

TITLE: Financial Assistance Policy	
EFFECTIVE DATE: December 13, 2013 REVISION EFFECTIVE DATE: <p style="text-align: center;">November 28, 2017</p>	<input checked="" type="checkbox"/> St. David's Georgetown Hospital <input checked="" type="checkbox"/> St. David's Round Rock Medical Center <input checked="" type="checkbox"/> St. David's North Austin Medical Center <input checked="" type="checkbox"/> St. David's Medical Center <input checked="" type="checkbox"/> St. David's Rehabilitation Hospital <input checked="" type="checkbox"/> St. David's South Austin Medical Center <input checked="" type="checkbox"/> Heart Hospital of Austin <input checked="" type="checkbox"/> St. David's Surgical Hospital
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This policy establishes a framework pursuant to which St. David's Healthcare Partnership (SDHP) will identify patients that may qualify for financial assistance with respect to emergency and medically necessary care.

In order to ensure that all patients are adequately informed about this policy, SDHP has undertaken the following:

- Information about the Financial Assistance Policy, a plain language summary of the policy, and the Financial Assistance Application and instructions for completion are available on the SDHP website at: <http://stdavids.com/patients-visitors/charity-discount-policy.dot>.
- At registration, patients are provided a document describing the availability of the uninsured discount as well as other discount options that may be available (Exhibit 1).
- The Financial Assistance Application is available at the facilities and by mail.
- Signs that prominently present information about the charity mission and guidelines are present at all points of admission.
- A patient document, entitled "A Guide to Your Hospital Bill" is provided to patients. This document explains the billing process and also provides information on the Financial Assistance Policy.
- A summary of this policy is provided to local non-profit organizations near SDHP hospitals.

CHARITY CARE ELIGIBILITY SYSTEM

Application. In order to qualify for charity care, SDHP requires the completion of the SDHP Financial Assistance Application (Exhibit 2).

The Financial Assistance Application, the Financial Assistance Policy, and a plain language summary of the financial assistance policy are available upon written request to the following address (please specify English, Spanish, Vietnamese, Chinese Simplified, Korean or Arabic). If you need assistance you may contact patient account services at the address below or by calling the

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telephone number listed below:

Patient Account Services
6000 N.W. Parkway Ste. 124
San Antonio, TX 78249

Georgetown Hospital	866-396-1025
Heart Hospital of Austin	866-291-3547
North Austin Medical Center	866-391-2015
Round Rock Medical Center	866-391-2017
South Austin Medical Center	866-391-2018
St. David's Medical Center	866-391-2021
St David's Surgical Hospital	855-890-3304

The Application allows for the collection of information in accordance with state law and the income and documentation requirements set forth below. In the case of repeat hospital visits, SDHP will attempt to re-verify with the patient or responsible party the Application and income information for each subsequent encounter; however, a new Application and new supporting documentation must be obtained after twelve months have passed.

Calculation of Immediate Family Members Patients requesting financial assistance must verify the number of family members in their household.

Adults. In calculating the number of family members in an adult patient's household, include the patient, the patient's spouse and any dependents.

Minors. In calculating the number of family members in a minor patient's household, include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father.

Income Calculation. Patients must provide their household's yearly income.

Adults. For adults, the term "Yearly Income" for purposes of classification as Financially Indigent or Medically Indigent in accordance with this Policy means the sum of the total yearly gross income of the patient and the patient's

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spouse.

Minors. If the patient is a minor, the term "Yearly Income" means total yearly gross income from the patient, the patient's mother and the patient's father.

Income Verification. Patients or the responsible party must verify the income reported on the Financial Assistance Application in accordance with the Documentation Requirements set forth below.

Documentation Requirements. The income reported on the Financial Assistance Application may be verified through any of the following mechanisms:

Income Indicators. By the provision of third party financial documentation, which may include but is not limited to, IRS Form W-2, Wage and Tax Statement; Pay Check Remittance; Individual Tax Returns; telephone verification by employer; bank statements; Social Security payment remittances, unemployment insurance payment notices, or Unemployment Compensation Determination Letters. Additionally, the Company considers the economic demographics of the zip code in which the patient resides.

Participation in a Public Benefit Program. By the provision of documentation showing current participation in a public benefit program such as Medicaid; County Indigent Health Program; AFDC; Food Stamps; WIC; Texas Healthy Kids; Children's Health Insurance Program; or other similar indigency related programs. Proof of participation in any of the above programs is required with the completed Financial Assistance Application.

Verification Procedure. In determining a patient's total income, SDHP may consider other financial assets and liabilities of the patient as well as the patient's family income and the patient's family's ability to pay. If a determination is made that a patient has the ability to pay the remainder of the bill, such determination does not preclude a re-assessment of the patient's ability to pay upon presentation of additional documentation.

Classification Pending Income Verification. SDHP may consider a request for financial assistance at any time before, during or after the dates of service. During the

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verification process, while SDHP is collecting the information necessary to determine a patient's income, the patient may be treated as a private pay patient in accordance with SDHP policies.

