



**GILA REGIONAL**  
*Medical Center*

<b>Policy/Procedure Title</b>	Financial Assistance Policy				<b>Policy #</b>		
<b>Manual Location(s)</b>	Business Office Manual	<b>Original Effective</b>	June 6/1/18	<b>Revised Date</b>	N/A	<b>Page</b>	1 of 8
<b>Department Generating Policy</b>	Business Office						
<b>Affected Departments</b>	All Departments						
<b>Prepared By</b>	Richard Stokes	<b>Date/ Title</b>	6/20/19, Chief Financial Officer				

**POLICY:**

Gila Regional Medical Center (GRMC) shall contribute appropriate resources, advocacy and community support to promote the health status of the community, which it serves, within its economic ability to do so. Financial assistance will be provided to patients with a demonstrated inability to pay. The purpose of this policy is to establish criteria for determining if a patient's account qualifies for financial assistance. The amount of financial assistance to be made available, as well as any other changes to this policy, shall be assessed and determined by the hospital's Chief Executive Officer on an annual basis, and will adhere to federal and state guidelines, as applicable. The amount of financial assistance as well as the other terms of this policy may be changed by the hospital's Chief Executive Officer, subject to the approval of Gila Regional Medical Center Board of Directors.

**PROCEDURE:**

1. **Non-Discrimination.** The hospital is a non-profit corporation offering financial assistance to qualified patients. The hospital will not discriminate on the basis of race, ancestry, religion, national origin, citizenship status, age, disability or gender in its consideration of a patient's qualification for financial assistance.
2. **Patient Classification.** The classification of a patient as being eligible for financial assistance shall occur at the time sufficient information has been obtained to verify the patient's inability to pay for needed medical services, and as soon as possible after the patient first presents for services or indicates an inability to pay for services. It is ultimately the patient's responsibility to provide the necessary information to qualify for financial assistance.
3. **Other Payor Sources.** Patients must fully cooperate and comply with eligibility requirements for any other healthcare program(s) for which they may be qualified prior to their evaluation for financial assistance. Federal and/or state assistance may be available for those who meet qualifications. Before financial assistance is provided, all available avenues of assistance from third-party payors must be exhausted.

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4. **Medical Necessity.** This policy applies to all emergency and other medically necessary care provided in this hospital or any substantially related entity of the hospital. All services must be medically necessary in order to qualify for financial assistance (e.g., elective services such as cosmetic surgery do not qualify for financial assistance). Eligible services will be based on those services for which Medicare provides coverage.
  
5. **Eligibility Criteria.** All patients may apply for financial assistance at any time during the continuum of care or after care is received. Each patient's situation will be evaluated according to relevant circumstances, such as income, assets or other resources available to the patient or patient's family when determining the ability to pay the outstanding patient account balance. Taking this information into consideration, the attached Financial Assistance Eligibility Discount Guidelines (Attachment A) are utilized to determine what amount, if any, of the outstanding patient account balance will be discounted after payment by all third parties.
  - **PLEASE NOTE: The financial assistance offered under this policy does not apply to physician or other professional fees billed separately from the hospital's fees. The hospital reserves the right to further limit the services covered by this policy.**
  
6. **Method for Applying for or Obtaining Financial Assistance.**
  - a. **Application Process.** Applying for financial assistance can be initiated by a patient requesting assistance in person, over the phone at 575-574-4989, through the mail at 1313 E 32<sup>nd</sup> Street, Attn: PFS Dept., Silver City, NM 88061. Additionally, the hospital can initiate a financial assistance application on behalf of the patient.
  - b. **Presumptive Eligibility for Financial Assistance.** The hospital may use Discovery Healthcare Consultant Group and other publicly available information to determine, consistent with applicable legal requirements, estimated household size and income amounts for the basis of determining financial assistance eligibility when a patient does not provide a financial assistance application or supporting documentation. A letter to the patient informing him/her of qualifying for financial assistance will be sent to the patient.
  
