Facility: **System wide**	
Policy Number: 90.03.11	Policy Title: Hospital Charity Assistance Policy
Department:	Originated By: Finance
Effective Date: 01/17/1996	Revised Date: June 2005
Reviewed Date: 07/01/2004	Supersede:
Release Information: Non- release or release only with approval	JCAHO:
Approval: President & CEO	

I. POLICY

Advocate Health Care (Advocate) is an expression of the healing and teaching ministries of the Evangelical Lutheran Church in America and the United Church of Christ. The fundamental purpose of Advocate Health Care is to provide quality health care and health-related services that effectively and efficiently meet the needs of individuals, families and communities.

Consistent with Advocate's values of compassion and stewardship, it is the policy of Advocate Health Care to provide charity assistance to patients in need. This policy identifies circumstances under which Advocate hospitals will extend services free-of-charge, or at a reduced amount, to an individual whose financial status makes it impossible or impractical to pay fully for the services. Given the sensitive nature of these requests, all communications with the patient or family members will be handled in strict confidence and in a compassionate manner.

The provision of charity assistance is subject to various requirements, including the timely completion and submission of a charity assistance application and supporting documentation. Nothing in this policy shall be deemed to take precedence over federal, state or local laws or regulations currently in effect or that may be promulgated in the future.

This policy is intended to benefit Advocate's community consistent with its values of compassion and stewardship. This policy does not guarantee any third party or person any rights, claims, benefits or privileges. The existence of a charity care policy does not constitute an offer to any particular patient and creates no contractual rights or obligations. This policy is subject to change or modification. The hospital may also depart from the criteria described below on a case-by-case basis where the hospital determines it is appropriate to do so.

II. DEFINITIONS OF TERMS

Charity Assistance: Health care services that Advocate facilities provide free-of-charge, or are at a reduced amount, to individuals who meet certain financial eligibility criteria.

Cost of Providing Services: The hospital's established usual and customary charges at the time of initial billing, multiplied (reduced) by the hospital's relationship of costs to charges (also referred to as the hospital's "cost to charge ratio"), taken from the most recently Medicare cost report Costs will be updated annually..

Emergency services: Services provided to a patient for a medical condition with acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or with respect to a pregnant woman, the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or her unborn child.

Urgent services: Services to treat an unexpected illness or injury that requires immediate medical attention (usually within 48 hours), is not life threatening, but where a prolonged delay in treatment may threaten the patient's health or well-being.

Elective services: Services to treat a condition that does not require immediate attention, so that the timing of care is subject to the choice of the patient or physician. Elective services include procedures that are advantageous to the patient, but not urgent and also include non-medically necessary services, such as cosmetic and dental surgery performed solely to improve appearance or other elective procedures not typically covered by health insurance plans. Elective services that are not medically necessary will not be considered for charity assistance.

Medically Necessary services: Services or supplies that are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area, are covered by and considered medically necessary by the Medicare and Medicaid programs, and are not mainly for the convenience of the patient or physician. Medically necessary services do not include cosmetic surgery or non-medical services, such as social, educational or vocational services. Medically necessary services may be provided in emergency, urgent or elective situations.

Federal Poverty Level: Level of income at which an individual is deemed to be at the threshold of poverty. This income level varies by the size of the family unit. The poverty level is updated annually by the United States Department of Health and Human Services and published in the Federal Register. For purposes of this policy, the poverty level indicated in these published guidelines represents gross income. Eligibility criteria will be updated annually.

Gross Income: Gross earnings reportable to the federal government.

Uninsured Patient: A patient who does not have third party coverage from a health insurer, a health care service plan, crime victim's assistance program, Medicare, or Medicaid, and whose injury is not compensable for purposes of workers' compensation, automobile insurance, or other insurance, as determined by the hospital based on documents and information provided by the patient or obtained from other sources, to pay for health care services provided.

Patient Cooperation: Patient cooperation is required as a condition of receiving assistance. Patient cooperation includes providing, in a timely and forthright manner, information regarding any available third party coverage; and financial information and documents needed to apply for third party coverage through government or other programs (e.g., Medicare, Medicaid, Kid Care, Family Care, third party liability, Crime Victims funds, etc.) and to determine the patient's eligibility for charity assistance. Patients are asked to provide the information and documents within thirty (30) days of the hospital request unless other compelling circumstances are brought to the hospital's attention. Patients are also asked to provide information to or file documents with such third parties where necessary.

