Cook Children’s Northeast Hospital
Financial assistance policy

PURPOSE

To describe how Cook Children's Health Care System (CCHCS) will allocate resources for emergency and other medical care provided at Cook Children's Medical Center (CCMC) to meet the needs of patients that need financial assistance and to manage CCHCS' limited resources to appropriately provide necessary health care to:

A. The residents of the communities in CCHCS' primary service area;
B. Those patients residing outside of the primary service area, including out of state, who come to CCHCS through established physician relationships; and
C. Recognize that reasonable limits must be established for the amount of financial assistance that can be furnished to the intended recipients to assure the continued financial viability of CCHCS and its affiliated entities.

The CCHCS primary service area is comprised of Tarrant, Johnson, Parker, Denton, Hood, and Wise counties.

POLICY

In connection with CCHCS and CCMCs' exemption from certain federal and state taxes, and in support of CCHCS' mission to serve the health care needs of the community, CCHCS entities will provide charity care or financial assistance to eligible needy patients.

Information about charity or financial assistance must be widely publicized and made available to guarantors whose children have received care from Cook Children's Medical Center and:

A. Are classified as financially, medically, or catastrophically indigent;
B. Have applied for Medicaid and complied with applicable Medicaid requirements when Medicaid eligibility is a possibility; and
C. Have been denied financial assistance (e.g., Medicaid, Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN), Supplemental Security Income (SSI), or other government funded programs) from their service area.

Financial assistance may be granted to United States (U.S.) citizens or lawful permanent residents who are not residents of the CCHCS primary service area within the limitations of this policy. The application for financial assistance from these individuals will be approved in accordance with the levels of authority indicated in this policy. The approving individual(s) will review and document that the aforementioned policies were followed.

Charity and/or financial assistance will be available to all individuals that are admitted to CCMC on an emergency basis and do not have the resources to pay for the services, regardless of residency or citizenship status.

CCHCS will, through the Case Management Department, on a case-by-case basis, provide prescription medications to a patient whose family has no resources with which to fill physician prescribed medications. These medications will be dispensed in accordance with applicable state and federal statutes and will be done only for inpatients at CCMC, and/or outpatients in the hospital-based specialty clinics, and emergency room. Other CCHCS entities, also on a
case-by-case basis, may provide prescription medications to a patient whose family has no resources to fill physician-prescribed medications.

CCHCS will also assist families whose children are in current treatment and require financial assistance with other aspects of a child’s care which might include such things as lodging, transportation, etc. This will be done on a case-by-case basis and after all other sources of assistance have been explored or exhausted.

Charity and/or financial assistance will be granted, if qualified, without regard to gender, race, creed, color, or national origin.

CCHCS is required to make a reasonable effort to determine whether an individual is eligible for financial assistance in accordance with the terms of this policy. Eligibility must be determined no later than 240 days after CCMC provides the individual with the first billing statement for care rendered. It is the goal of CCHCS to make a charity or financial assistance determination as soon as possible after all information is collected in the application process.

There may be unique situations when a guarantor may have a financial hardship, but not meet the requirements of this policy to receive financial assistance.

**DEFINITIONS – FOR PURPOSES OF THIS POLICY AND APPLICATION FORM**

**Family** - A group of two or more persons related by birth, marriage, or adoption; all such related persons are considered members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple’s nephew all lived in the same house or apartment, they would all be considered members of a single family.

**Unrelated individual** - A person 15 years old or over (other than an inmate of an institution) who is not living with any relatives. Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

**Household** - A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.

**Income** - Total annual cash receipts before taxes from all sources, with the exceptions noted below. Income includes money wages and salaries before any deductions; net receipts from self-employment; regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers’ compensation, veterans’ payments, public assistance and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

**Exclusions From Income** - Income does not include the following types of money received: capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car, tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury, or non-cash benefits.
Resident - An individual who is either a U.S. citizen or a lawful permanent resident and lives in the CCHCS primary service area. A lawful permanent resident is issued an alien registration card, an I-551 card, which is better known as a "green card." Persons in the U.S. on any valid visa are not considered to be residents.

Undocumented Immigrant - A non-citizen who enters the U.S. without inspection or who overstays his/her visa. Also referred to as "person not lawfully present," "illegal alien," or "illegal immigrant."

