LORETTO HOSPITAL
POLICY

Effective Date:	**SECTION: Patient Accounts Policies/Procedures**	**POLICY NUMBER:**
Revisions:	**TITLE: Financial Assistance/Charity Care For Uninsured & Underinsured Patients**	==========
	==========	**PAGE**
Reviewed:	**AUTHORIZED BY:**	
	Kenneth McGhee 03-01-16 **Kenneth McGhee** **Date** **Chief Financial Officer**	

FINANCIAL ASSISTANCE/CHARITY CARE FOR UNINSURED & UNDERINSURED PATIENTS

PURPOSE:

This policy identifies the circumstances under which Loretto Hospital will extend medical care free of charge or at a discount commensurate with the patient's ability to pay. The necessity for medical treatment of all patients will be based upon clinical judgment without regard to the financial status of the patient.

DEFINITIONS:

AGB – amounts generally billed for emergency or medically necessary care to individuals who have insurance coverage.

Bad Debt Expense – health care services provided that are expected to result in the generation of payment of services, but due to the patients' unwillingness to meet their financial obligation, resulted in non-collection of those services.

Charity (Free) or Discounted Care – health care services provided that are not expected to result in the generation of payment in full, in accordance with procedures established in this policy. This does not include contractual allowance amounts between hospital gross charges and contracted third party reimbursement rates.

ECAs – extraordinary collection actions are actions taken by Loretto Hospital against an individual related to obtaining payment of a bill for care covered under Loretto Hospital's FAP that require a legal or judicial process or involve selling an individual's debt to another party, or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

FAP – financial assistance policy.

FAP-Eligible Individual – an individual eligible for financial assistance under Loretto Hospital's FAP (without regard to whether the individual has applied for assistance under the FAP).

Insurance Payments – health care services that were expected to result in the generation of payment of services from Medicare, Medicaid, Blue Cross, HMO's, PPO's and any other valid and qualifying insurance that the patient possesses. This includes any valid supplemental insurance to meet deductible and co-insurance payments required by insurance providers described above.

Patients without Insurance (Uninsured Patients) – patients requiring medically necessary services who are not covered by or eligible for Medicare, Medicaid HMO's, PPO's or other third party payers at the time healthcare services are provided.

Presumptive Charity Care – health care services to uninsured patients that are not expected to result in payment and no Financial Assistance Application is completed.

POLICY:

It is the policy of Loretto Hospital to provide quality medical health care to all persons regardless of race, creed, sex, national origin, handicap, age or the ability to pay. Loretto Hospital recognizes that not all individuals possess the ability or means to purchase essential medical services, and, further, that our mission is to serve the community with respect to providing healthcare services and healthcare education. Therefore, in keeping with the Loretto Hospital's commitment to serve all members of the community, charity and/or subsidized care will be considered where the need and/or an inability to pay are identified.

Charity and/or subsidized care includes medical services provided to uninsured non-governmental patients, indigent government program patients and/or other low income, underinsured patients. Loretto Hospital will also consider cases of medical need in catastrophic cases where income or assets would otherwise be considered too high to qualify for assistance. Each patient will be reviewed based upon the standards set forth within this policy. Charity and/or subsidized care will be granted solely for the benefit of the patient and his/her family and is not intended to relieve the patient of liability for payment to other third parties.

PROCEDURES:

Determination of Eligibility for Charity, Presumptive Charity or Discounted Care:

1. Charity or discounted care is available for medically necessary services as defined by Medicare to patients who meet the financial and documentation criteria defined below. Each situation is reviewed on an individual case by case basis. While not absolutely essential, the need for potential charity or discounted care should be established in advance of admission or rendering of service or shortly thereafter.

2. Based on Federal Poverty Guidelines (FPG), financial assistance discounts are determined by a sliding scale of total household income. See attached Federal Poverty Guidelines Sliding Scale (Attachment A). To determine the write off applicable to the patient's bill, his/her total annual household income will be compared to the most current Federal Poverty Guidelines.

Income Level	Discount from Gross Charges
200% FPG or below	100% Discount
Above 200%; at or below 300% FPG	80% Discount
Above 300%; at or below 400% FPG	65% Discount
Above 400% FPG	Patient to pay balance *(unless patient qualifies under the Illinois Hospital Uninsured Patient Discount Act)*

3. In order to be eligible for charity or discounted care, the patient must be willing to provide verification of income, assets, etc., by filling out the Financial Assistance Application (Attachment B). It is the responsibility of the patient to voluntarily submit any and all documentation in order to be eligible to receive the discount.