III. PROCEDURES

A. Communication

The hospital will communicate the availability of charity assistance in the applicable languages of the hospital community. Means of communication will include:

1. The **health care consent** that is signed upon registration for hospital services will include a statement that financial counseling, including charity assistance consideration, is available upon request.

2. **Signs** will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to hospital access, registration, emergency department, cashier, and business office locations.

3.**Brochures** will be placed in hospital access, registration, emergency department, cashier, and business office locations, and will include guidance on how the patient may obtain information on applying for Medicare, Medicaid, Kid Care, Family Care etc., and the hospital's charity assistance program. A hospital contact and telephone number for financial assistance will be included.

4.Hospital **bills** to patients registered without insurance will include a request that the patient inform the hospital of any available health insurance coverage, Medicare or Medicaid; a statement that the uninsured patient may be eligible for Medicare, Medicaid, FamilyCare, KidCare or the hospital's charity assistance program; and a hospital contact and telephone number to request financial assistance.

B. Evaluation Guidelines

1. Gross income is defined as gross earnings reportable to the federal government. The amount of charity assistance approved will be based on the table below and may be adjusted based on the financial status of the patient, which includes a review of income, assets, expenses (including medical expenses), extenuating financial circumstances and the availability of third party health care benefits, such as those listed in the earlier paragraph concerning "patient cooperation". Specific criteria and formulas used as guidelines to determine hospital charity assistance adjustments will be revised annually after the poverty level guidelines are published by the federal government and will include the most recent Medicare cost to charge ratios..

2. The following table shall be used to determine the discounts to be offered to patients qualifying for charity care consideration.

Multiple of FPL	0 - 1	1 - 2	2 - 3	3 - 4
Expected Payment	$0	$0	Cost of Services Provided	Cost of Services Provided
Maximum Expected Payment	$0	$0	5% of Income	10% of Income

Federal poverty level income guidelines and maximum payment thresholds may be found in ***<u>Exhibit 1</u>***.

Expected payment is determined by multiplying (reducing) the charges on the patient bill by the hospital's cost to charge ratio, subject to the

maximum payment levels provided above. The hospital cost to charge ratios are found in ***Exhibit 2***.

Charity assistance consideration for elective services: Charity assistance discounts related to elective services are subject to budget constraints and are at the discretion of the hospital. Nothing in this paragraph is intended to change the hospital's obligations or practices pursuant to federal or state law respecting the treatment of emergency medical conditions without regard to the patient's ability to pay.

3. The amount of charity assistance will be determined once all third-party payment amounts have been identified.

C. Procedures

1. Requests for financial assistance may be initiated by any of the following individuals and at any point during the patient account cycle:

   a. The patient/guarantor
   b. A representative for the patient/guarantor
   c. A hospital representative on behalf of the patient/applicant
   d. Patient's attending physician

2. Notwithstanding considerations outlined elsewhere in this policy, it is the responsibility of the patient to cooperate with the charity assistance process. This includes providing information about any available third party health coverage; providing in a timely and forthright manner all documentation needed to apply for funding through government or other programs (e.g., Medicare, Medicaid, KidCare, FamilyCare, third party liability, Crime Victims funding, etc.) and to determine the patient's eligibility for hospital charity assistance; and signing or submitting such forms as might be requested by potential third party payors. Failure to do so may adversely affect consideration of the patient's charity assistance application. Patients are asked to provide the information and documents within thirty (30) days of the hospital request unless other compelling circumstances are brought to the hospital's attention.

   The application for charity assistance must be completed and signed by the patient (or guarantor/representative). The hospital financial counselor will assist the applicant in the process. Applications are considered complete when all the necessary documentation is provided. Applications without sufficient documentation will be placed on hold until the required documentation is received or denied if not received after the hospital has made reasonable attempts to request the documentation.

If the patient is deceased and a responsible party is not identified, a hospital representative may generate the request and complete the application using available information and documents (e.g., IDPA spend down form, estate document, etc.).

3. Family income is defined as gross earnings reportable to the federal government. Income documentation is defined as one or more of the following, and must be provided prior to the adjudication of the application.

   a. Prior year's income tax return or most recent W-2 form.

   b. Paycheck stubs or employer statement documenting wages for two or more months prior to the application for assistance.

   c. Current IDPA spend down form or IDPA eligibility documentation.

   If no documentation is available, a signed statement on a form provided by the hospital which testifies to the patient's financial status may be provided by the person(s) providing financial support to the patient.

