Administrative and Operational Policies and Procedures

Policy Number:	1.10	**Original Date Issued:**	01/15/2013
Section:	Finance	**Date Reviewed:**	04/29/2013
Title:	Financial Assistance Policy	**Date Revised:**	01/01/2014 11/01/2016 02/01/2018
Regulatory Agency:	Department of Treasury, IRS		

I. POLICY:

Children's Healthcare of Atlanta, Inc. ("Children's") understands that patients and/or guarantors may not be able to pay for hospital/medical expenses due to unforeseen circumstances, a lack of health insurance coverage or self-pay amounts due beyond their financial means. Children's offers financial assistance options for patients and/or guarantors and this policy outlines the process for requesting financial assistance and the criteria used to determine eligibility.

This policy covers provider based services including emergency services--provided by Children's Healthcare of Atlanta; however, it does not include physician professional charges. The list of specific locations and covered services covered by this policy is included in Appendix A.

For the purposes of this policy the phrase "patients and/or guarantors" reflects the person(s) with financial responsibility for a Children's Healthcare of Atlanta account--the patient, a parent or guardian or anyone else identified as a guarantor on a Children's account.

Medically Necessary is defined per Centers of Medicare & Medicaid Services (CMS) as: Service or supplies that: are proper and needed for the diagnosis or treatment of a patient's medical condition, are provided for the diagnosis , direct care and treatment of the medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of the patient or his/her doctor.

CMS defines **"Provider-based entity" as**: a provider of health care services that is either created or acquired by the main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, administrative and financial control of the main provider. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at the facility."
Provider based services are rendered in a hospital department or location that the hospital owns or leases space from and employs physicians and other support personnel who are involved in patient care.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r57soma.pdf

II. PROCEDURE:

Children's takes appropriate steps to provide for communication to patients and/or guarantors regarding its Financial Assistance Program and the associated application process.

A. Eligibility Criteria for Children's Financial Assistance Program

Eligibility for Children's Financial Assistance Program requires the following criteria:

- The patient and/or guarantor's financial status meets a needs testing. Children's uses a sliding scale consistent with the current poverty guidelines published in the Federal Register. Patients and/or guarantors are eligible for full or partial financial assistance where household income is at or below 340% of the published Federal Poverty Guidelines.
- The service provided to the patient was medically necessary but not covered or fully covered by any insurance. Where the patient/guarantor had a remaining financial obligation after insurance payment.
- Patient was not approved for any Federal, State agency or private foundation funding program.
- Patient/guarantor fully complied with the application process seeking funding from a Federal, State or private foundation program.
- Patient and/or guarantor exhausted all other sources of financial assistance from private foundations and or other health-related and social service organizations.
- Patient and/or guarantors meeting the above criteria may apply for assistance at any point before, during or after care is provided.
- Children's has discretion to grant assistance on evidence other than that described in the Financial Assistance Policy (FAP).

B. Method for applying for Children's Financial Assistance Program

1. Children's routinely screens all patients with limited financial resources for eligibility in the following programs:

   - Group Health Insurance Plans
   - Individual Health Insurance Plans
   - COBRA
   - Health Coverage Tax Credits
   - Peachcare for Kids
   - Medicaid (including Emergency Medicaid, Medically Needy, Katie Beckett, Presumptive Medicaid, etc.)

2. Patients who qualify under any of the above programs must enroll in the program or fully comply with the application process, submitting all required documents, or such patients may not be eligible for Children's Financial Assistance Program. Specific program requirements can be found at *http://dfcs.dhs.georgia.gov/medicaid*.

3. If it is determined that the patient and/or guarantor is not eligible for State or Federal assistance or from private foundations and/or other health-related and social service organizations, the patient and/or guarantor may complete a Children's Financial Application Form for financial assistance.