4. During the registration and information gathering process, the Financial Counselors will first determine if the patient qualified for medical assistance from other existing financial resources such as Medicare, Medicaid, Kid Care, Family Care or other state or federal programs. If the patient refuses to apply for existing financial resources or to provide information necessary to the application process, charity or discounted care cannot be granted. If the application for existing financial resources is denied or has been previously denied, consideration for charity or discounted care will then be given.

5. Patients will qualify for Presumptive Charity Care assistance based on their individual life circumstances, homeowner status, living address and other measurable socio-economics factors. Assistance provided under Presumptive Charity Care will be the most generous assistance available under the FAP (including free care). Presumptive eligibility may be determined on the basis of individual life circumstances, including, but not limited to, state-funded prescription programs; homeless or received care from a homeless clinic; participation in Women, Infants and Children (WIC) programs; food stamp eligibility; subsidized school lunch program eligibility; eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down); low income/subsidized housing is provided as a valid address; or patient is deceased with no known estate.

6. Once the information on the Financial Assistance Application form is received, the Financial Counselor and the Director of Patient Financial Services (PFS) will determine the eligibility for charity or discount care. Loretto Hospital will suspend any ECA's while the Financial Assistance Application is being reviewed. The only criteria to be considered for financial assistance will be income and family size. Income will be evaluated against the matrix of Federal Poverty Guidelines to determine whether full or partial discount can be approved. Documentation of income can be submitted in the form of paycheck stubs, income tax return, Social Security checks, and other documents that are indicative of income. If the information submitted is not perceived to be accurate or reliable, Loretto Hospital reserves the right to request additional documentation to substantiate income or family size.

7. The insured patient with a large balance due to deductible and/or co-payments may be eligible for charity or discounted care. In order to qualify, the patient must complete the Financial Assistance Application and return it to the Financial Counselor for evaluation and recommendation.

8. Patients requesting to speak with a Financial Counselor or to obtain an application or itemized bill may contact the Financial Counselor at 773-854-5097, or, if coming in person, the address of Loretto Hospital is Patient Account Department, 645 S. Central Ave., Chicago, Illinois 60644.

Determination of Eligibility under the Illinois Uninsured Patient Discount Act:

1. Illinois residents who have a family income that is no more than 600% of the Federal Poverty Guidelines (as determined each year), and who do not have any health insurance (or coverage under workers' compensation, accident liability insurance, or other third party liability) as documented through Loretto Hospital's insurance verification procedures, will receive a discount in accordance with the Illinois Hospital Uninsured Patient Discount Act (Act). Uninsured patients who own assets with a value of more

than 600% of the Federal Poverty Guidelines (excluding the patient's primary residence, personal property exempt from judgment under Illinois law, and amounts held in a pension or retirement plan) are excluded from the discount required under the Act.

2. For medically necessary services, charges will be discounted to 135% Medicare cost with the discount applicable to charges greater than $300.00. The maximum amount collectible in a 12-month period from a patient without insurance will be 25% of the family's annual gross income.

3. For services excluded by the Act, i.e., elective cosmetic surgery, Loretto Hospital may provide a discount from billed charges based on the patient's ability to pay, as verified through Loretto Hospital's procedures.

4. Requests for the Hospital Uninsured Patient Discount under the Act need to be made within 60 days of the date of discharge or date of service. Loretto Hospital's obligation under the Act shall cease if the patient fails to provide the hospital with the Financial Assistance Application and required documents or to apply for coverage under public programs when requested within 30 days of the hospital's request.

Approval of Charity or Discounted Care:

To insure that the determination of charity or discounted care receives appropriate levels of considerations the following approval guidelines and levels will be followed:

Charity or Discounted Care	Appropriate Personnel
$1 - $30,000	Director, PFS
$30,000 - and above	CFO

Basis for Calculating Amounts Charged to Patients:

Following the determination of FAP-eligibility, a FAP-eligible individual will not be charged more for emergency or other medically necessary care than the amounts generally billed (AGB) to individuals who have insurance covering such care. The methodology used by Loretto Hospital to calculate AGB is the Look-back Method. Members of the public may readily obtain the current AGB percentage and a description of how the percentage was calculated by contacting the Loretto Hospital Patient Account Department at 773-854-5097.

Actions That May Be Taken in the Event of Nonpayment:

The actions that Loretto Hospital may take in the event of nonpayment are described in a separate Billing and Collection Policy. Members of the public may readily obtain a free copy of that policy by contacting the Loretto Hospital Patient Account Department at 773-854-5097.

Measures to Widely Publicize the Financial Assistance Policy:

1. Every patient will, upon admission as an inpatient or outpatient, receive a written notice that shall contain information about the availability of financial assistance, including information about this policy as well as contact information for a hospital employee or office from which the person may obtain further information about the policy.

2. Signs will be posted conspicuously in the admission and registration areas to notify patients and visitors about the availability of financial assistance. The signage will contain the following language, in accordance with the Illinois Hospital Fair Patient Billing Act:

"You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information contact Loretto Hospital Financial Counselors at 773-854-5097."

