**Financial Hardship Policy**

**Policy Number: RCM002**

**Effective Date: 05/11/2017**

**Last Revised: 10/24/2017, 02/01/2018, 07/16/2021, 09/09/2022**

**Policy Owner: Hunter Woods-Moore, Practice Manager**

**PURPOSE**

This policy is intended to determine the appropriate use of discounted care to those who have no means, or limited means, to pay their medical services. In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full. The Patient Account Representative’s role is that of patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

SOG will offer a sliding fee discount (SFD) program to all who are unable to pay for their services. SOG will base program eligibility on a person’s ability to pay and will not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin.

The Federal Poverty Guidelines (Attachment A) are used in creating and annually updating the SFD to determine eligibility:

<http://aspe.hhs.gov/poverty>

**STATEMENT OF POLICY**

Under no circumstances will SOG engage in any of the following practices with respect to the waiving or lowering of co-insurance and/or deductibles:

1. Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our policy.
2. Charge Medicare/Medicaid beneficiaries or private insurance beneficiary’s different amounts than those charged to other persons for similar services.
3. Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence or managed care contracting. (to obtain referrals or to induce patients to seek care in our practice vs. another provider’s practice who does not waive co-pays and/or deductibles).
4. Accept “insurance only” or TWIP (take what insurance pays) as payment in full for services rendered.
5. Fail to make a reasonable collection effort to collect a patient’s balance.

**PROCEDURE**

Financial Hardship Notification:

SOG will notify patients of the SFD Program by:

* Offering notification of the SFD Program to all patients upon check in. Patients interested in the SFD program will be provided the SFD application by the front office staff.
* SFD Program options will be defined within collection notices sent out by SOG.
* An explanation of our SFD Program and our application form are available on SOG’s website as well as available at our practice locations.
* SOG places notification of SFD Program in the clinic waiting area.

Financial Hardship Criteria:

SOG will make the decision whether to reduce on a sliding scale or waive certain fees by reviewing:

* + 1. The patient/guarantor’s annual income; and
    2. The patient/guarantor’s family size

Incomeincludes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

In order to verify income,applicants must provide one of the following:

* Prior year W-2,
* Two most recent pay stubs,
* Letter from employer, or
* Form 4506-T (if W-2 not filed).
  + Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

Familyis defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

SOG reviews all applications in combination with the current year’s federal poverty guidelines to assist in determining qualifications for a financial hardship reduction or waiver. (Attachment A).

Those with incomes at or below 100% of poverty will only have a nominal fee of $10.00. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest Federal Poverty Guidelines.

In certain situations, patients may not be able to pay the discounted fee. Waiving of charges may only be used in special circumstances and must be approved by the Directory of RCM, or their appointed designee. Any waiving of charges will be documented in the patient’s medical record along with an explanation.

An application for a financial hardship (Attachment C) for medical expenses must be completed by the patient and/or guarantor in its entirety. The financial hardship application form can be obtained by visiting one of the SOG practices or online at [https://www.sogmd.org/](https://www.sogmd.org/%20) (under the Fill Out on Line Tab). Forms may also be requested from the SOG Business Operations Office through submission of a written request via email, fax at 410-939-8278, or U.S. Mail at Susquehanna OBGYN 308 N Union Ave Havre de Grace, MD 21078.

Applicants are required to return the completed forms and submit all required documentation to SOG within 180 days of the date of service.

Required Confidentiality of Information:

SOG requires independent information to support claims of financial hardship. The information submitted will be treated confidentially and will only be reviewed by SOG administrative staff involved in processing and reviewing information for reduction or waiver of medical expenses.

Time Frame:

After an application and verification information is received, the SOG patient account specialist is required to place a note in e-MD’s indicating the date they received the application, and that the application is under review. The patient account specialist will consider the overall financial situation of the applicant and render a decision based on the guidelines as set forth in this policy.

If an application, is received from the patient, at the front desk. The individual collecting the application must scan the document into docman and send a task to the billing team in e-MD’s with a log note attached to notify them of the application.

Once the decision is rendered the case must be reviewed and signed off by the Director of Revenue Cycle (Attachment B). The patient account specialist will note e-MD’s with the final decision and indicate the date and time the patient was contacted to inform them of the decision. If a verbal conversation has taken place with a patient, a summary of the conversation must be documented in e-MD. All of the paperwork used throughout the financial hardship process must be placed in the patients chart in e-MD.