   Financial Application Forms can be obtained freely at any of Children's Hospital facilities or requested via telephone, fax or mail or walk-in during business hours at the Financial Counseling Department office:
   Tel: 404/785/5060, Fax: 404/785/9236, Address: 1644 Tullie Circle, Atlanta GA 30329. Children's Financial Application Form is available in English and Spanish and can be downloaded from Children's website at:
   www.choa.org/Patients-families/Billing-and-Insurance/Financial-Assistance.

4. The completed Financial Application form should be submitted along with required documents to the attention of Children's Financial Resource Coordinator for consideration for Children's financial assistance.

   Refer to Appendix B for documentation required by Children's Financial. Application Form.

5. Any incomplete application will not be considered and a letter requesting missing documents will be mailed to applicant.

6. Once the completed application and all supporting documents have been received, the Financial Resource Coordinator will flag the account in Children's billing system to stop all collections efforts while the application is being reviewed.

7. The review process may take up to ninety (90) days from date of receipt of the completed application and all supporting documents.

8. If the financial assistance application is not complete and all supporting documentation not provided within thirty (30) days of a follow up request from a financial counselor, the application will be closed, and the patient and/or guarantor will receive a bill for the outstanding balance.

9. Once a completed application is received, the Financial Resource Coordinator will review the fully completed application and all supporting documentation under the following guidelines:

   - If the patient and/or guarantor is **uninsured**, the eligibility screening shall be based on family size and income using the then-current Federal poverty level guidelines. Financial assistance shall be awarded to eligible patient and/or guarantor on a tiered basis from zero percent (0%) to one hundred percent (100%) to be applied to the outstanding balance.

- If the patient and/or guarantor is **insured**, eligibility is determined by a review of the Financial Assistance application and Federal poverty level guidelines, as noted above. Patient accounts that do not meet the criteria for one hundred percent (100%) discount are reviewed by the Charity Exception Committee for any discount available based on the specific patient and/or guarantor circumstances.

10. Following the conclusion of the review process, a letter of eligibility determination shall be sent to the patient and/or guarantor communicating the status of the applicant's Financial Application along with Children's basis for the determination.

11. If approved for Children's financial assistance, the effective date of approval, and level of assistance will be communicated via letter including the percentage discount on any outstanding balance and the amount due.

12. Once approved, the adjustment of the patient's hospital bill shall be processed.

13. If the patient and/or guarantor is due a refund as a result of the discount applied, a refund will be issued.

14. If a partial discount is granted, the remaining balance is required to be paid in full or have an option to set up an interest-free payment plan.

15. The patient and/or guarantor may choose to appeal Children's financial assistance's decision. The request for appeal is reviewed by the Charity Exception Committee, which has the responsibility for determining that reasonable efforts were taken to determine if the patient and/or guarantor was eligible and confirming that Children's policies have been applied consistently. Should the patient and/or guardian chooses not to appeal the decision, the application shall be closed and collection activities will resume as payment shall be expected on the outstanding balance.

16. A patient and/or guarantor may submit a new application if their care needs or financial circumstances change.

C. Collection and billing practices in the event of partial approval or non-approval of financial assistance.

1. The patient and/or guarantor will be billed if the entire balance is patient responsibility (self-pay) and
   - The self-pay balance is greater than or equal to $10.00.
   - The patient's account does not have any statement holds or billing indicators on the account, which prevent these bills from being generated, including a pending Financial Assistance Application.

- A valid mailing address is on file with no returned mail.