   5. Applicants whose current financial position is, in their judgment or in the judgment of the hospital, not adequately reflected by the above income reports may submit, or be required to submit, additional statements and/or documentation which more completely describes any extenuating circumstances affecting their financial position; (i.e., an individual who is temporarily disabled may submit a physician's report documenting his/her inability to work for a given period of time.)

Exhibit 1: Federal Poverty Level Guidelines
Exhibit 2: Hospital Cost to Charge Ratios

Exhibit 1
Federal Poverty Level (FPL) Guidelines

Revised: February 18, 2005

The poverty guidelines referenced in this policy are those issued each year by the Department of Health and Human Services as published in the Federal Register.

The income thresholds in the current poverty guidelines are as follows:

Size of Family Unit	Max. Income to Qualify for Free Care	Max. Income to Qualify for Discount
	FPL 0 – 2	FPL 4
1	$19,140	$38,280
2	25,660	51,320
3	32,180	64,360
4	38,700	77,400
5	45,220	90,440
6	51,740	103,480
For each additional person, add:	$3,260	$13,040

For purposes of this policy, the income levels specified above are understood to be at gross income, although certain provisions of the Hospital Charity Assistance Policy allow for adjustments to income for extraordinary medical expenses.

For use in this policy, FPL income levels are to be updated annually after their revision and publication by the federal government in the Federal Register.

Exhibit 2
Hospital Cost to Charge Ratios

Revised: June 1, 2005

For patients with annual incomes between two and four times the Federal Poverty Level, expected payment is based upon the cost of services provided, subject to maximum caps. For purposes of this policy, cost is based on the hospital-wide total (not department specific) cost to charge ratio on the most recent Medicare cost report. Expected payment, then, is determined by multiplying (reducing) the hospital cost-to-charge ratio by the total charges on the patient bill, subject to maximum payment cap considerations outlined elsewhere in this policy.

The following table provides the cost to charge ratios for each Advocate hospital and the corresponding percent of charges that should be expected in payment (subject to maximum cap considerations outlined elsewhere in this policy).

Hospital	Cost-to-Charge Ratio	Expected Payment (as % of Charges)	Discount from Charges
Bethany	38%	38%	62%
Christ	36%	36%	64%
Good Samaritan	32%	32%	68%
Good Shepherd	37%	37%	63%
Illinois Masonic	29%	29%	71%
Lutheran General	37%	37%	63%
South Suburban	33%	33%	67%
Trinity	35%	35%	65%

For use in this policy, cost-to-charge ratios and corresponding amounts of expected payment (as a percent of charges) are to be updated annually at the time the Federal Poverty Levels are updated.

Advocate Health Care

June 2005

2005 Financial Assistance Guidelines Based on Gross Family Income and Size

Family Size	Poverty Threshold	Up to 2 Times Poverty	2-3 Times Poverty Level				3-4 Times Poverty Level			
			Income		5% Payment Cap		Income		10% Payment Cap	
1	$9,570	$19,140	$19,141	$28,710	$957	$1,436	$28,711	$38,280	$2,871	$3,828
2	$12,830	$25,660	$25,661	$38,490	$1,283	$1,925	$38,491	$51,320	$3,849	$5,132
3	$16,090	$32,180	$32,181	$48,270	$1,609	$2,414	$48,271	$64,360	$4,827	$6,436
4	$19,350	$38,700	$38,701	$58,050	$1,935	$2,903	$58,051	$77,400	$5,805	$7,740
5	$22,610	$45,220	$45,221	$67,830	$2,261	$3,392	$67,831	$90,440	$6,783	$9,044
6	$25,870	$51,740	$51,741	$77,610	$2,587	$3,881	$77,611	$103,480	$7,761	$10,348
Discount Amount:		**100% Discount**	**Charges Reduced to Cost**				**Charges Reduced to Cost**			
Per Episode Minimum Payment:		**$0**	**Cost of Providing Services***				**Cost of Providing Services***			
Maximum Payment:		**$0**	**5% of Income**				**10% of Income**			

The base salary ($9,570) has been increased by $3,260 for each additional family member. Accordingly, $3,260 should be added to $19,350 for each family member beyond six (6).

* Cost of Providing Services: The hospital's published charges at the time of billing, multiplied by the hospital's most recent relationship of costs to charges taken from the Medicare Cost report.

Note: This table is provided as a guideline for determining financial assistance write-offs. Extenuating circumstances should beconsidered in the evaluation. (e.g., Costly medical expenses can effectively reduce a family's available/disposable income.)