SUBJECT: CHARITY ***CODE: C - 2***

EFFECTIVE DATE: 03/93
REVISION DATE: 6/07, 4/08, 10/08, 1/14, 1/15, 1/16, 7/16
REVIEW DATE: 6/07, 4/08, 10/08, 10/11, 2/13, 1/14, 1/15, 1/16, 7/16

RELATED POLICIES:

POLICY: United Hospital Center acknowledges that there are patients who do not possess the ability to pay for healthcare services and those individuals will be provided financial assistance (also referred to as "charity care") as established by this policy.

Cosmetic and/or purely elective procedures are not eligible to be covered under charity. Payment for these elective or cosmetic/plastic procedures may be required prior to performance of specific procedures. Any procedure that is questionable will be reviewed to determine its eligibility.

Hospital assistance does not apply to accounts relating to services incurred due to and payable by general liability, motor vehicle or workers compensation insurance. Also not applicable, are accounts that have a viable payer source, such as the patient's insurance that will process for payment but the claim is pending upon receipt of information from the patient. Applicants must also be a citizen or permanent resident of the United States (foreign students are not eligible).

Charity care will be provided at 100% only to those patients where the household income (defined as income for the patient and any related guarantor as listed on the most recent Federal Tax Return) is at 200% or below federal poverty guidelines as published annually by the Community Services Administration in the Federal Register. All financial assistance applicants in this grouping must provide proof that they have been denied Medicaid coverage before UHC will provide charity care. Applicants in this grouping will be encouraged (and assisted by UHC) to enroll in the Health Insurance Marketplace Exchange.

All financial assistance is also only granted where there are not substantial cash convertible assets as defined below.

Identification of charity care is provided through Financial Counseling, Registration, Patients Accounts Representative, Credit Counselors and/or other Associates in the Patient Accounts Department. Charity is predicated on the patient seeking Medicaid eligibility. Medicaid eligibility/denial within 90 days of processing the application will need to be included before application can be finalized. Charity is contingent on the completion of the Patient Financial Status Statement. An individual's failure to comply with our documentation and/or soliciting Medicaid eligibility shall be excluded from consideration.

Patients admitted with a valid Health Access card are not required to complete a Patient Financial Status Statement. Health Access has completed all the required screening of the patient. Patient's having valid assistance from the following listed

system hospitals will be honored and are not required to complete a new application or additional Medicaid screening. The patient will need to submit a current approval letter showing valid dates of assistance. The Medicaid process would have been completed at the hospital that processed the approval. The charity approval letter will need scanned to the account under charity.

The following hospitals are included:
Ruby Memorial
Camden Clark Medical Center
St Joseph's Hospital of Buckhannon
Potomac Valley Hospital
Berkeley Medical Center
Jefferson Medical Center

COMPLETION OF THE PATIENT FINANCIAL STATUS STATEMENT:

Any patient completing the Patient Financial Status Statement must provide demographic information; sources of income, monthly earnings from employer, total household income, and asset information. The patient is required to attach proof of income, which includes but is not limited to, current tax returns, current pay stubs, current bank statement (dated within the past 90 days), and any other supporting information. If the appropriate documentation is not submitted with the application, the associate will return the application with a letter indicating what is needed. This information is to be returned within 30days of the request and this is indicated on the return letter.

UHC will analyze the statement as follows:

Calculations:

- Balances of convertible assets; such as checking, savings and money market accounts are totaled and listed on the calculation sheet.
- The patient portion of the UHC bill is listed on the calculation sheet and a screen print of current account balances (if a patient has multiple active accounts, all accounts will be included to determine charity eligibility) considered during the calculation of this application will be included for finalizing and scanning of the application.
- All hospital, physician office, prescription and other medical bill balances are considered for total medical bills on calculation sheet.
- Monthly Gross income is listed, totaled and then multiplied by twelve on the calculation sheet. If the applicant is self-employed their net income is used in the calculation.