2. Accounts qualify for in-house collection activities within Children's for non-payment. After exhausting all efforts through in-house collection activities, if still unpaid, account may be placed with an outside collection vendor as "Bad Debt". Children's takes appropriate steps to confirm that patients and guardians are aware of the efforts that are taken before sending accounts to a bad debt vendor. A summary of activities completed are as follows:

a. "In House" Collections

- Guarantor receives statements or and collection letters monthly.
- After approximately ninety (90) days, after the first statement is sent, if balance is not paid in full and no payment arrangement has been made, a final collection letter/statement is issued.

b. "Bad Debt " Collection

- After approximately one hundred and twenty (120) days of internal in-house collection efforts -including sending the final collection letter/statement, the account will be outsourced to a bad debt collection agency.
- Accounts are placed with the agency for six (6) to twelve (12) months, during which time the collection agency will make additional efforts to collect on remaining balances. If still unable to collect, balance may be written off to bad debt.

c. Children's is governed by the Fair Debt Collection Practices Act. "Children's does not implore any extraordinary collection action as defined by the IRS". At no time does Children's or vendors acting on Children's behalf, report to any credit bureau (e.g., Equifax, Transunion, Experian) or use legal or judicial processes to collect self- pay debt. This policy applies to all self-pay balances for hospital and professional billing for all Children's entities. Additionally, Children's does not "sell" its accounts receivables to outside vendors.

D. How We Charge For Services

Basis for Determining Amounts Charged to Patients

- Amounts charged for emergency and medically necessary hospital-based medical services (excludes physician professional fees) to patients eligible for Financial Assistance will not be more than the amounts generally billed to individuals with insurance covering such services.

- Financial hardship and charity care adjustments may be considered for those patients whose income and assets will not allow full payment within a reasonable time. The amount that a patient and/or guarantor is expected to pay is determined by his or her eligibility for Children's Financial Assistance Program, as determined by the Eligibility Criteria outlined in II. A. Eligibility Criteria for children's Financial Assistance Program.

- Children's may deny a request for financial assistance for a variety of reasons including, but not limited to:

    - Sufficient income.
    - Sufficient asset level.
    - Lack of patient and/or guarantor cooperation or unresponsive to reasonable efforts to responsibly resolve the balance owed or secure Medicaid eligibility or other financial coverage.
    - Requests for care when there is no identifiable means of obtaining long-term support (e.g. medication or implantable devices) needed to sustain the initial successful outcomes of care—does not include care for an emergency condition.
    - Incomplete Financial Assistance application despite reasonable efforts to work with the patient.
    - Pending insurance or liability claim.
    - Withholding insurance information or payment and/or insurance settlement funds, including insurance payments sent to the patient to cover services provided, and personal injury and/or accident related claims.
    - Providing inaccurate information as a means of securing approval for financial assistance.

E. Measures to Publicize Children's Financial Assistance Program Include:

- Information about Children's Assistance Program is provided to patients and/or guarantors:

    - upon a patient's registration or admission to the hospital, including a flyer placed in the Admission packet provided to patients upon admission.
    - during Children's Financial Counselors visit to a patient's room.

- Posting the availability of Financial Assistance in the waiting room areas.
- On Children's external website, www.choa.org
- On billing statements and collection letters to patients and/or guarantors.
- During calls to Children's Customer Service Department.
- In advertisements of Children's Financial Assistance Program in the Atlanta Journal-Constitution annually.

Administrative and Operational Policies and Procedures

APPENDIX A

Children's Financial Assistance Program covers provider based services performed at any Children's facilities/entities:

Children's Healthcare of Atlanta
• Children's Healthcare of Atlanta at Egleston (Inpatient and Outpatient) • Children's Healthcare of Atlanta at Scottish rite (Inpatient and Outpatient)
Freestanding Ambulatory Surgery Center
• Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza

- Professional Services (Profees) are not covered under this policy except Emergency Department profees.
- Services provided by Children's Healthcare of Atlanta at Hughes Spalding are **NOT** covered under this policy. (Children's Healthcare of Atlanta at Hughes Spalding is owned by Grady Health System® and managed by HSOC Inc., an affiliate of Children's. Care provided is covered by the separate Grady Health System Financial Assistance/Charity Policy; available on the Grady Memorial Hospital website at https://www.gradyhealth.org/fap/policy/).

