INcompass Healthcare Policy and Procedure		
TITLE: Financial Assistance	**SECTION:** Services	**POLICY #:** 903
EFFECTIVE DATE: 1/1/2025	**LAST REVIEW:**	# of Pages: 4

Financial Assistance Policy (FAP)

I. **Purpose**:

This policy is intended to establish guidelines for a structured procedure so as not to exclude anyone from seeking medical services on the grounds that such a person may not have adequate resources to pay for those services rendered. It is intended to address those that do not have the ability to pay and to offer a discount on billed charges. This policy follows the guidelines set forth in the Internal Revenue Code Section 501(r).

II. Application: This policy applies to all clients of INcompass Healthcare.

III. Policy Statement:

It is the policy of INcompass Healthcare that no clients seeking medical service that can be provided by INcompass Healthcare will be denied access to those services solely because of the inability to pay for those services. INcompass Healthcare will provide without discrimination, care for emergency services, and medically necessary services to individuals regardless of whether they are eligible based on the Financial Assistance Policy (FAP). INcompass Healthcare is available to assist clients with applying for health insurance through the insurance marketplace, applying for government assistance, and determining if they qualify for financial assistance for services provided.

INcompass Healthcare may make available services without charge or at a reduced charge, based on the ability to pay as determined by INcompass Healthcare. The amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance will not be more than the amounts generally billed (AGB) to individuals who have insurance covering the same care.

All clients have the opportunity to apply for financial assistance prior to the organization engaging in any extraordinary collection activities (ECA). INcompass Healthcare will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for the care.

In the event the client dies, the organization reserves the right to pursue all possible claims against the decedent's estate or against any other person or entity having a legal obligation to pay for the decedent's medical services to recover amounts owed to the organization by the decedent for services rendered which were unpaid at the time of the decedent's death.

This policy is posted on INcompass Healthcare’s website and is available at various locations throughout the organization. Clients and the community are also notified via signage located throughout the organization.

A plain-language summary of the FAP is on display in all waiting areas available, offered as part of the intake process, and available upon request.

IV. Procedure:

The following processes describe how the policy will be executed, including steps taken by INcompass Healthcare and responsibilities of the clients in order to complete and submit a financial assistance application.

Alternative sources of payment

All commercial, federal, and state health and medical payment sources available to the client will be billed prior to receiving financial assistance under the FAP.

Eligibility Criteria and Determination

Eligibility is based upon the sliding fee scale in place, utilizing the current Federal Poverty Guidelines (FPG). Eligible clients with incomes above 100 percent of poverty, but at or below 200 percent of poverty, will be charged a reduced fee according to the sliding fee scale. To promote efficient use of resources and personal responsibility, INcompass Healthcare charges a nominal fee of $5 per service provided for clients with family income at less than or equal to 100% of FPG. The nominal charge is established by the organization at a fee that is deemed fair, affordable, and aligns with the goals of the organization. The nominal fee is not a threshold for receiving medically necessary care, and thus is not a minimum fee or co-payment.

Examples of income documentation to determine and verify eligibility:

- Four of your most current pay stubs from employer
- W-2 earnings statement/tax return
- Social security statement of earnings or Supplemental security income -SSI
- Unemployment compensation determination letters
- Worker's compensation
- Retirement benefits/pension
- Veterans' benefit statement
- Statement of self-employment earnings

Any discount provided will be based upon both family income and size. The discount will be valid for one (1) calendar year and will apply to all services received at INcompass Healthcare during this time. Clients can reapply by submitting a new financial assistance application. Clients are responsible for submitting updated financial information throughout the year when/if their financial circumstances change.

Refusal to Pay

All client balances will be handled through the standard billing and collection process. If the client has not completed a financial assistance application, one will be offered. Any clients who demonstrate an unwillingness to pay for services within 120 days from the date of service are subject to be referred to the organization’s contracted collection agency.

