



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:	03/01/2019
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 expenses due to unforeseen circumstances, a lack of health insurance coverage or self-pay balances 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.

The list of specific locations and services covered by this policy is included in Appendix A.

Definitions

Patients and/or guarantors is defined as the person(s) with financial responsibility for payment of a Children's Healthcare of Atlanta account. It may be the patient, a parent or guardian or whomever has been identified as the guarantor for a specific Children's Healthcare of Atlanta 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."

Charity Exception Committee is defined and described within the Children's Charity Policy. The group reviews and recommends the criteria to be used to determine if services provided to patients with insurance coverage qualify for financial assistance for any patient responsible balance due after insurance payment.



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II. PROCEDURE:

A. Eligibility Criteria for Children's Financial Assistance Program

To be eligible for financial assistance

- The patient and/or guarantor's financial status must meet a needs testing. Children's uses a sliding scale consistent with the current Federal Poverty Level guidelines published annually 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 Levels.
- Service provided to the patient was medically necessary but not covered by any insurance plan, or where there was a balance remaining after all insurance payments have been received.
- Patient has not been approved for any Federal, State or private foundation programs. Children's routinely screens all patients with limited financial resources for eligibility in the following programs:
 - Group Health Insurance Plans
 - COBRA
 - Individual Health Insurance Plans, including those available on the HealthCare.gov Health Insurance Marketplace.
 - Health Coverage Tax Credits
 - Peachcare for Kids
 - Medicaid (including Emergency Medicaid, Medically Needy, Katie Beckett, Presumptive Medicaid, etc.)
- Patient and/or guarantor fully complied with the application process seeking funding from any appropriate Federal, State or private foundation programs. Patients who may qualify under any of these programs must enroll in the program or fully comply with the application process, submitting all documents required by the agency or organization.
- 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 guarantor has completed the Children's Financial Assistance Application in full and provided all appropriate supporting documentation requested.

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

1. 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 Form (see Appendix B) can be obtained at no cost at any Children's Hospital location or it can be requested via telephone, fax, mail or walk-in during business hours at the Financial Counseling Department office:



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Address:
1644 Tullie Circle
Atlanta GA 30329
Tel: (404) 785-5060
Fax: (404) 785-9236

The Children's Financial Assistance Application is available in English and Spanish and can be downloaded from Children's website at:

www.choa.org/Patients-families/Billing-and-Insurance

2. The completed Financial Application form should be submitted along with required supporting documentation noted on the application to the attention of Children's Financial Resource Coordinator at the address above for consideration for Children's financial assistance.

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

3. Any incomplete application will not be considered, and a letter requesting missing documents will be mailed to applicant.
4. 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 hold collections efforts while the application is being reviewed.
5. 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.
6. 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 are **uninsured**, the eligibility screening shall be based on family size and income using the 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%) of the Children's Amount Generally Billed.
 - If the patient and/or guarantor are **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 a one hundred percent (100%) discount are reviewed by the Charity Exception Committee for



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- any discount available based on the specific patient and/or guarantor circumstances.
7. The review process may take up to ninety (90) days from date of receipt of the completed application and all required supporting documents.
 8. Children's may deny a request for financial assistance for a variety of reasons including, but not limited to:
 - a. Income higher than Federal Poverty Level guidelines.
 - b. Sufficient asset level.
 - c. Lack of patient and/or guarantor cooperation, including unresponsive to reasonable efforts to secure Medicaid eligibility or other financial coverage.
 - d. Requests for elective service or care without evidence of long-term support (e.g. those needed for medication regimens or implantable devices) needed to sustain successful outcomes of care.
 - e. Incomplete Financial Assistance application following reasonable efforts if Children's staff to secure the information.
 - f. Pending insurance or liability coverage and/or claims.
 - g. Withholding insurance information, third-party payments or settlement funds, including insurance payments sent to the patient to cover services provided, as well as personal injury and/or accident related claims.
 - h. Providing inaccurate information as a means of securing approval for financial assistance.
 9. 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.
 10. 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.
 11. Once approved, the adjustment of the patient's hospital bill shall be processed.
 12. If the patient and/or guarantor are due a refund as a result of the discount applicable, a refund will be issued.
 13. 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.
 14. 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



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guardian choose not to appeal the decision, the application shall be closed and collection activities will resume as payment shall be expected on the outstanding balance.

15. A patient and/or guarantor may submit a new application if their care needs or financial circumstances change.
16. Children's may determine eligibility for charity or other financial assistance presumptively based on information other than, or in addition to, that included on a completed Financial Assistance Application.

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 is not being held for any reason, including a pending Financial Assistance Application.
 - A valid mailing address is on file.
2. Any open self-pay account balances qualify for in-house collection activities until the account is paid in full. Once in-house collection activities have been exhausted and an account remains unpaid, the account may be placed with an outside collection vendor for additional collection actions. Children's takes appropriate steps to confirm that patients and/or guardians are aware of the efforts that are taken before sending accounts to any outside collection vendor.
3. A summary of Children's Billing and Collection process is as follows:
 - In-House Collections
 - Guarantor receives statements and then collection letters monthly.
 - After approximately 120 days and after an account has been sent at least two statements and three collection letters, if balance is not paid in full and no payment arrangement has been made, a final collection letter/statement is issued and the account is eligible for referral to an outside collection agency.
 - Outside Collection Agency
 - Accounts are placed with the agency for six (6) to twelve (12) months, during which time the agency will make additional efforts to collect on balances outstanding. If still unable to collect, the balance may be returned to Children's and deemed uncollectible.