PUBLICIZING CCHCS CHARITY / FINANCIAL ASSISTANCE

CCHCS will widely publicize information in this Financial Assistance Policy by:

1. Making paper copies of this Financial Assistance Policy and its application form available upon request and to the public free of charge in English and Spanish at least 30 days before the application deadline or as discussed in Procedure section, below;
2. Conspicuously displaying items like signs or brochures with general information about the availability of charity and financial assistance in public areas of the medical center;
3. Notifying members of the community likely to need financial assistance of its availability by providing Financial Assistance Policy summary information sheets for distribution at local agencies and nonprofit organizations that address the health needs of the community's low-income populations, along with instructions on how they may obtain more information;
4. Posting this Financial Assistance Policy, a summary of it, and the application form on the Cook Children's website, so that these forms may be easily accessed, downloaded, viewed, and printed without the need for special software;
5. Providing a direct URL or website address where individuals can find information about the financial assistance program and application upon request; and
6. Notifying individuals about the availability of financial assistance in all oral communications made regarding the amount due for care that occurs within 240 days after the individual is provided with their first billing statement for care rendered. Once an application has been received, notifications may cease.
7. Provide a plain language summary of this Financial Assistance Policy and an application form must be offered before the patient is discharged from CCMC.

ELIGIBILITY FOR CHARITY CARE

Except for individuals that are admitted to CCMC on an emergency basis, to be eligible for charity or financial assistance, the individual must be a resident of either Denton, Hood, Johnson, Parker, Tarrant, or Wise county or they must be a patient of a physician that has an established relationship with CCHCS.

A. Financially Indigent
   1. A financially indigent guarantor is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the eligibility criteria set forth in this policy.
   2. To be eligible for charity care as a financially indigent guarantor, a person's income must be at or below 400% of the federal poverty guidelines. CCHCS may consider other financial assets and liabilities of the person when determining eligibility.
   3. CCHCS will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent guarantor. The poverty income guidelines are published in the Federal Register each year and for purposes of this policy become effective the first day of the month following the month of publication.
4. In no event will CCHCS establish eligibility criteria for financially indigent guarantors which set the income level for charity lower than that required for counties under the Texas Indigent Health Care and Treatment Act, or higher than 400% of the federal poverty income guidelines. CCHCS may, however, adjust the eligibility criteria from time to time based on the financial resources of CCHCS and as necessary to meet the charity care needs of the community.

B. Medically Indigent
   1. A medically indigent guarantor is a person whose medical or hospital bills exceeds five percent of the guarantor's annual gross income, has no third party insurance coverage, family income exceeds 400% of the poverty guidelines and is unable to pay. CCHCS may consider other financial assets and liabilities of the person when determining ability to pay.
   2. Write-off of a portion of the guarantor's balance in cases of medical indigency will be based upon the sliding scale found in Attachment A of this policy.
   3. If a determination is made that a guarantor has the ability to pay the remainder of the bill, such a determination does not prevent a re-assessment of the guarantor's ability to pay at a later date.

C. Catastrophically Indigent
   1. A catastrophically indigent guarantor is a person:
      a. Whose medical bills after payment by third-party payers, exceeds thirty-five percent of the guarantor's annual gross income, or
      b. Whose medical bills exceed thirty-five percent of the guarantor's annual gross income and that income exceeds 500 percent of Federal Poverty Guidelines and is unable to pay the remaining bill.
   2. Write-off of a portion of the guarantor's balance in cases of catastrophic indigency will be based upon the sliding scale found in Attachment A of this policy.
   3. If a determination is made that a guarantor has the ability to pay the remainder of the bill, such a determination does not prevent a re-assessment of the guarantor's ability to pay at a later date.

D. Automatic Qualifications
   1. Charges for services not covered by Medicaid/CSHCN will be automatically written off to charity if the patient was a Medicaid/CSHCN beneficiary at the time of the uncovered service.
   2. When a patient has been approved for CHIP, but services are received prior to the effective date, then charity will be automatically approved for those services that are within 60 days of the effective date.

Accounts worked by contracted collection agencies that have been screened for financial ability to pay and are determined not to be able to pay account balances will be considered to be charity. Collection agencies will provide separate reports for accounts returned to CCHCS indicating the accounts where the guarantor does not have the ability to pay and those that have been determined to have the ability to pay but refuse NON-ELIGIBILITY FOR CHARITY CARE.

Patients may not be covered under this charity policy if they are covered by a commercial insurance company that:

   A. Does not have a contract with CCHCS and will not pay out-of-network benefits to CCHCS; and
   B. Does not authorize services to be rendered at CCHCS.