All decisions will be made within 10 working days from the time that SOG receives, and reviews all required information. All determinations are pursuant to the hardship guidelines and are discretionary and in the sole determination of SOG.

Applicants will receive written notification, from the Patient Account Specialists, outlining whether or not the application has been approved or denied and the reasons why (attachment D& E). If an application is denied the patient and/or guarantor is able to reapply if their financial situation significantly changes.

SOG administrative staff will maintain all documentation related to the financial hardship waiver process as confidential. This documentation will include all supporting documentation including the waiver request and all documents provided in support of the request. Verification of ongoing qualification for financial hardship may be conducted at any time at SOG’s discretion or at the applicant’s request.

THE ATTACHED APPLICATION AND FINANCIAL STATEMENT CANNOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL STATEMENT IS FULLY COMPLETED AND SIGNED.

**IMPLEMENTATION**:

Each department providing patient access, financial counseling or patient accounting services is responsible for following the procedures outlined in this policy.

Education related to this policy and necessary documentation will be provided to all applicable SOG staff.

Performance improvement procedures will be instituted to support compliance with the provisions of this policy

**Financial Hardship- Attachment A**

2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES WITH DISCOUNT SCALE

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Size** | **Gross Yearly Family Income (GYFI)** | | | | | |
|  | *100% of FPL\** | 125% of FPL\* | 150% of FPL\* | 175% of FPL\* | 200% of FPL\* | >200% of FPL\* |
| 1 | $13,590 | $16,987.50 | $20,385 | $23,782.50 | $27,180 | $27,181 |
| 2 | $18,310 | $22,887.50 | $27,465 | $32,042.50 | $36,620 | $36,621 |
| 3 | $23,030 | $28,787.50 | $34,545 | $40,302.50 | $46,060 | $46,061 |
| 4 | $27,750 | $34,687.50 | $41,625 | $48,562.50 | $55,500 | $55,501 |
| 5 | $32,470 | $40,587.50 | $48, 705 | $56,822.50 | $64,940 | $64,941 |
| 6 | $37,190 | $46,487.50 | $55,785 | $65,082.50 | $74,380 | $74,381 |
| 7 | $41,910 | $52,387.50 | $62,865 | $73,342.50 | $83,820 | $83,821 |
| 8 | $46,630 | $58,287.50 | $69,945 | $81,602.50 | $93,260 | $93,261 |
| *More than 8* | *For families/households with more than 8 persons, add $4,720 to the 100% of FPL for each* | | | | | |
| ***Discount if <=GYFI*** | Nominal Fee $10.00 | 80% | 60% | 40% | 20% | 0% |

Payment plans are available

*\*FPL= Federal Poverty Level as specified by the Department of Health and Human Services.*

*Source:* [*http://aspe.hhs.gov/poverty-guidelines*](http://aspe.hhs.gov/poverty-guidelines)

**Financial Hardship Internal Approval Form- Attachment B**

**Patient’s name: DOB: Patient Account #:**

|  |  |
| --- | --- |
| **Total Balance Due** | |
| **Invoice #** | **Dollar Amount** |
|  | **$** |
|  | **$** |
|  | **$** |
|  | **$** |
|  | **$** |
| **Total Amount Due:** | **$** |

|  |  |
| --- | --- |
| **Household Size (List all names)** | |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Yearly Gross Household Income: Sliding Scale Discount:**

**Employee Signature:**

**Director Signature:**

**Financial Hardship Application- Attachment C**

To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions.

Your answers will be kept on file and in strict confidence. You must verify your gross annual income at least every year. We will need proof of the household income for each working household member.

The documents needed for review for a financial hardship discount are as follows:

* Prior year W-2,
* Two most recent pay stubs,
* Letter from employer, or
* Form 4506-T )if W-2 not filed)

Your annual income and your family size will be used to determine if a SFD is allowed.

Please complete the application and attached financial statement. Please return all forms and required documentation in person, by e-mail, by fax 410-939-8278, or by U.S. Mail to Susquehanna OBGYN to 308 N Union Ave Havre de Grace, Md 21078.