Inconsistent or Incomplete Information. This policy in no way limits SDHP's ability to conduct additional due diligence concerning a patient's ability to pay if information provided by the patient during the application process appears to be inconsistent or incomplete. For example, SDHP may choose to inquire why little or no assets were reported if a patient's income is high.

Information Falsification. Falsification of information may result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance, SDHP finds material provision(s) of the Financial Assistance Application to be untrue, charity care status may be revoked and the financial assistance may be withdrawn.

Classification as Financially Indigent Financially Indigent means an uninsured or underinsured person who is accepted for care with no obligation or with a discounted obligation to pay for the services rendered based on the Charity Care Eligibility System.

Classification. Patients may only be granted classification as Financially Indigent if their Yearly Income is less than or equal to 200% of the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services ("Federal Poverty Guidelines"). The updated Federal Poverty Guidelines should be applied beginning the first day of the month following their release.

Classification as Medically Indigent Medically Indigent means a patient whose medical or hospital bills, after payment by third-party payers, exceeds a specified percentage of the person's Yearly Income, and who is unable to pay the remaining bill.

Initial Assessment. To be considered for classification as a Medically Indigent patient, the amount owed by the patient after payment by all third-party payers must exceed ten percent (10%) of the patient's Yearly Income and the patient must be unable to pay the remaining bill. If the patient does not meet this initial assessment criteria, the patient may not be classified as Medically Indigent.

Acceptance. SDHP may accept a patient who meets the Initial Assessment criteria for Medically Indigent and meets the criteria set forth below:

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Yearly Income Between 200% and 500% of the Federal Poverty Guidelines. The patient's income must be greater than 200% but less than or equal to 500% of the Federal Poverty Guidelines. In these instances, SDHP will determine the amount of financial charity assistance granted to these patients based upon the patient's Yearly Income as compared to the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services ("Federal Poverty Guidelines"). The range of discount will vary from 40-90%. The uninsured discount will be applied to the remaining balance due after the charity discount is applied.

Approval Procedures. SDHP will work with all uninsured patients to determine eligibility for Medicaid or charity assistance, as outlined in the "Uninsured Patient Information Document" attached as Exhibit 1. Patients will be notified by mail of eligibility for financial assistance once the application has been reviewed and processed. In reviewing an application for approval, Shared Service Center (SSC) Management will make the determination of eligibility, including a determination that reasonable efforts were undertaken to determine eligibility. Such manager may also make further inquiry into available information such as assets, etc. to determine a patient's ability to pay or make further inquiry regarding qualifying the patient for governmental or other funding.

In the event that a patient does not qualify for charity assistance, or the patient is responsible for a portion of the balance after charity assistance has been applied, the uninsured discount will be applied to the account. The amount due will not exceed amounts generally billed to patients with insurance as determined by using the look-back method described in the Internal Revenue Service Regulations. Patients may request information on this calculation by submitting a request to the following:

Patient Account Services
6000 N.W. Parkway Ste. 124
San Antonio, TX 78249

Please take notice that if you do not submit a financial assistance application within 120 days from the date of the billing statement then the hospital facility (or other authorized party) may take certain actions against you in order to obtain payment of the bill including, but not limited to, reporting adverse information about the debt you owe to the hospital facility to credit reporting agencies or credit bureaus, and/or filing a civil lawsuit in order to obtain a judgment against you for the amount that you owe to the hospital facility.

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<p><u>RESERVATION OF RIGHTS</u></p> <p style="text-align: center;">SDHP reserves the right to limit or deny financial assistance at its sole discretion.</p> <p><u>NON-COVERED SERVICES</u></p> <p>Attached as Exhibit 3 and fully incorporated herein by reference is a list of providers who may deliver emergency or other medically necessary services in SDHP hospitals. Exhibit 3 specifies which providers are and which providers are not covered by this Financial Assistance Policy. Providers of elective procedures or other care that is not emergency care or otherwise medically necessary are not covered by the Financial Assistance Policy. The attached Exhibit 3 is updated monthly.</p> <p>Members of the public may obtain a copy of Exhibit 3 by written request to the following address: Patient Accounting Services, 6000 N.W. Parkway, Ste. 124, San Antonio, TX 78249; or by calling the facility telephone number listed in Financial Assistance Policy. Patients can also download a copy of Exhibit 3 from this website: http://stdavids.com/patients-visitors/charity-discount-policy.dot.</p>

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Exhibit 1

Patient Name: _____ Account Number: _____

Uninsured Patient Information Document

This document is intended to help provide uninsured patients with an understanding of the financial aspects of their healthcare. Patients covered by automobile, third party liability or other reimbursement that may be billed for these services, will not qualify for the uninsured discount.

This document also provides options available to assist you in resolving your account. In an effort to assist uninsured patients, HCA will apply a discount to your account and then will work with you to resolve your remaining account balance.

The following information is an outline of how an uninsured account will be processed and the discount options that may be available to you. If you have received an elective cosmetic or flat rate procedure, these discounts do not apply. Otherwise, HCA discounts all uninsured bills. The discounted balance due on the account is expected to be paid in full at the time of service.

