I. POLICY

Shenandoah Medical Center (SMC), as a not-for-profit entity, recognizes the importance of charity care in fulfilling its corporate mission and community interest. SMC is committed to providing Charity Care and Financial Assistance to eligible persons who have healthcare needs and are uninsured, underinsured, ineligible for government programs, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with our mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, SMC strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. SMC will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Charity Care and Financial Assistance require the expenditure of significant resources and funds by SMC. Such expenditures include “Charity Care”, i.e., free care, and “Financial Assistance”, i.e., discounts, reduced payments and extended payment schedules. Eligibility for Charity Care or Financial Assistance under this Policy shall be based on an individual determination of the patient’s needs and available resources.

SMC’s financial commitment to Charity Care and Financial Assistance will be established annually as part the budget process and will be approved by the Board of Trustees. SMC’s bad debt collection policies, e.g., criteria for commencing a collection action and implementing post-judgment collection remedies, shall be consistent with this Policy.

Accordingly, this Policy:

- Includes eligibility criteria for financial assistance – free and discounted (partial charity) care.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy.
- Describes the method by which patients may apply for financial assistance.
- Describes how SMC will widely publicize the policy within the community.
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to the amount generally billed (received by) the hospital for commercially insured or Medicare patients.

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with SMC’s procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow SMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity and Financial Assistance.
II. DEFINITIONS

For the purpose of this policy, the terms below are defined as follows:

- **Charity Care**: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider’s policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

- **Family**: Using the Census Bureau definition, a group of two or more people who reside together and who are related by 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 the purposes of the provision of financial assistance.

- **Family Income**: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
  - Includes earnings, unemployment compensation, workers’ compensation, Social Security, Supplement Security Income, 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;
  - Noncash benefits (such as food stamps and housing subsidies) DO NOT COUNT
  - Determined on a before-tax basis;
  - Excludes capital gains or losses; and
  - If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

- **Uninsured**: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

- **Underinsured**: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

- **Gross Charges**: The total charges at the organization’s full established rates for the provision of patient care services before deductions from revenue are applied.

- **Emergency medical conditions**: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

- **Medically necessary**: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

- **Notification**: A letter will be sent to notify the patient of the approval or denial of the application for financial assistance / charity care. Denials may be appealed if appropriate income verification is received after the application has been processed.

- **Services**: Elective services do not qualify for a financial assistance / charity designation.

- **Disqualifications**: Any applicant fraudulently misrepresenting his or her income level will be immediately disqualified for consideration for charity care. All charges for services previously rendered will be billed to the responsible party.

- **Time Line**: Approved charity care and financial assistance will be effective for 12 months. Patient is required to report any changes in their financial condition that occur during this 12 month period.
III. **PROCEDURE**

A. **Services Eligible Under This Policy.** For the purposes of this policy, “charity” or “financial assistance” refers to healthcare services provided by SMC without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis at SMC’s discretion.

B. **Eligibility for Charity:** Eligibility for charity will be considered for those individuals, who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account, age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

C. **Method by Which Patients May Apply for Charity Care / Financial Assistance.**

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
   a. Include an application process, in which the patient or the patient’s guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
   b. Include the use of external publically available data sources that provide information on a patient’s or patient’s guarantor’s ability to pay;
   c. Include reasonable efforts by SMC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs;
   d. Take into account the patient’s available assets, and all other financial resources available to the patient; and
   e. Include a review of the patient’s outstanding accounts receivable for prior services rendered and the patient’s payment history.

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior,
or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. SMC’s values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and SMC shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient’s eligibility for charity care, SMC could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstance that may include:

1. State-funded prescription programs;
2. Homeless; a homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible for Indigent Care, even if they are unable to provide all the documentation required for the application
3. Participation in Women, Infant, and Children’s programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);
7. Low income / subsidized housing is provided as a valid address; and
8. Patient is deceased with no known estate

E. **Eligibility Criteria and Amounts Charged to Patients.** You must be a documented resident within a 60 mile radius of Shenandoah, Iowa; (to include the following counties: Iowa – Mills, Montgomery, Page, Freemont, Taylor, Pottawattamie; Missouri – Atchison, Holt; Nebraska – Otoe. Documents required to be submitted with the completed, signed application include: Proof of income, Medicaid response letter and for the Medical Needy program if denied for Medicaid, Photo ID – must be an Iowa, Missouri or Nebraska driver’s license or permanent residency card. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by SMC to be eligible for financial assistance, the patient shall not receive any future bills based on undiscounted gross charges. The basis for income qualification is detailed in attachment.