Patients are ineligible if they do not provide all required information to CCHCS or to their insurance company. If the family chooses to receive non-emergency care for their child(ren) at CCHCS, even though they know the services will not be covered, the family will be responsible for payment of the estimated amount of the claim in full prior to service.
A. If it is determined that a patient may qualify for a government-sponsored program but the family refuses to apply for assistance, the bill will not be considered for charity. The family will be responsible for the entire balance and payment of the estimated amount at the time of the services.

B. Elective cosmetic procedures may not qualify for charity assistance. Elective cosmetic procedures must be approved in advance by the President of the entity or his/her designee.

PROCEDURE TO IDENTIFY ELIGIBILITY FOR FINANCIAL ASSISTANCE AND CHARITY

A. Financial Assistance Eligibility
   1. CCHCS will widely publicize the availability of its financial program, as stated above, which includes information about how a guarantor may apply for charity care.
   2. Patient Registration will refer those guarantors who may qualify for financial assistance from a governmental program to the appropriate program, such as Medicaid, CHIP, CSHCN, or SSI.
   3. For patients with no insurance coverage, upon denial from a government program, a Financial Evaluation form (refer to Attachment B) will be completed by the guarantor and forwarded to the Patient Accounting department for financial assistance screening. If it is apparent the patient will not qualify for governmental assistance because income exceeds thresholds, the requirement for a denial will be waived.
   4. For patients with insurance coverage, the Financial Evaluation form will be completed by the guarantor and forwarded to the Patient Accounting department for financial assistance screening without the need for the guarantor to apply for assistance from a governmental program when it is apparent that the guarantor's income exceeds the threshold for government programs. If it is not apparent that the guarantor's income exceeds the income threshold, then the guarantor should be screened for eligibility under governmental assistance programs.
   5. Financial Evaluation forms will be provided to guarantors who have:
      a. Provided all required information regarding insurance coverage in a timely manner;
      b. Provided all required information to their insurance company; or
      c. Applied for and been denied assistance from a governmental program, such as Medicaid, CHIP, CSHCN, or SSI, unless it is apparent and can be documented that the guarantor would not qualify for one of these programs based on income or assets.
   6. The notification period for the availability of the financial assistance program begins on the date the care is provided to the patient and ends on the 120th day after the first billing statement is issued. Collection efforts may begin after this notification period, however, financial assistance applications must be accepted, processed, and an eligibility determination made within 240 days after the first billing statement is issued. It is the goal of CCHCS to make a determination concerning the guarantor's eligibility for financial assistance as soon as sufficient information is available concerning the guarantor's financial resources and eligibility for governmental assistance.
   7. The following documentation must be received in order to process the request for financial assistance:
      b. One of the following types of proof of income proof must be provided for both the guarantor and his/her spouse. For any type of check stub or letter, proof must be provided for the three most recent pay periods:
         i. W-2;
         ii. Prior year’s tax return (this is required for all self-employed guarantors/spouses);
         iii. Pay check stubs;
         iv. Retirement check stubs;
         v. Social Security letters or deposit slips showing the amount of the Social Security deposits;
vi. U.S. unemployment check stubs;
 vii. Other governmental program check stubs;
viii. Letter from employer, on employer letterhead, indicating the payment amount; and
ix. In exceptional cases, verbal or written attestation may be used as proof of income. The
   Director of Patient Accounting or Vice President of Finance has final approval authority
   regarding verbal or written attestation.
c. Medicaid denial for the period including the dates of service for all accounts. This
   requirement will be waived if it is apparent the patient will not qualify for governmental
   assistance. If the patient has governmental coverage for only a portion of the treatment
days, an application/denial may be required for the date span not covered by
   Medicaid/CSHCN.

B. Factors To Be Considered For Charity Determination
1. The following factors are to be considered in determining the eligibility of the guarantor for charity care:
   a. Household Gross income;
   b. Family size; and
   c. The federal poverty income guidelines, as updated annually by the Department of Health and
      Human Services (DHHS).

C. If all required documentation is not received (i.e., the application is incomplete), the applicant will be
   provided with information relevant to completing the application along with summary of this financial
   assistance policy. No collection efforts will be pursued until financial assistance eligibility has been
   definitively determined.

D. At least one written notice that the hospital or collection agency may initiate or resume collection efforts if the
   individual does not complete the application or pay the amount due by completion of the specified deadline
   will be provided at least 30 days before the deadline (deadline is 240 days from the date CCHCS provided
   the individual with the first billing statement of care).

