

Policy: Financial Assistance Policy	Date Issued: 5/29/2018	Department Approval:
Business Office	Revised: 06/18/19	Administrative Approval:

Outcome Statement

Purcell Municipal Hospital's (PMH) Financial Assistance Policy identifies opportunities for financial assistance to patients who are financially indigent and demonstrate an inability to pay for the services provided to them or their dependents. The Financial Assistance Policy (FAP) provides and establishes facility-wide guidelines for financial assistance that ensures compliance with all state, federal, and regulatory guidelines.

Purcell Municipal Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured or underinsured. Consistent with our mission to enrich the health and lives of those we serve through individualized, compassionate, and exceptional care. Purcell Municipal Hospital will provide, without discrimination, emergency care for medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance
- Describes the basis for calculating Amounts Generally Billed (AGB) to patients eligible for financial assistance under the policy
- Describes the method by which patients may apply for financial assistance
- Describes how Purcell Municipal Hospital will 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 Amounts Generally Billed (AGB)

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with PMH procedures for obtaining 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 healthcare services, for their overall personal health, and for the protection of their individual assets. Purcell Municipal Hospital may at any time define and revise the criteria determining eligibility for financial assistance.

In order to manage its resources responsibly and to allow Purcell Municipal Hospital 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 Financial Assistance.

Definitions:

- I. **Application Period:** Defined as the time provided to patients by the hospital to complete the Financial Assistance application. It begins on the first day care is provided and ends on the 90th day after the hospital provides the individual with the first post-discharge billing statement for the care provided.
- II. **Family Size:** Family size is defined by the Internal Revenue Service and is equal to the number of individuals for whom the taxpayer is allowed a deduction on their federal tax return.
- III. **Family Income:** Family income is determined from the Census Bureau definition, which uses the following income when computing Federal Poverty Level (FPL):
 - A. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, incomes for estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
 - B. Non-cash benefits such as food stamps and housing subsidies do not count;
 - C. Determined on a before-tax basis;
 - D. Excludes capital gains or losses; and
 - E. If a person lives with a family, include the income of all the family members (Non-relatives, such as housemates, do not count).
- IV. **Federal Poverty Level (FPL):** The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities. It is determined by the Department of Health and Human Services and is adjusted for inflation and reported annually in the form of poverty guidelines.
- V. **Financial Assistance:** Defined as free or discounted health care services provided to persons who cannot afford to pay all or a portion of their financial liability for services and who meet Purcell Municipal Hospital's financial assistance policy criteria.
- VI. **Medically Necessary:** Defined by Medicare as services or items reasonable and necessary for the diagnosis, prevention, or treatment of an illness, injury, or disease.
- VII. **Patient Liability:** The amount a patient is personally responsible for paying after all available discounts, including uninsured discount, and financial assistance discount.
- VIII. **Uninsured:** The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.
- IX. **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.

Process

- I. **Services Eligible:** For purposes of this policy, all emergency and medically necessary services provided at PMH, including inpatient hospital stays are eligible. Non-medically necessary services and procedures will not qualify for Financial Assistance.
- II. **Eligibility for Financial Assistance:** Eligibility for financial assistance will be considered for those individuals who:
 - A. Have limited or no health insurance;
 - B. Cooperate with Purcell Municipal Hospital's policies and procedures;
 - C. Demonstrate financial need;
 - D. Supply all required information to process the application; and
 - E. Reimburses the Hospital for any monies paid directly to patient by insurance.

The granting of financial assistance shall be based on an individualized determination for financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. A determination of financial assistance will be effective for a period of up to 3 months from the date the application was approved and will include outstanding account balances for 3 months prior to approval date.

Additionally, this policy does not apply to internationally traveling/vacationing patients who seek treatment at Purcell Municipal Hospital.

Financial need and eligibility will be determined in accordance with the following procedures:

- A. **Application** – In order to be eligible for financial assistance consideration, the patient or guarantor must complete the Patient Financial Assistance Application form and submit the documentation requested to support reported income and expenses. One application will cover the unpaid patient liabilities for open accounts up to 3 months prior to approval date for the same guarantor. Applications for financial assistance should be complete and accurate and include verifiable proof of income and/or assets as well as unusual expenses.

Patients can also submit an application verbally at a face to face appointment with the Business Office Manager or designee. The information will be documented, and the patient will verify and attest to all the information recorded. All supporting documentation must be supplied for the application to be considered complete.

Applications will not be considered complete unless the required documentation is received and evaluated. Purcell Municipal Hospital will mail a written notice regarding the decision of their application. The applicant will receive an updated statement(s) reflecting any financial assistance discounts during their next regular billing cycle.