7. **Length of Eligibility.** Once financial assistance has been approved, it is effective for all outstanding patient accounts and for all services provided within six (6) months after the financial assistance application is signed by the patient or responsible party or the hospital employee ("Date of Completion"). Financial assistance may be extended for an additional six (6) months with affirmation of the patient's income or estimated income and household size. All patients must reapply after the initial twelve (12) month period is over.
  - Approval under Section 6(b) above will only apply to the date(s) of service on the patient account balance being evaluated. Eligibility will not apply to accounts for future dates of service.
  
8. **Basis for Calculating Amounts Charged; Amounts Generally Billed.** The level of financial assistance will be based on a classification as "Financially Indigent" or "Medically Indigent" or "Catastrophically Medically Indigent," as defined below. In all situations, once the patient is determined to qualify for financial assistance that

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individual will not be charged more for emergency or other medically necessary care than the **amounts generally billed (AGB)** to individuals who have insurance covering such care.

9. **Financially Indigent.** “Financially Indigent” means a patient whose Yearly Household Income (as defined below) is less than or equal to 200% of the Federal Poverty Guidelines (“FPG”). These Financially Indigent patients are eligible for a 100% discount on outstanding patient account balances as set forth in Part 1 of the Financial Assistance Eligibility Discount Guidelines (Attachment A).
10. **Medically Indigent.** “Medically Indigent” means a patient whose medical or hospital bills from all related or unrelated providers, after payment by all third parties, whose Yearly Household Income is greater than 225% but less than or equal to 300% of the FPG, and who is unable to pay the outstanding patient account balance. These Medically Indigent patients are eligible for a discount on outstanding patient account balances as set forth in Part 2 of the Financial Assistance Eligibility Discount Guidelines (Attachment A).
11. **Catastrophically Medically Indigent.** “Catastrophically Medically Indigent” means a patient whose medical or hospital bills from all related or unrelated providers, after payment by all third parties, whose Yearly Household Income is greater than 225% but less than or equal to 300% of the FPG, and who is unable to pay the outstanding patient account balance. These Catastrophically Medically Indigent patients are eligible for a discount on outstanding patient account balances as set forth in Part 3 of the Financial Assistance Eligibility Discount Guidelines (Attachment A).
12. **Financial Assistance Eligibility Discount Guidelines.** The Financial Assistance Eligibility Discount Guidelines are attached to and are made a part of this policy (Attachment A). The method for determining appropriate discount percentages will be reviewed annually to ensure patients’ outstanding account balances after discount are no more than AGB.
13. **Determination of Eligibility for Financial Assistance.** Determination of eligibility for financial assistance will be in accordance with procedures that may involve (a) an application process, in which the patient or the patient’s guarantor is required to supply information and documentation relevant to making a determination of financial need; and/or (b) the use of other publicly available information that provide information on a patient’s or a patient’s guarantor’s ability to pay.
  - **Review and Final Authority.** All Applications for financial assistance under this Policy are reviewed and determinations are made by GRMC staff based on the information provided on the financial assistance application. In extraordinary circumstances the determination can be made by the Chief Financial Officer or Chief Executive Officer based on other information that is not described in this policy.

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**14. Yearly Household Income and Household Size.** If the patient is an adult, “Yearly Household Income” means the sum of the total yearly gross income or estimated yearly income of the patient and the patient’s spouse, and “Household Size” includes the patient, the patient’s spouse, and any dependents (as defined by the IRC). If the patient is a minor, “Yearly Household Income” means the sum of the total yearly gross income or estimated yearly income of the patient, the patient’s mother and the patient’s father, and “Household Size” includes the patient, the patient’s mother, the patient’s father, dependents of the patient’s mother, and dependents of the patient’s father.

**15. Income Verification.** Household income will be documented through any of the following mechanisms:

- **Third Party Documentation.** By the provision of third party financial documentation including any three of the following:
  - IRS Form W-2 (Wages and Tax Statement or a 1099 R form))
  - pay check remittance
  - individual tax return
  - telephone verification by employer
  - bank statements
  - Social Security Notification of Benefits, such as SSA-1099; SSA-1042F or SSA-1099-SM
  - worker’s compensation payment remittance
  - unemployment insurance payment notice
  - unemployment compensation determination letters
  - response from a credit inquiry
  - and other publicly available information; or other appropriate indicators of the patient’s income.