A.1 - **“Shenandoah Medical Center Charity Income Guidelines”**

1. Patients whose family income exceeds the guidelines based on FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of SMC; however the discounted rates shall not be
greater than the amounts generally billed to (received by the hospital for) commercially insured or Medicare / Medicaid patients.

F. Communication of the Charity Program to Patients and Within the Community. Notification about the charity and financial assistance available from SMC, which shall include a contact number, shall be disseminated by SMC by various means which may include, but are not limited to, the publication of notices in patient bills and by posting notices in emergency department, urgent care / walk-in clinic, admitting and registration departments, hospital business office, SMC website and patient financial services office. Referral of patients for financial assistance / charity may be made by any member of the SMC hospital staff or medical staff, including physicians, nurses, financial counselor, social workers, and case mangers. A request for charity may be made by the patient or a family member, close friend, or associate of the patient, subject to privacy laws.

G. Relationship to Collection Policies: SMC management shall develop policies and procedures for internal and external collection practices (including actions and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient’s good faith effort to apply for a government program or from charity form SMC, and a patient’s good faith effort to comply with his or her payment agreements with SMC. For patients who qualify for charity and who are cooperating in good faith to resolve their discounted hospital bills, SMC may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. SMC will not impose extraordinary collections actions such as wage garnishments; liens on primary residences or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:
1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by SMC
2. Documentation that SMC has or has attempted to offer the patient the opportunity to apply for charity care pursuance to this policy and that the patient has not complied with SMC’s application requirements;
3. Documentation that the patient does not qualify for financial assistance on a presumptive basis;
4. Documentation that the patient has been offered a payment plan and has not honored the terms of that plan.

H. Regulatory Requirements. In implementing this Policy, SMC management and facilities shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

I. Approval and Reconsideration Process: If a patient is considered to be eligible under this Policy, the following approval will be obtained based on the level of Charity Care or Financial Assistance that is being proposed.
1. Up to $1,000 will be approved by Manager – Business Office
2. From $1,001 - $10,000 will be approved by the Director – Revenue Cycle
3. From $10,001 - $50,000 will be approved by CFO
4. In excess of $50,000 will be approved by the CEO

- Reconsideration Process; If a patient is determined to be ineligible under this Policy, the denied application and the reason(s) for the denial, including but not limited to failure to cooperate in the application process, will be noted in the patient’s financial file. The patient will be notified that he/she is permitted to request reconsideration of his/her application by the following:
  o Director – Revenue Cycle
  o Chief Financial Officer

J. **Proof of Income Required with Application:** All applicants must provide the following information or an explanation as to why this information is not available.

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Income</td>
<td>Tax return for the most recent tax period. Copy of three most recent pay stubs</td>
</tr>
<tr>
<td>Self-Employment</td>
<td>Tax return for most recent tax period</td>
</tr>
<tr>
<td>Social Security / Retirement</td>
<td>Tax return for the most recent tax period Award Letter from Social Security Adm stating monthly payment Monthly payment notification from Social Security Adm</td>
</tr>
<tr>
<td>Disability</td>
<td>Tax return for most recent tax period Award Letter from disability stating monthly disability payments Monthly payment notification from disability</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Tax return for most recent tax period Award Letter from unemployment stating weekly or monthly benefit amount Weekly/ monthly payment notification from Unemployment</td>
</tr>
<tr>
<td>Spousal / Child Support</td>
<td>Tax return for the most recent tax period Letter stating monthly award amount</td>
</tr>
<tr>
<td>Rental Property</td>
<td>Tax return for most recent tax period</td>
</tr>
<tr>
<td>Investment Income</td>
<td>Tax return for most recent tax period</td>
</tr>
<tr>
<td>Proof of Dependents</td>
<td>Tax return for most recent tax period</td>
</tr>
</tbody>
</table>

**AUTHORITY**

This policy is issued by the Revenue Cycle Department and is recommended for approval by:

- Director, Revenue Cycle
- Chief Financial Officer
- Executive Officer
- Board of Trustees
ATTACHMENT A.1

SHENANDOAH MEDICAL CENTER

CHARITY AND SLIDING FEE SCALE DISCOUNT GUIDELINES

Methodology: The patient responsible portion is based on income and family size.