Required documents include:

1. Completed written/verbal application
2. Bank/Savings Statements for most recent three months
 - a. An explanation of any unusual deposits/expenses on the bank/savings statements
 - b. Documents must reflect all deposits
3. Income verification for applicant. If guarantor filed married, filing joint on most recent taxes, the guarantor must send income verification for spouse as well.
 - a. Verification of income can include (not an inclusive listing): pay stubs, unemployment checks, social security award letters/checks, disability award letters, child support documentation, and pension verification. If the patient has no income, a notarized statement of such must be provided with the application.
4. Tax Return Documentation
 - a. Most recently filed tax return or Non-Filing Letter from the IRS. Taxes must be accompanied by all supporting schedules (A-F) and documents (W2s, 1099s) to be considered complete.
5. Medicaid Approval/Denial Letter
 - a. This is only a requirement if the Hospital has pre-screened the patient for Medicaid eligibility. If patient is pre-screened as potentially eligible, they must cooperate with Medicaid application process to be eligible for financial assistance with Purcell Municipal Hospital.

Documents that are altered will not be accepted.

- B. Incomplete Applications – All incomplete applications will receive a letter of notification that will detail the information that is needed to satisfy the documentation requirements for eligibility. If the applicant sends in incomplete documentation a second time, the applicant will receive a letter and a phone call attempt to notify the patient that their application is not complete.

Applications for financial assistance may be hand delivered to the Admissions Manager of Purcell Municipal Hospital, 2301 N 9th Ave Purcell, OK 73080

**Applications may be mailed to: Purcell Municipal Hospital Attn: Admissions Manager
PO Box 511, Purcell, OK 73080**

Applications may be faxed to the Business Office Manager: (405) 527-6963

If, at any time it is determined a third party is, or may be liable for your services, any recovery takes precedence over financial assistance and any financial assistance will be void. You will be responsible for payment of all charges of any covered service.

Purcell Municipal Hospital's values in human dignity and stewardship shall be reflected in the application process, financial need determination, and granting financial assistance. Requests for financial assistance shall be processed promptly and Purcell Municipal Hospital shall notify the patient or applicant in writing within a reasonable period of time from receipt of a completed application.

Each patient has the opportunity to apply for financial assistance prior to treatment, and throughout the Application Period. The need for financial assistance shall be re-evaluated at each subsequent time of service if the last financial evaluation was completed more than 6 months prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

Questions about the Financial Assistance Policy may be directed to the Admissions Manager at (405) 527-6524 X-3312.

- C. Approved Financial Assistance Adjustment Amounts – Once the supporting documentation has been submitted and the individual has been approved for financial assistance, the following discounts will apply off gross charges.

PURCELL MUNICIPAL HOSPITAL CHARGES					PROFESSIONAL CHARGES
FEDERAL POVERTY LEVEL	PATIENT RESPONSIBILITY (INPATIENT, OBSERVATION, SAME DAY SURGERY)	PATIENT RESPONSIBILITY (OUTPATIENT, RECURRING)	PATIENT RESPONSIBILITY (EMERGENCY)	AMOUNT OF FINANCIAL ASSISTANCE APPROVED	PROFESSIONAL FEES FOR PROVIDERS LISTED IN EXHIBIT B
0-150%	\$887 copay per visit	\$85 copay per visit	\$125 copay per visit	100% (less copay)	20% of charges
151-200%	40% of charges	40% of charges	40% of charges	40%	40% of charges
201-250%	60% of charges	60% of charges	60% of charges	60%	60% of charges

*If at any time the hospital determines that the patient responsibility amount due is a barrier to care for the patient, the application will be taken in front of the administrative team to determine if the remaining balance should be adjusted as an administrative adjustment per the administrative adjustment policy.

- D. Individual Patient Responsibilities – A patient who qualifies for financial assistance must cooperate with the hospital to establish a payment plan per the hospital's financial policy and adhere to the hospital's payment collection policy to avoid their account being turned to a third-party collection agency.
- E. Additional extraordinary circumstances may qualify for financial assistance on a case-by-case basis:
1. Individual is homeless;
 2. Individual is deceased and has no known estate able to pay hospital debts;
 3. Individual is incarcerated;
 4. Individual is currently eligible for Medicaid, but was not eligible at the date of service;

III. Amount Generally Billed (AGB)/Limitation of Charges. Purcell Municipal Hospital limits the amount charged for emergency and medically necessary care provided to patients who are eligible for financial assistance under this policy to not more than gross charges for the care multiplied by the AGB percentage. The AGB percentage is determined using the look-back method. (See Exhibit C).

The AGB percentage is calculated at a hospital facility level, at a minimum annually, with implementation not more than 120 days after the end of the 12 month period utilized above.

IV. Relationship to Collection Policies. Patients/guarantors are expected to pay the amount of their account that is not eligible for assistance under this policy. After application is approved, payment in full is

expected, or a payment plan must be established. Patients/guarantors who fail to pay their balance within 90 days after discounts have been applied will be subject to normal collection procedures.

- V. **Providers Covered.** A list of providers that are covered under this policy and those that are not accompanies this policy under Exhibit B. Any questions about inclusion or exclusion of providers that are covered under this policy can be directed to the Business Office Manager at (405) 527-6524 X-3312.
- VI. **Regulatory Requirements.** In implementing this policy, Purcell Municipal Hospital management and facility shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.
- VII. **Documentation.** In effort to adequately document its fair application of this policy, the Business Office will maintain records of its financial assistance applications, determinations of financial assistance, and notices to patients for at least 24 months.
- VIII. **Communication of the Charity Program to Patients and Within the Community:** Communication about the PMH financial assistance program will be publicized on the Hospital's website. Program information will include a contact phone number, and will be written in the primary language spoken by the community's population.