- The number of dependents is listed and the corresponding poverty guidelines threshold for the applicant's yearly income.
- The value of checking, savings or assets are added to the net income and the total of all medical bills or prescriptions are subtracted leaving the total income.
- If substantial hard assets exist, they will be considered.
- If yearly income is greater than 200% of federal poverty guidelines, the applicant is not eligible for assistance.
- Bills for elective or cosmetic procedures are not eligible.
- Bills payable by general liability, motor vehicle insurance or workers compensation are not eligible.
- If the applicant is residing in a nursing home and all income is utilized for their care they may qualify for financial assistance from UHC.
- Medical expenses higher than 7.5% of the adjusted gross income will be considered to determine if a one-time percentage write-off should occur.
- The charity percentage approved, either 100% or 0% is noted on the calculation sheet.
- The calculation sheet is then signed by the UHC Associate reviewing the application and any pertinent information used in the decision will be noted.

UHC will insure that Medicaid eligibility is verified and if the patient indicates recent unemployment, and the employer did not offer COBRA, UHC will ascertain options in that regard.

Upon approval, UHC will send the charity card and to the patient for the patient to endorse. A letter is also included that will explain that the patient will be required to show the card at each visit to the hospital. It will also be the patient's responsibility to contact UHC if they receive a statement to receive a charity write-off. It will also explain that the charity card is valid for six months from the date of the approval and may be discontinued during that time if it is determined that the patient is Medicaid eligible. For patients that have out of state Medicaid claims they can apply for charity. The accounts are listed as self-pay and the patient would submit proof of active out of state Medicaid. After six months, if the patient requires services at UHC, a new application and approval will be required. Denials will be explained in a letter sent to the patient.

Applicants that are not eligible for Charity care may complete a new application six months after the denial letter is mailed from the Business Office unless a significant change in patient's financial status or family can be substantiated.

Eligibility dates:

The eligibility date will be based on the date the application is received and processed. If the application is received and processed prior to the 15th of the month the approval date will be from the beginning of the month through the ending of the sixth month. If the application is received and processed after the 15th of the month the approval date will be from the first of the next month.

Once the charity cards for all family members and the approval letter has been sent to the patient, the UHC Associate will provide the supervisor with a listing of accounts that need to be written off if the account balance exceeds $10,000. A copy of the calculation sheet will also be submitted. All outstanding balances, excluding general liability accounts including motor vehicle insurance claims, workers compensation claims, cosmetic and/or elective procedures and those in the bad debt location older than eight months (240 days) from the date of service, will be processed to charity care and the shared drive write-off log will be completed.

All claimable Medicare charity accounts will be listed on the monthly Medicare charity logs. Medicare accounts will be processed and kept until requested for audit. All Medicare accounts are to include demand bill, Medicare EOMB account history and current credit application. Monthly quality reviews will be performed for all Associates who review charity applications (including Family Medicine).

Additional Requirements:

1. Send application to EGS for review.
2. Medicaid expansion became effective October 1, 2013; all applicants will have to apply for Medicaid to see if they qualify. There are a variety of ways to check your eligibility and apply for Medicaid including;
    a. Online at the Health Insurance Marketplace at www.Healthcare.gov
    b. Online at www.wvinRoads.org
    c. By calling the Federal call center at 1-800-318-2596
    d. In person at your local WV Department of Health and Human Resources (DHHR) office. A list of offices can be found at www.wvdhhr.org/bcf/county
3. Once a denial has been received from DHHR, if there are no changes to the applicant's information, this is verified with the patient and noted on the account. If the denial from DHHR is three months old, a new denial is needed. If the denial was due to spend down not being met, a new denial will be needed each month to verify.

4. Place the corporate number at the top of the assistance application.
5. Print screen of all accounts owed.
6. Standard notes should be utilized.
7. If an account is in bad debt status and at a collection agency the account can be considered for charity if the age of the account is within eight months (240 days) from the date of service.

Presumptive Charity Process

True self pay accounts scored by PARO that meet the qualified presumptive charity score of 650 or lower are noted with standard note 0195 and will be written to presumptive charity write off code 1010. This applies to true self pay accounts where applications have not been received however the financial result score indicates financial assistance is needed. This would only apply to those true self pay accounts that are ready for outside collection agency and the account balance is due from the patient.

Cosmetic and/or purely elective procedures are not eligible to be covered under presumptive charity. Payment for these elective or cosmetic/plastic procedures may be required prior to performance of specific procedures. Any procedure that is questionable will be reviewed to determine its eligibility.

Presumptive charity assistance does not apply to accounts relating to services incurred due to and payable by general liability, motor vehicle or workers compensation insurance. Also not applicable, are accounts that have a viable payer source, such as the patient's insurance that will process for payment but the claim is pending upon receipt of information from the patient.