APPENDIX B

Children's Financial Application Form

Children's Healthcare of Atlanta at Egleston and Scottish Rite provide financial assistance for families to help pay children's medical bills. To apply for free or a reduced rate on medical services that have already been provided by Children's Healthcare of Atlanta, please supply all the information requested on the attached form: proof of income, including your most recently completed tax forms, W2's, as well as copies of your most recent paycheck stubs.

If we do not receive all information requested, as well as proof of income, we will not be able to process the application and the application will be closed, and the patient and/or guarantor will receive a bill for the outstanding balance.

Residents of Georgia may qualify for funds provided by the Georgia Indigent Care Trust Fund (Trust Fund), as well as other funding sources. A person is a resident if he or she has entered the state with a job commitment or is actively seeking employment and not receiving assistance from another state.

If you are not a resident of Georgia or there are any special considerations you would like us to consider, please use this same form to request consideration for financial assistance to the Trust Fund. Consideration of these requests will be determined by the availability of other funding sources for qualified applicants. Please note that completion of the application is not a guarantee of financial assistance from any source.

Within 60 days, you will be notified of the Committee's decision. While the decision is being made, your accounts will be put on hold.

Please remember that your application covers only medical services that have already taken place. If medical services occur after your application is submitted, please notify us so we can determine whether or not you need to complete another application.

If you have any questions regarding Children's financial assistance, please call us at (404) 785-5060, Monday through Friday, 8:30am - 4:00pm. Information is also available on-line at www.choa.org.

Please mail the completed application to:

Financial Resource Coordinator,
Children's Healthcare of Atlanta
1644 Tullie Circle
Atlanta, Georgia 30329

As noted above, please attach the following as proof of income: most recent 1040 tax form with the accompanying W-2's as well as two most recent pay stubs. You may also fax the completed application and proof of income to (404) 785-9236. *Applications without proof of income will not be considered for financial assistance*.

Financial Statement

(Please Print)

Account #(s): ______________________ MR #: ______________

Patient Name: ______________________ Male ______ Female ______

Last *First* *Middle*

Patient Date of Birth ______________ Date of Admission (s): ______________

Applicant Information

Name: Dr. Mr. Mrs. Ms. ______________________

Social Security Number: ______________________

Street Address: ______________________

City: ______________ State: ______________ Zip: ______________

No. Years at This Address: ____________

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: ________

Name of Employer: ______________________

Address of Employer: ______________________

City: ______________ State: ______________ Zip: ______________

No of Years with This Employer: ____________

Position/Title: ______________ Type of Business: ______________

Home Phone: ______________ Business Phone: ______________

Spouse or Co-applicant Information

Name: Dr. Mr. Mrs. Ms. ______________________ ______________

Social Security Number: ______________________

Street Address: ______________________

City: ______________ State: ______________ Zip: ______________

No. Years at This Address: ____________

Marital Status: Married ____ Divorced ____ Single ____ Separated ____

Number of Children: ________

Name of Employer: ______________________

Address of Employer: ______________________

City: ______________ State: ______________ Zip: ______________

No of Years with This Employer: ____________

Position/Title: ______________ Type of Business: ______________

Home Phone: ______________ Business Phone: ______________

For Office Use

____

____

Advisory Board:

____

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Comments:

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Monthly Income before Taxes

Please attach the following as proof of income: Most recent 1040 tax form with accompanying W-2s as well as two most recent pay stubs. *Applications without proof of income will not be considered for financial assistance.*

Applicant		Spouse or Co-Applicant*	
Wage per Hour	$	Wage per Hour	$
Hours work per week		Hours work per week	
Social Security per month	$	Social Security per month	$
Disability per month	$	Disability per month	$
Net Rental Income	$	Net Rental Income	$
Unemployment per month	$	Unemployment per month	$
Child Support per month	$	Child Support per month	$
Alimony per month	$	Alimony per month	$
Public Assistance	$	Public Assistance	$
Other	$	Other	$
Monthly Total	**$**	**Monthly Total**	**$**