- Total charges for services provided are applied to the account
- Uninsured discount is applied to total charges, thereby reducing the account balance
- If you are unable to pay the discounted account balance in full, we will work with you to establish monthly payment arrangements.
- If you cannot establish monthly payment arrangements, we will assist you with applying for Medicaid assistance
- If you obtain Medicaid we will bill them and you will only be responsible for any non-covered charges
- If you do not qualify for Medicaid, you may complete the Financial Assistance Application, provide supporting documentation as needed and have this visit reviewed for a potential Charity discount
- If you qualify for a Charity discount based upon Federal Poverty Guidelines, your account will be considered paid in full. If you do not meet the required Federal Poverty Guidelines, you will need to make arrangements to resolve your bill immediately.

HCA provides a 100% discount on approved charity accounts. All other uninsured accounts will receive a partial discount.

Patient/Responsible Party Signature _____ Date _____

Witness Signature _____ Date _____

SSD.FT.COLL.627 Uninsured Patient Information Document
PAS COPY – SIGNATURE ON FILE

UNINSURED PATIENT INFORMATION DOCUMENT

DOB: _____
 St. David's Medical Center

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St. David's Healthcare Partnership Financial Assistance Application

Patient Name _____ Patient Account Number _____

Telephone Number _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Employed
 Unemployed _____

Employer (Name, Address and Telephone Number)

Spouse Name _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Father (if patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

Patient's Mother (if patient is a minor) _____ Social Security Number _____ Birth Date (Month/Day/Year) _____

A. Wages: Please provide the wages for each of the following persons in your household.

	Circle One		Circle One
	Hr/ Wk/ Month/ Year		Hr/ Wk/ Month/ Year
Patient \$ _____		Patient's Father (if patient is a minor) \$ _____	
Spouse \$ _____		Patient's Mother (if patient is a minor) \$ _____	

B. Other Resources: Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, etc. \$ _____

Please provide the amount of yearly income you receive from these other resources, including interest income, dividends, rental income, etc. \$ _____

C. Family Members: Please provide the number of persons in the patient's household. _____

D. Income Verification: Please provide any of the following types of documentation to verify your income.

- IRS Form W-2
- Paycheck Remittance
- Tax Return
- Bank Statements
- Employer Verification
- Proof of Participation in Governmental Assistance programs such as food stamps, CDIC, Medicaid or AFDC
- Social Security or Unemployment Compensation Determination Letters
- Other, Please Describe

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

I understand St. David's Healthcare Partnership (SDHP) may verify the financial information contained in this Financial Assistance Application ("Application") in connection with SDHP' evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize SDHP to request reports from credit reporting agencies and the Social Security Administration. I certify that this information is true to the best of my knowledge and I am aware that falsification of information on this Application may result in denial of financial assistance.

I understand that any financial assistance is based on my inability to pay and that if any new source of income becomes available, SDHP may reverse its grant of financial assistance in whole or in part.

Date _____

Signature of Patient or Responsible Party _____

Date _____

SDHP Employee Signature if any part of Financial Assistance Application Completed by an SDHP Employee

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St. David's Healthcare Partnership Financial Assistance Application Information and Instructions

Instructions:

As part of its commitment to serve the community and in fulfilling one of the charitable purposes of St. David's Healthcare System, St. David's Healthcare Partnership elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed form to the Registration Representative, or the completed form may be mailed to the following address:

Patient Account Services
6000 N.W. Parkway Ste. 124
San Antonio, Tx. 78249

Section A: Wages

In Section A of the Financial Assistance Application, please indicate the Dollar Amount each listed person receives as compensation and whether the amount represents hourly, weekly, monthly, or yearly compensation.

Section B: Other Resources

In the first blank in Section B of the Financial Assistance Application, please indicate the Dollar Amount you have invested in checking accounts, savings accounts, stocks, etc. In the second blank please indicate the Dollar Amount of income you receive yearly from such investments. For example, in the first blank one might put that they have \$5,000 in a savings account and in the second blank they might put that they earn \$250 interest yearly on that account.

Section C: Family Members

Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents. If the patient is a minor, please include the patient, the patient's mother and/or father and/or legal guardian and any Resident Dependents of the patient's mother and/or father, and/or Legal Guardian.

Section D: Income Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a copy of an IRS Form W-2, Wages and Tax Statement; pay check remittance; tax return; bank statement or other appropriate indicator of income or proof of participation in a public benefit program such as Social Security, Unemployment Compensation, Medicaid, County Indigent Health Program, AFDC, Unemployment Insurance, Food Stamps, WIC, Texas Healthy Kids, Children's Health Insurance Program, or other similar indigency related programs.

You may also verify your wages by having your employer provide written verification or by having your employer speak with an SDHP representative.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

Physician Services

The physicians providing services are not employees of St. David's Healthcare Partnership. You will receive separate bills from your private physician and from other physicians whose services you required. For questions regarding these bills, or to make payment arrangements for physician services, please contact the individual physician's office.