EXHIBIT A: Federal Poverty Guidelines -2025

EXHIBIT B: Amount Generally Billed (AGB)

EXHIBIT A: Federal Poverty Guidelines - 2025

Household Size	100% FPL	133% FPL	150% FPL	200% FPL	300% FPL	400% FPL
1	\$15,650	\$20,815	\$23,475	\$31,300	\$46,950	\$62,600
2	\$21,150	\$28,130	\$31,725	\$42,300	\$63,450	\$84,600
3	\$26,650	\$35,445	\$39,975	\$53,300	\$79,950	\$106,600
4	\$32,150	\$42,760	\$48,225	\$64,300	\$96,450	\$128,600
5	\$37,650	\$50,075	\$56,475	\$75,300	\$112,950	\$150,600
6	\$43,150	\$57,390	\$64,725	\$86,300	\$129,450	\$172,600
7	\$48,650	\$64,705	\$72,975	\$97,300	\$145,950	\$194,600
8	\$54,150	\$72,020	\$81,225	\$108,300	\$162,450	\$216,600
Each additional person	+\$5,500	+\$7,315	+\$8,250	+\$11,000	+\$16,500	+\$22,000

EXHIBIT B: Limitation of Charges/Amount Generally Billed (AGB) for Purcell Municipal Hospital

Method Used:

Under this method, all claims paid by Medicare fee-for-service and private health insurers over the last 12 months are used. For these claims, the sum of all allowable reimbursement amounts is divided by the sum of the associated gross charges.

Financial Assistance Application Instructions

Please answer all the questions in each section. If a section does not apply, please write "Not Applicable or N/A". Blank spaces or any omission of required documents may result in delay or denial.

Please be sure to include a copy of the following with your application:

1. Bank/Savings Statements for most recent 3 months
 - a. An explanation of any unusual deposits/expenses on the statements
 - b. Documents must reflect all deposits
2. Verification of Income
 - a. Verification of income can include pay stubs, unemployment checks, social security award letters/checks, disability award letters, child support documentation, and pension verification. If the patient or other family member does not work, a notarized letter stating such is required.
3. Tax Return Documentation
 - a. Your family's most recently filed tax return or Non-filing status letter from IRS. Taxes must be accompanied by all supporting schedules(A-F) and documents (W2s, 1099s) to be considered complete.
4. Medicaid Approval/Denial Letter
 - a. This is only required if the Hospital has pre-screened the patient for Medicaid eligibility. If patient is pre-screened as potentially eligible, they must cooperate with Medicaid application process to be eligible for financial assistance with Purcell Municipal Hospital.
5. A copy of the patient's driver's license or photo ID. If the patient is under 18 years old, provide a copy of parent's driver's license or photo ID.
6. The insurance information on page 1 of the Application **MUST BE PROVIDED**. If you are uninsured, please report "NONE".

If approved, financial assistance will only apply to services provided and billed by Purcell Municipal Hospital. **You may receive other bills from Radiology, Pathology, ER Physicians, etc. that are not a part of Purcell Municipal Hospital.**

Applications will be reviewed promptly upon receipt. PMH will notify the patient or applicant in writing regarding the decision of their application.

Questions? Please call the Admissions Manager at 405-527-6524 X-3312.

FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Date: _____

Section 1: Applicant

Last Name: _____ First: _____ MI: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Email: _____ Cell Phone: _____ Work Phone: _____

List Household Members	Relationship	DOB	Medicaid#

Section 2: Medicaid

Have you filed for Medicaid? ☐ No ☐ Yes If Yes denial date: _____

Section 3: Health Insurance

Type of policy:

☐ Group ☐ Individual ☐ HMO ☐ Work Comp ☐ Other _____

Name of Insurance: _____

Address for Submission of Claims: _____

Policy#: _____ Policy Holder SSN: _____ Group# _____

Policy Holder's Name (first, last) _____

Address: _____

Relationship to patient:

☐ Self ☐ Father ☐ Mother ☐ Other _____

Section 4: Employment

Name of Applicant's Employer: _____ Work Phone#: _____

Employer Address: _____

Name of Spouse's Employer: _____ Work Phone#: _____

Address: _____

Section 5: Calculating Income

Current Monthly Income

1. Applicant's Income: _____
2. Spouse's Income: _____
3. Child Support: _____
4. Alimony: _____
5. SSI: _____
6. Family Support: _____
7. Parental Support: _____
8. Retirement: _____
9. Section 8: _____
- Total Income:** _____

If you have additional information that may be useful in determining eligibility, please list in the space below.

CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true and correct. I authorize Purcell Municipal Hospital to utilize information contained in or provided with this application for financial assistance eligibility for this program, and to obtain records pertaining to eligibility from a financial institution or from any insurance company. This information may also be released for the purpose of acquiring financial assistance among other creditors (i.e.: radiology and ER physicians)

Applicant Signature: _____

Date: _____