***If married, spouse information must be included on application.**

Monthly Living Expenses

Home Mortgage Pymt	$	Unpaid Balance	$
Rent Pymt	$	Unpaid Balance	$
Utilities	$	Unpaid Balance	$
Automobile	$	Unpaid Balance	$
Loans	$	Unpaid Balance	$
Credit Cards	$	Unpaid Balance	$
(list)		(reason)	
Insurance	$	Unpaid Balance	$
Doctor	$	Unpaid Balance	$
Hospital	$	Unpaid Balance	$
Other	$	Unpaid Balance	$
Total	**$**	**Total**	**$**

If you have not listed income, please explain how are you paying for food and housing:

____

____

Consent and Agreement

I confirm that the information in this application is correct and complete and that Children's Healthcare of Atlanta has my permission to double-check it for accuracy. I understand that if Children's Healthcare of Atlanta finds any of this information to be intentionally false, I will not be eligible for financial assistance and will be responsible for all charges.

Signature of Applicant: ______________________ Date: ____________________

Signature of Spouse or Co-Applicant: __________________ Date: _____________________

APPENDIX C
Family Size and Income FPL Chart

2018 INCOME LEVELS - MONTHLY

FEDERAL POVERTY GUIDELINES (FPG) & SELECTED PERCENTAGES THEREOF

(Per Federal Register /Vol. 83, No. 12 /Thursday, January 18, 2018, on pages 2642-2644)

	MONTHLY Income Under									
	125%	145%	165%	185%	200%	235%	270%	305%	340%	
Family	FPG	FPG	FPG	FPG	FPG	FPG	FPG	FPG	FPG	Family
Size	A	B	C	D	E	F	G	H	I	Size
1	$1,265	$1,467	$1,669	$1,872	$2,023	$2,377	$2,732	$3,086	$3,440	1
2	$1,715	$1,989	$2,263	$2,538	$2,743	$3,223	$3,704	$4,184	$4,664	2
3	$2,165	$2,511	$2,857	$3,204	$3,463	$4,069	$4,676	$5,282	$5,888	3
4	$2,615	$3,033	$3,451	$3,870	$4,183	$4,915	$5,648	$6,380	$7,112	4
5	$3,065	$3,555	$4,045	$4,536	$4,903	$5,761	$6,620	$7,478	$8,336	5
6	$3,515	$4,077	$4,639	$5,202	$5,623	$6,607	$7,592	$8,576	$9,560	6
7	$3,965	$4,599	$5,233	$5,868	$6,343	$7,453	$8,564	$9,674	$10,784	7
8	$4,415	$5,121	$5,827	$6,534	$7,063	$8,299	$9,536	$10,772	$12,008	8
9	$4,865	$5,643	$6,421	$7,200	$7,783	$9,145	$10,508	$11,870	$13,232	9
10	$5,315	$6,165	$7,015	$7,866	$8,503	$9,991	$11,480	$12,968	$14,456	10
11	$5,765	$6,687	$7,609	$8,532	$9,223	$10,837	$12,452	$14,066	$15,680	11
12	$6,215	$7,209	$8,203	$9,198	$9,943	$11,683	$13,424	$15,164	$16,904	12
13	$6,665	$7,731	$8,797	$9,864	$10,663	$12,529	$14,396	$16,262	$18,128	13
14	$7,115	$8,253	$9,391	$10,530	$11,383	$13,375	$15,368	$17,360	$19,352	14
15	$7,565	$8,775	$9,985	$11,196	$12,103	$14,221	$16,340	$18,458	$20,576	15
16	$8,015	$9,297	$10,579	$11,862	$12,823	$15,067	$17,312	$19,556	$21,800	16
*	$450	$522	$594	$666	$720	$846	$972	$1,098	$1,224	*

* For family units over 8, the amount shown has been added for each additional member.

J	Income Over 340% of Federal Poverty Guidelines