Sliding Fee Schedule: Annual income thresholds by Percent Poverty and Sliding Fee Discount Pay Class

<table>
<thead>
<tr>
<th>Family of 1</th>
<th>Family of 2</th>
<th>Family of 3</th>
<th>Family of 4</th>
<th>Family of 5</th>
<th>Family of 6</th>
<th>Family of 7</th>
<th>Family of 8</th>
<th>Each Additional Person</th>
<th>Poverty Level</th>
<th>Patient Payment Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>$11,770</td>
<td>$15,930</td>
<td>$20,090</td>
<td>$24,250</td>
<td>$28,410</td>
<td>$32,570</td>
<td>$36,730</td>
<td>$40,890</td>
<td>$+4,160</td>
<td>100%</td>
<td>Minimum Fee $5.00</td>
</tr>
<tr>
<td>$14,713</td>
<td>$19,913</td>
<td>$25,113</td>
<td>$30,313</td>
<td>$35,513</td>
<td>$40,713</td>
<td>$45,913</td>
<td>$51,113</td>
<td>$+5,200</td>
<td>125%</td>
<td>20%</td>
</tr>
<tr>
<td>$17,655</td>
<td>$23,895</td>
<td>$30,135</td>
<td>$36,375</td>
<td>$42,615</td>
<td>$48,855</td>
<td>$55,095</td>
<td>$61,335</td>
<td>$+6,240</td>
<td>150%</td>
<td>40%</td>
</tr>
<tr>
<td>$20,598</td>
<td>$27,878</td>
<td>$35,158</td>
<td>$42,438</td>
<td>$49,718</td>
<td>$56,998</td>
<td>$64,278</td>
<td>$71,558</td>
<td>$+7,280</td>
<td>175%</td>
<td>60%</td>
</tr>
<tr>
<td>$23,540</td>
<td>$31,860</td>
<td>$40,180</td>
<td>$48,500</td>
<td>$56,820</td>
<td>$65,140</td>
<td>$73,460</td>
<td>$81,780</td>
<td>$+8,320</td>
<td>200%</td>
<td>80%</td>
</tr>
<tr>
<td>$23,541</td>
<td>$31,861</td>
<td>$40,181</td>
<td>$48,501</td>
<td>$56,821</td>
<td>$65,141</td>
<td>$73,461</td>
<td>$81,781</td>
<td>$+8,320</td>
<td>&gt;200%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Patient responsible portion can be paid in full or payment arrangements may be established with the Financial Counselor. If the patient does not maintain current payments in accordance with the payment schedule, they will be considered in default and the remaining balance of patient responsibility (the amount that did not qualify for charity care) will be subject to established collection policy and may qualify for bad debt.
ATTACHMENT A.2
APPROVAL LETTER

Date

Re: Acct #:
Patient Name:
Balance before allowance:

**2015 Financial Assistance Allowance:**
New Balance:

Dear ______,

We have reviewed your application for Financial Assistance and have determined that you meet our established guidelines for reduced rates as a part of our community benefit program. Your allowance for Financial Assistance is _____% based on your current financial assistance application information. If your financial situation changes, it will be your responsibility to contact the Shenandoah Medical Center Business Office at 712-246-7113 or 712-246-1230. This Financial Assistance is only allowed for emergent and/or medically necessary services. Elective services do not qualify for this program.

I have applied $_____ in financial assistance to your current accounts. Your new balance is $_____. Please remit the balance due with 30 days. If you require a monthly payment arrangement, please contact me as soon as possible to execute that agreement.

If you have any questions, please feel free to contact me between the hours of 7:30AM and 4:00PM, Monday through Friday. I can be reached at 712-246-7113.

Sincerely,

Patient Accounts Representative’s Name
DENIAL LETTER

Dear_____,

We have reviewed your application for Financial Assistance and have determined that you do not meet our established guidelines for charity care and/or sliding fee scale discount at this time.