Third party documentation provided under this subsection will be handled in accordance with the hospital’s information security procedures and the requirements of securing protected health information.

- **Written Verification.** In cases where third party documentation is unavailable, verification of the patient’s Yearly Household Income can be done (i) by obtaining a financial assistance application signed by the patient or responsible party attesting to the accuracy of the patient’s income information provided, or (ii) through the written attestation of the hospital employee completing the financial assistance application that the patient or responsible party verbally verified the patient’s income information provided.

In any instance in which the patient or responsible party is unable to provide the requested third-party verification of patient’s income, the patient or responsible party is required to provide a reasonable explanation of why the patient or responsible party is unable to provide the required third-party verification. Reasonable attempts will be used to verify patient’s attestation and supporting information.

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**16. Expired Patients.** Expired patients, with no surviving spouse, may be deemed to have no income for purposes of calculation of Yearly Household Income. Documentation of income is not required for expired patients; however, documentation of estate assets may be required. The surviving spouse of an expired patient may apply for financial assistance.

**17. Prima Facie Write-offs.** The hospital may choose to grant Financial Assistance based solely upon the initial determination. Any patients who are:

- on state assistance
- are unemployed
- disabled
- transient
- or incompetent

may be valid "prima facie" candidates. In such cases, the hospital may not complete full verification or documentation of any request.

**18. Financial Assistance Disqualification.** Disqualification after financial assistance has been granted may be for reasons that include, but are not limited to, one or more of the following:

- **Information Falsification.** Financial assistance will be denied to the patient if the patient or responsible party provides false information including information regarding income, household size, assets or other resources available that might indicate a financial means to pay for care.
- **Third Party Settlement.** Financial assistance will be denied if the patient receives a third-party financial settlement associated with the care rendered by the hospital. The patient is expected to use the settlement amount to satisfy any patient account balances.

**19. Relationship to Collections of Accounts Policy.** During the verification process, while information to determine a patient's income is being collected, the patient may be treated as a private pay patient in accordance with other hospital policies. A payment plan may be established during the verification process. A copy of the hospital's Payment Plan Policy can be obtained free of charge by contacting 575-574-4989 or in person at the Patient Financial Services (PFS) office. After the patient's account is reduced by the discounts based on the Financial Assistance Eligibility Discount Guidelines (Attachment A), the patient is responsible for the remainder of the outstanding patient account balance which shall be no more than AGB (Amounts Generally Billed). Once the patient qualifies for financial assistance, the hospital will not pursue collections on the amount qualified for financial assistance. Patients will be invoiced for any remaining amounts in accordance with the hospital's Collections of Accounts Policy.

**20. Time Frame for Final Determinations.** The hospital shall provide final determination within fourteen (14) calendar days of receipt of a complete application.

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**21. Copayments.** The hospital reserves the right to bill and collect a reasonable copayment for services rendered from patients who qualify for financial assistance.

**22. Patient Payments on Accounts.** In the event that a responsible party pays a portion or all of the charges related to appropriate medical services, and is subsequently found to have met the financial assistance criteria at the time that services were provided, any payments in excess of amount owed after charity care has been applied to the account shall be refunded to the patient within thirty days of achieving the financial assistance designation. There will NOT be a refund for accounts that receive financial assistance if it was determined with presumptive charity care.

**23. Denial Appeals.** Denials will be written and include instructions for appeal or reconsideration as follows: The responsible party may appeal the determination of eligibility for Financial Assistance by correcting any deficiencies in documentation to the designated representative. Upon the receipt of an appeal, there will be a thirty (30) day hold in the collection process. The Chief Financial Officer will review and respond to all appeals within fourteen (14) days of receipt. If this review affirms the previous denial of Financial Assistance, written notification will be sent to the patient/guarantor. If the denial is reversed the patient shall immediately be declared an eligible candidate

Collection efforts will cease if an appeal has been filed for Financial Assistance.

