SUBJECT: FINANCIAL ASSISTANCE	REFERENCE #
DEPARTMENT: PATIENT ACCOUNTS	PAGE: 1 OF: 4
	EFFECTIVE: 01/01/96
APPROVED BY: Management Executive Committee	REVISED: 05/16, 05/17 5/18, 5/19, 11/19, 5/20

PURPOSE:

This policy serves to establish and ensure a fair and consistent method for the review and completion of requests for financial assistance to patients in need. This includes insured and uninsured patients.

POLICY:

A. Fitzgibbon Hospital will provide essential medical services regardless of the patient's ability to pay.

B. Eligible services include medical services provided and billed by John Fitzgibbon Memorial Hospital and its medical providers (collectively “FH”). Financial Assistance is available only for emergency or medically necessary services. It does not apply to elective services/procedures such as chiropractic services, long term care, or cosmetic surgery. It also does not apply to the portion of services that have been paid for by another insurance company or government program. Financial Assistance is available to patients who live in Missouri. Patients who live outside Missouri may be considered for assistance on an individual basis.

C. Discounts are offered based upon family/household size and household annual income. All alternative payment resources must be exhausted, including all third-party insurance payment(s), pending litigation, Federal programs, and State programs prior to applying the discount.

D. A sliding fee schedule is used to calculate the basic discount and is updated each year using the Federal Poverty Guidelines (FPG). The sliding fee schedule allows for household incomes at 100% of FPG to qualify for 100% financial assistance through household incomes at 200% of FPG to qualify for 63% financial assistance. The patient eligible for partial financial assistance will not be billed more than Amount Generally Billed.

E. Amount Generally Billed (AGB) is calculated by reviewing all past claims that have been paid to FH for medical care by Medicare fee-for-service and private insurances in a prior twelve (12) month period. This amount can include co-insurance, copayments, and deductibles. The AGB will be calculated at least annually. See Appendix A for AGB.

F. A determination of financial assistance will be effective for a period of up to 6 months including subsequent emergent or medically necessary care from the date the application was approved and will include all outstanding receivables, including those at bad debt agencies, but excluding those in legal status. A change in financial situation or the addition of third party payer eligibility may alter the approval period and require further review. If FH has received payments during the application period FH will refund excess payments unless amount is less than five dollars ($5.00). The application period will begin when the completed application and all required documents outlined in Discount Application Process section B are received.

G. In the case of a catastrophic medical event, patients who may not ordinarily qualify for Financial Assistance may be granted aid on a case by case basis.

H. Those patients, without insurance, that have inquired and are not eligible for financial assistance under this policy will receive a twenty percent (20%) discount on the balance due and will be considered for additional discounts and assistance.

DISCOUNT APPLICATION PROCESS:

A. All Patients will be offered a Plain Language Summary and an application for financial assistance under the Financial Assistance Policy (FAP) as part of the intake or discharge process to/from FH. Information regarding the FAP may be available through the following resources: Patient Accounts Department at (660) 831-3730; FH website at www.fitzgibbon.org; FH facility at 2305 South 65 Highway, Marshall, MO 65340.

B. A completed application, including required documentation, family/household income, family/household size, and insurance coverage, must be on file and approved by the Patient Accounts office before a discount will be granted (see attached form titled "Request for Financial Information"). Required documents include a copy of last year's federal income tax return; income verification including three prior pay period pay stubs, government assistance support documentation, and/or retirement income documentation; and last month's bank statement. Applications will be accepted any time – before, during or after care, up to two hundred forty (240) days after the first post discharge billing statement.

C. Once all necessary documents are received by the Patient Accounts office, processing will occur within thirty (30) days.

D. If application is incomplete or additional information is needed to complete the application the Patient Accounts office will notify the applicant. The applicant will have two-weeks from the date of notification to provide the information. If information is not provided, reasonable effort will have been made and collection will resume according to the Billing and Collection Policy. The Billing and Collection Policy may be available through the following resources: Patient Accounts Department at (660) 831-3730 or FH facility at 2305 South 65 Highway, Marshall, MO 65340.