Limitation of Charges/Amounts Generally Billed (AGB)

INcompass Healthcare limits the amounts charged for emergency and medically necessary services provided to individuals eligible for assistance under this Policy to not more than the amounts generally billed to individuals who have insurance coverage for such care. The AGB is derived by dividing (1) the sum of all claims for Medically Necessary services provided at the Hospital and paid during the relevant period by Medicare fee-for-service and all private health insurers as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-pays, co-insurance or deductibles, by (2) the charges set forth in the organization’s chargemaster at the time the services are rendered. The Organization-Specific AGB Percentage shall be calculated annually for a twelve (12) month period from January 1 to December 31 and allows 120 days for such calculation to be made and updated in the FAP. The calculation of the Organization-Specific AGB Percentage shall comply with the “look-back method” described in the IRS Regulation 501(r)-5(b) (1) (B).

Methods for Applying for Financial Assistance

To apply for financial assistance, clients may:

1. Review financial assistance information provided on INcompass Healthcare's website at www.incompasshc.org and download a financial assistance application from the website,

2. Request information by mail from the following address: INcompass Healthcare, ATTN: Patient Accounts, 285 Bielby Road, Lawrenceburg, IN 47025, or

3. Request information by phone by calling INcompass Healthcare at 812-537-1302 and ask to speak with Patient Accounts.

Completed applications can be mailed to:

INcompass Healthcare
285 Bielby Rd
Lawrenceburg, IN 47025

Notification Requirements

The availability of the FAP will be widely publicized within the communities serviced by INcompass Healthcare. All waiting areas shall have visuals prominently displayed that advise clients of the existence of FAP and will make available copies of the plain language summary (PLS) of the FAP. All documents related to the FAP will be available on the organization's website in an easy to locate area.

Write-Offs and Adjustments

Emergency and medically necessary services will be written off, in whole or in part, if the client's financial assistance application is approved. Any client living in the state of Indiana whose income is below 138% of the FPG is requested to and can be assisted with applying for Indiana Medicaid to possibly secure funding for current and future services.

All determinations pertinent to this FAP are to be made by the Client Financial Services team and approved by the Director of Client Financial Services.

Signature Authority

FAP write-offs will be granted subject to the following approval limits:

1. Up to $5,000 – Director of Client Financial Services

2. Over $5,000 – Chief Financial Officer

V. **Definitions**:

Amounts Generally Billed (AGB) means the Usual and Customary Charges for Covered Services provided to individuals eligible under the Basic Financial Assistance Program, multiplied by the Organization-Specific AGB Percentage applicable to such services.

Emergency Services means a medical condition of a patient that has resulted from the sudden onset of a health condition with acute symptoms which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions of the patient or result in serious dysfunction of any bodily organ or part.

Extraordinary Collection Actions (ECA) Actions taken by the organization against an individual related to obtaining payment of a bill for care that requires a legal process, selling an individual's debt to another party, or reporting adverse information to consumer credit reporting agencies.

Family Using the Census Bureau definition, a group of two or more people who reside together and who are related at 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.

FAP-Eligible means an individual eligible for financial assistance under this Policy.

Federal Poverty Guidelines measures of income levels issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for this financial assistance program.

Income Using the Census Bureau definition, income includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources.

Limitation on Charges refers to limiting the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to not more than the amounts generally billed to individuals who have insurance covering the same care. In addition for billing and collection, the Hospital may not engage in ECAs before reasonable efforts have been made to determine whether the individual is eligible for financial assistance.

Medically Necessary Services means those inpatient and outpatient services required to identify and treat an illness or injury.

Plain Language Summary is a written statement that notifies an individual that the Hospital offers financial assistance under a FAP and provides the information in a clear, concise, and easy to understand description.

VI. **References**:

Patient Protection and Affordable Care Act, Section 9007
Internal Revenue Code, Section 501(r)

VII. **Exhibits**:
Hospital List of Emergency and Medically Necessary Providers

Reviewed by: Policy Development Committee

Approved by: Greg Duncan, President & CEO