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4. Children's is governed by the Fair Debt Collection Practices Act. Children's does not engage in any Extraordinary Collection Actions as defined by the IRS. At no time does Children's or its collection agencies:
 - report to any credit bureau (e.g., Equifax, Transunion, Experian)
 - use legal or judicial processes to collect self-pay debt
 - "Sell" its accounts receivables to outside vendors

D. How We Charge For Services

- Amounts billed for emergency and medically necessary services billed by Children's Healthcare of Atlanta to uninsured patients and/or guarantors who complete a Financial Assistance Application will not be more than the average Amount Generally Billed for patients with third-party coverage.
- The Average Amount Generally Billed is calculated using a Look-Back methodology. The Look-Back amount is calculated based on the insurance allowable amounts for all insurance payments posted. Insurance payments include those from Medicare, Medicaid and all other third-party insurance payors.
- The Average Amount Generally Billed will be based on insurance payments posted each calendar year. The percentage will be calculated by February 28 each year and be used to calculate guarantor amounts due for services beginning March 1 and continuing through February 28 of the following year.
- The Average Amount Generally Billed is the ratio of total insurance allowable amounts for payments posted during the year to the total billed charges for accounts that had payments posted to them. The current ratio and a description of the calculation can be requested free of charge via an e-mail to billing@choa.org.
- The amount that a 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. The maximum amount a guarantor qualifying for Financial Assistance is expected to pay for services provided to an uninsured patient is 100% of the amount generally billed.
- Discounts for patients and/or guarantors who qualify for financial assistance and have insurance coverage will be applied to the patient responsibility identified by the insurance payor(s).



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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.
- The availability of Financial Assistance is posted in the waiting room areas throughout the hospital.
- Links to the Financial Assistance Policy, the Plain Language Summary, the Financial Assistance Application and a listing of Entities and Physician Practices covered by the Financial Assistance Policy are located on Children's external website, www.choa.org.
- Billing statements and collection letters sent to patients and/or guarantors include notes that Financial Assistance is available for qualifying patients and/or guarantors.
- The hold message used for calls to Children's Patient Accounting Customer Service Department states that Financial Assistance is available for qualifying patients and/or guarantors.
- The availability of free or discounted care is posted in notices published in the Atlanta Journal-Constitution each year.



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APPENDIX A

Children's Financial Assistance Program covers services performed at these Children's facilities:

Children's Healthcare of Atlanta
<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza

- Professional Services are not covered under this policy with the exception of:
 - Emergency Department professional fees,
 - Professional fees for Children's Physician Group services incurred while a patient is receiving care at Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite.
- 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/>.



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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 90 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.*



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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:

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: _____



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**APPENDIX C
Family Size and Income FPL Chart**

2019 INCOME LEVELS - MONTHLY

FEDERAL POVERTY GUIDELINES (FPG) & SELECTED PERCENTAGES THEREOF

(Per Federal Register /Vol. 84, No. 22 /Friday, February 1, 2019, on pages 1167-1168)

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	\$1,301	\$1,509	\$1,717	\$1,926	\$2,082	\$2,446	\$2,810	\$3,175	\$3,539	1
2	\$1,761	\$2,043	\$2,325	\$2,607	\$2,818	\$3,312	\$3,805	\$4,298	\$4,791	2
3	\$2,222	\$2,577	\$2,933	\$3,288	\$3,555	\$4,177	\$4,799	\$5,421	\$6,044	3
4	\$2,682	\$3,111	\$3,541	\$3,970	\$4,292	\$5,043	\$5,794	\$6,545	\$7,296	4
5	\$3,143	\$3,646	\$4,148	\$4,651	\$5,028	\$5,908	\$6,788	\$7,668	\$8,548	5
6	\$3,603	\$4,180	\$4,756	\$5,333	\$5,765	\$6,774	\$7,783	\$8,792	\$9,801	6
7	\$4,064	\$4,714	\$5,364	\$6,014	\$6,502	\$7,639	\$8,777	\$9,915	\$11,053	7
8	\$4,524	\$5,248	\$5,972	\$6,695	\$7,238	\$8,505	\$9,772	\$11,038	\$12,305	8
9	\$4,984	\$5,782	\$6,579	\$7,377	\$7,975	\$9,371	\$10,766	\$12,162	\$13,558	9
10	\$5,445	\$6,316	\$7,187	\$8,058	\$8,712	\$10,236	\$11,761	\$13,285	\$14,810	10
11	\$5,905	\$6,850	\$7,795	\$8,740	\$9,448	\$11,102	\$12,755	\$14,409	\$16,062	11
12	\$6,366	\$7,384	\$8,403	\$9,421	\$10,185	\$11,967	\$13,750	\$15,532	\$17,315	12
13	\$6,826	\$7,918	\$9,010	\$10,103	\$10,922	\$12,833	\$14,744	\$16,656	\$18,567	13
14	\$7,286	\$8,452	\$9,618	\$10,784	\$11,658	\$13,699	\$15,739	\$17,779	\$19,819	14
15	\$7,747	\$8,986	\$10,226	\$11,465	\$12,395	\$14,564	\$16,733	\$18,902	\$21,072	15
16	\$8,207	\$9,520	\$10,834	\$12,147	\$13,132	\$15,430	\$17,728	\$20,026	\$22,324	16
*	\$460	\$534	\$608	\$681	\$737	\$866	\$995	\$1,123	\$1,252	*
J	Income Over 340% of Federal Poverty Guidelines									

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