Reason for denial:

_____Income exceeds qualifications
_____Potential third party payer source through____________________________________
_____Application is not complete
_____Supporting documentation not adequate

If you have additional information or can provide the required documentation, please contact me for re-consideration. Otherwise, please remit your account balance within the next 30 days. If you require monthly payment arrangements, please contact me as soon as possible to execute that agreement. Should your financial situation change, you are invited to make another application.

If you have any questions, please feel free to contact the Shenandoah Medical Center Business Office between the hours of 7:30AM and 4:00PM, Monday through Friday at 712-246-7113 or 712-246-1230.

Sincerely,

Patient Account Representative
CHARITY CARE / FINANCIAL ASSISTANCE APPLICATION

Patient Account Number(s)____________________; _______________________; _______________________

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Shenandoah Medical Center 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. However, a Social Security number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit to Shenandoah Medical Center in person or by mail 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 eligibility.

<table>
<thead>
<tr>
<th>Instructions: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION</th>
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</thead>
<tbody>
<tr>
<td>PATIENT INFORMATION</td>
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</table>

<table>
<thead>
<tr>
<th>Email Address</th>
<th>Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>Street</td>
<td>Apt #</td>
</tr>
<tr>
<td>City</td>
<td>ST</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Home Phone</td>
</tr>
<tr>
<td>Employer</td>
<td>Address</td>
</tr>
<tr>
<td>Cell Phone</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Monthly Income</td>
</tr>
<tr>
<td>Work Phone</td>
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</tr>
</tbody>
</table>

GUARANTOR / SPOUSE (IF RESPONSIBLE PARTY, PATIENT IF MINOR)

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email Address</td>
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<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Home Phone</td>
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<tr>
<td>Employer</td>
<td>Address</td>
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<tr>
<td>Cell Phone</td>
<td></td>
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<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Monthly Income</td>
</tr>
<tr>
<td>Work Phone</td>
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</table>
Presumptive Eligibility: Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through benefits provided to their family are automatically eligible to receive free care and no proof of income will be requested. We verify eligibility electronically when possible, but may need you to assist us to demonstrate your eligibility.

Circle as many as apply:

- WIC
- LIHEAP: Low Income Home Energy Assistance Program
- SNAP
- Community-Based Medical Assistance Program
- Iowa Free Lunch / Breakfast
- Grant Assistance for Medical Services
- Incarcerated
- TANF: Temporary Assistance for Needy Families
- Homelessness
- Personal Bankruptcy
- Deceased with No Estate
- Affiliation with a Religious Order and Vow Of Poverty
- Medicaid Eligibility, But Not on the date of service or for non-covered service
- Iowa Hosing Development Authority’s Rental Housing Support Program
- Mental Incapacitation with no one to act on patient’s behalf.

If you demonstrate Presumptive Eligibility, you do not need to supply any income information; You still need to sign the Applicant Certification on the following page.

**INCOME INFORMATION**

Please provide one or more of the following for each employed family member and sign the statement below.

1. A copy of the most recent tax return
2. A copy of the most recent W-2 or 1099 Forms
3. A copy of the most recent pay stub
4. A statement from our employer if paid in cash
5. Any other verification from a third party about our income

You may receive income or support from another source for example: SSA, disability, child support, alimony, unemployment or worker’s compensation, veteran’s pension or disability, TANF, retirement income, or other income. Please indicate the source and amount of income.

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
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<tbody>
<tr>
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</table>

If you cannot provide any documentation relating to your income, fill out the statement below.
June 3, 2016

I, ______________________________________________(name), certify that I have no documents that prove my family’s monthly income of $__________________________

### DEPENDENT HOUSEHOLD MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship</th>
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**Other Information:** If you have additional documents that may help SMC make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, bank or checking statements etc.

**APPLICANT CERTIFICATION:** I certify that the information in this application is true and correct to the best of my knowledge. I will apply for state, federal or local assistance for which I may be eligible to help pay for my hospital / clinic bills. I understand that the information provided may be verified by the SMC, and I authorize SMC 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 be reversed, and I will be responsible for the payment of the medical bills. All information obtained in the application process will remain confidential and protected under patient’s rights to privacy.

Applicant Signature: ___________________________________________ Date: ______________________

You may return your completed charity care application and documents to Shenandoah Medical Center, Attn: Financial Counselor, 300 Pershing Ave., Shenandoah IA 51601. For questions call the Financial Counselor at (712) 246-7113.