3. Each hospital bill, invoice, or other summary of charges to an uninsured patient shall include with it, or on it, a prominent statement, in accordance with the Illinois Hospital Uninsured Patient Discount Act, to the effect that an uninsured patient who meets certain income requirements may qualify for an uninsured discount and information regarding how an uninsured patient may apply for consideration under Loretto Hospital's FAP.

4. The FAP, Financial Assistance Application and plain language summary of the FAP will be available on Loretto Hospital's website at www.lorettohospital.org. The documents will be posted in a format that will allow any individual with access to the Internet to access, download, view, and print a hard copy of the documents without requiring special computer equipment and without the payment of a fee. Loretto Hospital will provide any individual who asks how to obtain online access to a copy of the FAP, Financial Assistance Application form, or plain language summary of the FAP with the direct website address, or URL, of the web page on which these documents are posted.

5. Paper copies of the FAP, Financial Assistance Application and plain language summary of the FAP will be readily available in the admitting department and waiting areas. Patients may also call to obtain a copy and it will be mailed it to them at no cost.

6. The Patient Access Department will also notify those patients with no insurance of the availability of financial assistance and will give a copy of the Financial Assistance Application and plain language summary of the FAP to patients.

Documentation and Recording of Charity or Discounted Care:

In order to quantify the level of charity care, a general ledger report will be available to document the total value of all charity or discounted care. This report will be available for inspection by any government agency requiring levels of charity or discounted care as part of Loretto Hospital maintaining the exemption from federal, state, or local taxes.

Approved by:

CFO: Kenneth McNee Date 03-01-16

Director PFS: Carmen Nieves Date 3-1-16

ATTACHMENT A
FEDERAL POVERTY GUIDELINES (FPG) SLIDING SCALE
(2014)

Family Size	Federal Poverty Guideline 100%	Income below 200% (shown below) eligible for full write-off	Income 200% or above, but below 300% (shown below) eligible for partial write-off	Income 300% or above, but below 400% (shown below) eligible for partial write-off	Income 400% or above, but not more than 600% (shown below)
1	11,670	23,340	35,010	46,680	70,020
2	15,730	31,460	47,190	62,920	94,380
3	19,790	39,580	59,370	79,160	118,740
4	23,850	47,700	71,550	95,400	143,100
5	27,910	55,820	83,730	111,640	167,460
6	31,970	63,940	95,910	127,880	191,820
7	36,030	72,060	108,090	144,120	216,180
8	40,090	80,180	120,270	160,360	240,540
Discount	100%	100%	80%	65%	Discount as required by Illinois Hospital Uninsured Patient Discount Act

For family units of more than eight persons add $4,060 for each additional person.

Source: U.S. Department of Health & Human Services – 2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia.

Example:

STEP 1: Gross family income (family of 2) = $34,500

STEP 2: From chart above, the income is above 200% FPG, but below 300%

STEP 3: Patient is eligible for 80% discount on medically necessary services

ATTACHMENT B
FINANCIAL ASSISTANCE APPLICATION

Loretto Hospital

Mr(s) _____.

The following documentation is required in order to apply for Financial Assistance with Loretto Hospital. Please return these documents to the address below within 60 days following the date of discharge so that we may determine your eligibility.

- Identification, only one is required:
  - Driver's license, Passport, SS card, Etc.
- Proof of expenses:
  - Rent, Utilities, etc.
- Proof of income from Patient and Spouse and or Guarantor(s):
  - A complete copy of the previous year's income tax returns.
  - Unemployment benefit checks (If recently unemployed)
  - Last 4 checks stubs.
  - Social Security benefits letter (If retired)
  - Savings account balances.
- Letter of support. (If not employed)
- Proof of dependents. (if not listed on tax forms)
  - Birth Certificate, Social Security card or identification.

If you have any questions please feel free to contact us at (773) 854-5097 from 8:00 AM to 3:30 PM - Monday thru Friday.

PLEASE MAIL ALL THE DOCUMENTATION TO:
LORETTO HOSPITAL
645 S. Central Ave
Chicago, Il 60644
ATTN: Financial Counselor

Please Note: This Application is for Hospital Services Only.
You may receive a bill for the ER Physicians, Physician Services and/or any professional reading of X-ray, laboratory.