E. Collection Efforts:
1. No collection efforts will be pursued on a financial assistance or charity account until a determination
   for financial assistance eligibility is made unless a subsequent default occurs under this policy. The
   determination of eligibility may be valid for a period of up to one year.
2. Agreements with collection agencies must state that they will not begin collection efforts until CCHCS
   has made reasonable efforts as indicated in this policy to determine whether the individual is eligible
   for financial assistance or charity care. If the individual is determined to be eligible, the collection
   agency must take all reasonably available measures to reverse any collection efforts (with the
   exception of the sale of debt), taken against the individual to collect the debt at issue.

F. Following these measures, financial assistance may be denied. Only copies of documentation will be
   submitted; originals will not be returned to the guarantor.

G. Time Frame For Eligibility Determination - A determination of eligibility will be made by Patient Accounting
   Supervisor/Director or Vice President of Finance within 30 days from the time all information necessary to
   make a determination is received, but in no event longer than 240 days from the date CCHCS provided
   the individual with the first billing statement of care.

H. Documentation of Eligibility Determination - Once an eligibility determination has been made, the results of
   the determination will be noted in the account message area for each account affected by the determination.
   A statement that all regulatory requirements for determining financial assistance eligibility have been met
   must also be documented. The determination only has to be made once by any entity. The information can
   be shared between entities so that the process is not duplicated. All documentation provided for the
   determination will be kept in Patient Accounting records for a period of at least seven years.

I. Approval authorities for total write-off of a guarantor's accounts to charity will be as follows:
1. Guarantor balance less than $10,000 requires approval by the Patient Accounts or Billing Supervisor.
2. Guarantor balance from $10,000 to $50,000 also requires approval of the Manager/Director of Patient
   Accounting.
3. Guarantor balances greater than $50,000 also require approval of the Vice President, Revenue Cycle.

For automatic qualifications, approval is not required.

If payment arrangements are set, the payout period must not exceed 24 months from the date the payment schedule is arranged. Exceptions must be approved by the Patient Accounts Supervisor/ Director of Patient Accounting or the Vice President-Revenue Cycle.

J. Any exceptions to this policy require the written approval of the President of the entity granting the charity.

**BILLING**

A copy of the plain language summary of this policy must be included with all (and at least three) billing statements for the care rendered and all other written communications regarding the bill provided to the individual during the notification period (i.e., the period starting the date the care is provided and ending on the 120th day after CCMC provides the individual with the first billing statement for the care).

Documentation of the following is required following a determination of financial assistance eligibility:

A. All collection efforts are suspended;
B. The individual has been determined eligible for financial assistance;
C. The individual is notified of their eligibility for financial assistance;
D. Provide a billing statement to the individual that:
   a. Indicates the amount the individual owes as a result of being eligible for financial assistance;
   b. Specific website address where the individual can go to get information in writing and free of charge about the amounts generally billed (AGB) for the care provided, and how the amount owed by the individual was determined.
      i. (The individual may not be charged more than the AGB for emergency or other medical care provided to individuals with insurance or Medicare Advantage covering that care.
      ii. It is permissible to bill of the eligible person to show gross charges that were used as the starting point before allowances, discounts or deductions were applied provided that the gross charges are not the actual amount the eligible person is billed.

If any excess payments were made by the individual or any ECAs were taken against them prior to being determined eligible for financial assistance, those payments must be refunded and reasonable measures must be taken to reverse the ECAs (with the exception of the sale of Document Owner: Assistant to the President debt).

If the CCHCS does not know whether a person is eligible, it can bill the person its usual charges provided that it makes timely attempts to determine the person's eligibility and refunds excess payments if eligibility is found.

**ANNUAL REPORTING REQUIREMENTS**

Information regarding the amount of charity care provided by CCMC each fiscal year is aggregated and reported to the Texas Department of Health in the America Hospital Association (AHA)/ Department of Health and Human Services (DHHS)/Texas Hospital Association (THA) Annual Survey of Hospitals (cooperative annual survey). It is broken down into two sections: The American Hospital Association Annual Survey and the Texas Department of Health Survey Supplement.
REFERENCES


ATTACHMENT A

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<th>Number of household</th>
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Discount: 100% 85% 70%

**Catastrophic Eligibility** - Insured Patients or Patient's Income exceeds 500% of Federal Poverty Guidelines (also applies to Medically indigent).

Balance due must be equal to or greater than 35% of the patient's gross annual household income.

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