E. The discount applies to Fitzgibbon Hospital services, including inpatient, outpatient, and community-based services. See Appendix B for clinic and professional services which are also covered under FH financial assistance policy, as well as, services not covered.

ATTACHMENTS:

Financial Assistance Letter *(Form ID: FIN1)*

Request for Financial Information form *(Form ID: FIN2)*

Appendix A

The Amount Generally Billed (AGB) effective May 1, 2020 was calculated based on a rolling twelve month period of May 2019 through April 2020. Medicare fee-for-service and private insurance claims were used to determine the AGB of thirty-seven percent (37%).

Appendix B

Clinic and professional services which are covered under FH financial assistance policy are:

- Akeman-McBurney Health Clinic
- Fitzgibbon Anesthesia Group
- Fitzgibbon Family Health
- Fitzgibbon Hospitalist Group
- Fitzgibbon Mental Health
- Fitzgibbon Wound Clinic
- Grand River Clinic
- Marshall Emergency Physicians
- Marshall Family Practice
- Marshall Orthopedic & Sports Medicine
- Marshall Surgical Associates
- Marshall Women's Care
- Mid-Missouri Family Health
- Fitzgibbon Professional Building
- Fitzgibbon Outpatient Clinic

Clinic and professional services which are not covered under FH financial assistance policy are:

- Fitzgibbon Chiropractic Clinic

Fitzgibbon Hospital
Patient Accounts
2305 S. Highway 65, P.O. Box 250
Marshall, MO 65340
(660) 831-3730

Dear Patient/Guarantor:

A request has been made that you be evaluated for financial assistance on your outstanding bills with Fitzgibbon Hospital and/or its employed medical providers. Consideration for assistance will be based on your household annual income and family/household size.

All sources of payment must be exhausted before financial assistance is considered. Examples of payments would be all medical insurances, third party and liability claims. Should you qualify for financial assistance, you will be responsible for any patient convenience items.

To process this request for assistance, we need your immediate cooperation in providing the following information:

Applied for Assistance

Medicaid: Yes ____ Assigned number _____

No ____ If no, why?_____

_____

_____

A completed financial assistance application.

In order to verify income, we need:

- A copy of your last year's federal income tax return
- Three prior period income verification (i.e., paycheck stub)
- A copy of last month's bank statement

If you need assistance or more information, please call Patient Accounts at (660) 831-3730.

Fitzgibbon Hospital and Clinics
Marshall, MO

REQUEST FOR FINANCIAL INFORMATION

Date of Request:_____

PATIENT NAME	AGE	PHONE NO.	MARITAL STATUS	PATIENT SOC. SEC. #
			S M W D	*Optional*
GUARANTOR NAME	**AGE**	**RELATION TO PATIENT**		**SOC. SEC. #**
				Optional
SPOUSE NAME	**AGE**	**PHONE NO.**		**SOC. SEC. #**
				Optional

APPLICANT ADDRESS		NEXT OF KIN	
STREET		NAME	PHONE NO.
CITY, STATE, ZIP		ADDRESS – STREET, CITY, STATE, ZIP	
GUARANTOR EMPLOYER		**SPOUSE EMPLOYER**	
NAME	PHONE NO.	NAME	PHONE NO.
ADDRESS		ADDRESS	
POSITION / TITLE	HOW LONG EMPLOYED?	POSITION / TITLE	HOW LONG EMPLOYED?
GROSS MONTHLY INCOME	**$**	**GROSS MONTHLY INCOME**	**$**
PAYDAY: _____Weekly _____Every other week _____1st & 15th _____Once a month		PAYDAY: _____Weekly _____Every other week _____1st & 15th _____Once a month	

INCOME	GUARANTOR	SPOUSE
Wages / Salary		
Social Security / Pension		
Rental Income		
Alimony / Child Support		
Other Government Assistance / Public Assistance		
Unemployment		
Total Monthly Income	**$**	**$**

Number of Dependents, per Federal Income Tax, living in your home	**#**

I/We certify that the above statements and financial information are true and correct as of this date.

Signature of Responsible Party	Signature of Spouse
X	**X**