**I certify that the family size and income information shown above is correct.**

**Printed Name:**

**Signature: Date:**

**Financial Hardship Application- Attachment C**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Information | | | | | | | | | | | | Today's Date: | | | | | | | | |
| First Name: | | | | | Middle: | | | | Last: | | | | | | | | Other names: | | | |
| Home Address: | | | | | | | | | City: | | | | | | | | State: | Zip: | | |
| Mailing Address: | | | | | | | | | City: | | | | | | | | State: | Zip: | | |
| Home Phone #: ( | | | | | | | | | Home Phone #: ( | | | | | | | | | | | |
| Date of Birth: | I | | I | |  | | Social Security # (optional) | | | | | | | | | Do you have insurance? (circle one | | | Yes | No |
| Marital Status: | Single | |  | | In a relationship | | | | Married | | | Divorced | | Separated Widowed | | | | |  |  |
| Household Size | | | | | | | |  | | |  | | | | | | | | | |
| Name | | | | | | | | Date of Birth | | | Social Security Number (optional, not required) | | | | | | | | | |
|  | | | | | | | | I I | | |  | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | |
| Household Income | | | | | | | | | | | | | | | | | | | | |
| Name | | Amount (Gross wages, salaries, tips, etc) | | | | Frequency (Circle one) | | | | | | | Employer: | | | | | | | |
| You | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
| Spouse | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
| Children | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
| Other | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
|  | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
| TOTAL | | $ | | | | Weekly Monthly Yearly | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Other Income | | | | You | | | | Spouse | | Children | | | Other | | Subtotal | | | | | |
| Income from business, self-employment, and dependents | | | |  | | | |  | |  | | |  | |  | | | | | |
| Unemployment compensation, workers compensation, Social Security, Supplemental Security income, public assistance, veterans payments, survivor benefits, pension or retirement income. | | | |  | | | |  | |  | | |  | |  | | | | | |
| Retirement Pension | | | |  | | | |  | |  | | |  | |  | | | | | |
| Child Support, Alimony | | | |  | | | |  | |  | | |  | |  | | | | | |
| Interest Income | | | |  | | | |  | |  | | |  | |  | | | | | |
| Total | | | |  | | | |  | |  | | |  | | $ | | | | | |

**Approval Letter for Sliding Scale Discount- Attachment D**

Dear (Patient Name),

Susquehanna OBGYN and Nurse Midwifery thanks you for choosing our practice for your medical needs. In keeping with the values underlying our mission, we are committed to making a measurable difference in the health of the individuals in the communities that we serve.

An important element of this commitment is helping, within the resources reasonably available to us, to meet the healthcare needs of patients that are left with uninsured services in a manner that treats patients and their families with dignity, respect and fairness.

Based on information that you submitted on your confidential Application for Financial Hardship, we have determined your eligibility to be as noted below:

The total amount due on the account is $\_\_\_ but after we apply your discount of $\_\_\_your portion due is $\_\_\_\_.

This final decision in regard to the discounted amount was based on an assessment of the household income and family size compared to the Federal Poverty Guidelines issued by the United States Census Bureau and a discount scale we offer based on these guidelines.

Please be aware that you are responsible for any payments due as noted above.

If you should you have any questions regarding our determination of your financial responsibility, please contact one of our Patient Account Specialists at our Business Operations Office at 410-939-9569 Monday-Friday from 8:30AM-4:30PM.

Sincerely,

Susquehanna OBGYN and Nurse Midwifery

**Denial Letter for Sliding Scale Discount- Attachment E**

Dear (Patient Name),

Susquehanna OBGYN and Nurse Midwifery thanks you for choosing our practice for your medical needs. In keeping with the values underlying our mission, we are committed to making a measurable difference in the health of the individuals in the communities that we serve.

An important element of this commitment is helping, within the resources reasonably available to us, to meet the healthcare needs of patients that are left with uninsured services in a manner that treats patients and their families with dignity, respect and fairness.

Based on information that you submitted on your confidential Application for Financial Hardship, we have determined you are not eligible for a financial hardship discount.

This final decision was based on an assessment of the household income and family size compared to the Federal Poverty Guidelines issued by the United States Census Bureau and a discount scale we offer based on these guidelines.

Please be aware that you are responsible for any payments due:

The total amount due on the account is $\_\_\_

Susquehanna OBGYN and Nurse Midwifery may turn any unpaid amounts over to a collection agency, which could affect your credit status. We would like to work with you to avoid any such situation, so it is important that you contact on of our Patient Account Specialists at the number below to pay the balance in full or to set up a payment plan.

If you should you have any questions regarding our determination of your financial responsibility, please contact one of our Patient Account Specialists at our Business Operations Office at 410-939-9569 Monday-Friday from 8:00AM-5:00PM.

Sincerely,

Susquehanna OBGYN and Nurse Midwifery