical Center Financial Assistance Program is enclosed. Please complete the following items:

Step 1  Complete both sides of the Financial Application Form.

Step 2  Get proof of your income. We require proof of income for a (4)-week period ending with the date of your application. This must include income for all dependent members of the family. You may use a payroll check stub, a letter from the employer, a copy of your monthly check you may receive from the government (for example: alimony, child support, unemployment or social security). We will also need copies of your bank statement for the last (3) months and last year’s Federal and State Tax Return. For patients who are retired or on disability, we require your current Social Security Benefit notice and your current SSA-1099 Social Security Benefit Statement from Social Security.

Step 3  When steps 1 and 2 are completed, you can either mail the application or call to set up an appointment to have your application reviewed by either one of our Financial Counselors, their addresses and telephone numbers are as follows:

<table>
<thead>
<tr>
<th>Kent General Hospital</th>
<th>Milford Memorial Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attn: Financial Counselor</td>
<td>Attn: Financial Counselor</td>
</tr>
<tr>
<td>640 S. State Street</td>
<td>21 West Clarke Avenue</td>
</tr>
<tr>
<td>Dover, Delaware 19901</td>
<td>Milford, Delaware 19963</td>
</tr>
<tr>
<td>(302)  744 - 7481</td>
<td>(302) 430 - 5727</td>
</tr>
</tbody>
</table>

In order for your application to be considered it must be completed, dated, signed and return to the hospital within (30) days of being sent to you.

Sincerely,

Financial Counselor

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**SURGERY PATIENTS**

If you are scheduled, or being scheduled, for surgery it is important you advise us now and do your best to complete and return the application in its entirety to us as soon as possible prior to your surgery.

Surgery Date: __________________________

Physician Name: __________________________

Physician Phone Number: __________________________
Date__________________                                                                      SS#______________________________

Patient’s Name___________________________________________  Date of Birth_____________________

Home Address _____________________________________________________ Phone__________________

Patient’s Employer__________________________________________________Phone__________________

If Unemployed:  How long Unemployed_________  Former Employer_______________________________

Date Became Unemployed____________________  Are you eligible for COBRA____________________

Employer’s Address_________________________________________________________________________

(If Self Employed Provide Business Address )

Occupation_____________________________________________________How long Employed__________

To be Completed by Full-time Students Only:

Are you covered under your parent’s, or another insurance policy through the university? _________

If yes, provide policy information:_________________________________________________________

Are your parents claiming you as a dependent on their taxes?   _____Yes   _____No

Residence Location:  _____ On Campus Housing  _____Off Campus Housing

Responsible Party Name_______________________ SS#__________________  Date of Birth____________

Responsible Party Address___________________________________________ Phone___________________

Spouse’s Employer__________________________________________________Phone___________________

Spouse’s Name_______________________________SS#___________________ Date of Birth____________

Spouse’s Employer Address__________________________________________ Phone___________________

Spouse’s Occupation__________________________________________ How long Employed_____________

Total Monthly Gross Income________________________ Total Monthly Net Income___________________

All Other Income _____________________(Spouse emp., Alimony, Child Support, etc.)

Number of Dependents ________ (under 18 or 21 if full time student)

Name(s) of Dependents ______________________________________________________________________

FINANCIAL INFORMATION

Bank___________________________________City__________________State________________________

Own Home_____ Buying _____ Approx. Value ____________ Rent _________ How Long________________

Other Property__________________________ ___________________Approx. Value ________________

Mortgage Holder/Landlords Name & Address

Auto #1 _________ Make __________ Year _________ Financed by_______________________________

Auto #2 _________ Make __________ Year _________ Financed by_______________________________

Recreational Vehicles Own: ________ Boat, Motorcycle, Camper, etc.__________________________
**FINANCIAL APPLICATION**

**Office Use Only**

<table>
<thead>
<tr>
<th>Acct. #</th>
<th>Amt.</th>
<th>O/I</th>
<th>Acct. #</th>
<th>Amt.</th>
<th>O/I</th>
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List all debts owed in order excluding Bayhealth’s debt

<table>
<thead>
<tr>
<th>To Whom Indebted</th>
<th>Type of Acct.</th>
<th>Current Balance</th>
<th>Account Number</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Auto #1</td>
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</tr>
<tr>
<td>Auto #2</td>
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<td></td>
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<tr>
<td>Credit Cards</td>
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<tr>
<td>Banks Finance Co. Etc.</td>
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<tr>
<td>Medical Bills</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
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</table>

**MONTHLY HOUSEHOLD EXPENSES**

<table>
<thead>
<tr>
<th>Food</th>
<th>Elec.</th>
<th>Gas</th>
<th>Sanitation</th>
<th>Phone</th>
<th>Water</th>
<th>Cable</th>
<th>Child Care</th>
<th>Auto Ins.</th>
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**CREDIT INVESTIGATION AUTHORIZATION**

I hereby authorize Bayhealth Medical Center or its agent to investigate any references, statements, or other data made by me or any other person pertaining to my credit and financial responsibility. I affirm that the information given on my Financial Application Form is true and correct.

Signature ______________________ Date __________

**OFFICE USE ONLY**

Date Application Received ___________________________ Eligible Charges ___________________________

Comments:

Physician Office Response for Surgery: Urgent_____ Semi-Elective_____ Elective_____