Loretto Hospital

LORETTO HOSPITAL
Financial Assistance Application

Important: You may be able to receive free or discounted care: Completing this application will help Loretto Hospital determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

If you are uninsured, a social security number is not required to qualify for free or discounted care. While a social security number is not required for some public aid programs, including Medicaid, providing a social security number will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Internal Use Only:
Application Date: _____ MRN: _____

Account Number: _____

Approved %: _____ Denied/Reason: _____ Pt's Bal Due: _____

Patient Information:

Patient Name: _____ Phone #: _____

Patient Date of Birth: _____

Patient Address: _____

_____

Patient an Illinois resident at time of service? (circle one) YES NO

Patient involved in an alleged accident? (circle one) YES NO

Patient victim of an alleged crime? (circle one) YES NO

Patient Social Security Number (not required if uninsured): _____

Patient telephone or cell phone number: _____

Patient email address (if applicable): _____

If applicable: Guarantor Information (If patient is a minor or spouse/partner is responsible for patient):

Guarantor Name: _____

Guarantor Address: _____

_____

Guarantor telephone or cell phone number: _____

Family Household Information:

Number of persons in the patient's family/household: _____

Number of persons who are dependent of the patient: _____

List the ages of the dependents in the household:

Dependents	Age
Dependents 1	
Dependents 2	
Dependents 3	
Dependents 4	
Dependents 5	
Dependents 6	

Patient's Family Income and Employment Information:

Patient – are you employed? (circle one) YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

Spouse of patient – are you employed? (circle one) YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

If the patient is a minor, is the parent or guardian of the minor employed? (circle one) YES NO

If yes, please complete the following:

Name of employer: _____

Address of employer: _____

_____

Telephone number of employer: _____

Marital status of the patient (please circle one):

Single Married Widowed Separated* Divorced*

*If the patient is separated or divorced, is the financial responsibility for medical care set forth in the dissolution agreement or court order? (circle one) YES NO

Gross monthly family income:

$	Total household employment income (including self-employed)
$	Unemployment compensation
$	Social Security
$	Social Security Disability
$	Veterans' pension
$	Veterans' disability
$	Private disability
$	Workers' Compensation
$	Temporary Assistance for Needy Families
$	Retirement Income
$	Child Support, allmony or other spousal support
$	Other Income
$	Total gross monthly family income

Please provide documentation of the following:
Paycheck stubs (last 4)
Benefit statements
Award letters
Court orders
Federal tax returns
Other documents in support of income
Ex. Bank Statement

Are you enrolled I any of the following? (circle all that apply)
Women, Infants and Children Nutrition Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)
Illinois Free Lunch and Breakfast Program
Low Income Home Energy Assistance Program (LIHEAP)
Any community-based program that provides access to medical care based on low-income financial status

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Insurance/Benefit Information:

Does the patient have medical insurance? (circle one) YES NO

If yes, please specify:

Type of coverage (please circle one):

Health Medicare Medicare Part D Medicare Supplement Medicaid Veterans'

Insured Member Name: _____

Insurance Co. Name: _____

Subscriber ID: _____

Asset and estimated asset value information:

$	Checking
$	Savings
$	Stocks
$	Certificates of deposit
$	Mutual funds
$	Health savings/Flexible spending account
$	Real property
$	*Do you own a home or property?* *Yes or No*
$	Automobiles or other vehicles
$	Make: _____ Model: _____ Year: _____
$	Make: _____ Model: _____ Year: _____
$	Make: _____ Model: _____ Year: _____
$	Total assets and estimated assets information

Monthly expense information and estimated expense figures:

$	Housing (rent or mortgage)
	If nothing, please explain:
$	Utilities
$	Gas
$	Electric
$	Phone
$	Food
$	Transportation (car/bus fare/etc.)
$	Child Care
$	Loans (student/payday/etc.)
$	Medical expenses
$	Other expenses
$	Total monthly expense information

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may reverse, and I will be responsible for the payment of the hospital bill.

Patient or applicant's signature: _____ Date: _____

If a patient meets the presumptive eligibility criteria of Loretto Hospital or is otherwise presumptively eligible by virtue of the patient's family income, the patient shall not be required to complete the portions of the application addressing the monthly expense information and estimated expense figures.

PLEASE NOTE: THIS APPLICATION IS FOR HOSPITAL SERVICES ONLY. YOU MAY RECEIVE A BILL FOR THE PHYSICIAN/PROFESSIONAL SERVICES.

Loretto Hospital

LETTER OF SUPPORT

Date: _____

Name(s): _____

_____

Address: _____

_____

Phone # (s): _____

I/We provide room & board to (Patient's Name) _____

Since (date) _____ to present.

Relationship to Patient: _____

Signature: _____

_____

_____

CARTA DE SOSTENIMIENTO

Fecha: _____

Nombre (s): _____

_____

Dirección: _____

Teléfono: _____

Yo/Nosotros le proveemos albergue y comida a: _____
(Nombre del Paciente)

Desde (Fecha) _____ hasta el día de hoy.

Parentesco con el Paciente: _____

Firma (s): _____

_____