**24. Relationship to EMTALA and Other Policies.**

- **THIS POLICY DOES NOT AFFECT THE HOSPITAL'S OBLIGATION UNDER THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA). THIS POLICY ALSO DOES NOT ALTER OR MODIFY OTHER POLICIES CONCERNING EFFORTS TO OBTAIN PAYMENTS FROM THIRD-PARTY PAYORS.**

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**ATTACHMENT A  
FINANCIAL ASSISTANCE ELIGIBILITY DISCOUNT GUIDELINES**

**PART 1  
FINANCIALLY INDIGENT CLASSIFICATION**

<b>Yearly Household Income</b>	<b>Up to 200% of FPG</b>
<b>Discount Amount</b>	<b>100% of Outstanding Balance</b>

**PART 2  
MEDICALLY INDIGENT CLASSIFICATION**

<b>Yearly Household Income</b>	<b>Up to 225% of FPG</b>	<b>Up to 250% of FPG</b>	<b>Up to 275% of FPG</b>	<b>Up to 300% of FPG</b>
<b>Discount Amount</b>	<b>90% of Outstanding Balance</b>	<b>80% of Outstanding Balance</b>	<b>70% of Outstanding Balance</b>	<b>60% of Outstanding Balance</b>

**PART 3  
CATASTROPHICALLY MEDICALLY INDIGENT CLASSIFICATION**

<b>Yearly Household Income</b>	<b>Up to 225% of FPG</b>	<b>Up to 250% of FPG</b>	<b>Up to 275% of FPG</b>	<b>Up to 300% of FPG</b>
<b>Discount Amount</b>	<b>90% of Outstanding Balance</b>	<b>80% of Outstanding Balance</b>	<b>70% of Outstanding Balance</b>	<b>60% of Outstanding Balance</b>

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**ATTACHMENT B  
FINANCIAL ASSISTANCE LIST OF NONCOVERED SERVICES**

- ❖ PHYSICAL THERAPY PRESCRIBED AS A MAINTENACE REGIMENT
- ❖ ROUTINE PHYSICAL EXAM, EXCEPT FOR PRESCHOOL AND SPORTS PARTICIPATION FOR SCHOOL AGE CHILDREN
- ❖ ANY ELECTIVE SERVICE OR PROCEDURE
- ❖ ANY SERVICE PROVIDED AGAINST MEDICAL ADVICE
- ❖ ANY SERVICE OR PROCEDURE THAT IS NOT USUAL AND CUSTOMARY IN A CLINIC OR HOSPITAL

**FINANCIAL ASSISTANCE LIST OF COVERED PHYSICIANS  
PROVIDING EMERGENCY OR MEDICALLY NECESSARY CARE**

**FINANCIAL ASSISTANCE LIST OF NONCOVERED PHYSICIANS  
PROVIDING EMERGENCY OR MEDICALLY NECESSARY CARE**



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**ATTACHMENT C**  
**2019 Poverty Guidelines for the 48 Contiguous States**

Persons in family/household	Poverty guideline
1	\$12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430

19 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

For families/households with more than 8 persons, add \$4,420 for each additional person.

Persons in family/household	Poverty guideline	200%	225%	250%	300%
1	12,490.00	24,980.00	28,102.50	31,225.00	37,470.00
2	16,910.00	33,820.00	38,047.50	42,275.00	50,730.00
3	21,330.00	42,660.00	47,992.50	53,325.00	63,990.00
4	25,750.00	51,500.00	57,937.50	64,375.00	77,250.00
5	30,170.00	60,340.00	67,882.50	75,425.00	90,510.00
6	34,590.00	69,180.00	77,827.50	86,475.00	103,770.00
7	39,010.00	78,020.00	87,772.50	97,525.00	117,030.00
8	43,430.00	86,860.00	97,717.50	108,575.00	130,290.00