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Origination	3/23/2023	Owner	Ashley Moede: Patient Access Director
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Next Review	4/25/2025		

Financial Assistance Program, RC-09-DC

Replaces Policy: Community Care Financial Assistance Policy RC-08-DC

Purpose:

The Financial Assistance Program policy allows Door County Medical Center (DCMC) to determine eligibility for financial assistance for patients who meet the established eligibility criteria. This policy does not offer a provision for assistance to patients with sufficient means who refuse to pay for the medical services rendered to them or to their family members. The Financial Assistance Program is intended to help patients resolve their DCMC medical balances after exhausting all other financial options. The policy also identifies steps DCMC will take to communicate the availability of financial assistance and identifies timeframes and restrictions applicable to collection actions. Any information gathered by DCMC during this process is subject to DCMC' policies on protection of confidential information.

The policy is intended to satisfy applicable State and Federal requirements relating to charity care and the Code Section 501(r) of the Internal Revenue Code of 1986, as amended, and the regulations there under.

Governance:

The FAP is administered by the Revenue Cycle Division

Policy Statements:

Door County Medical Center's mission and values encourage reaching out to people in the communities we serve to provide care to all persons, including individuals and families with financial limitations. We are committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for government

programs, or otherwise unable to pay for emergency and other medically necessary care based on their individual financial situation.

The DCMC Financial Assistance Program is not a substitute for personal responsibility. Patients are expected to cooperate with DCMC' procedures for obtaining financial assistance and to contribute to the cost of their care based on their individual ability to pay. DCMC established the provisions in this Financial Assistance Program policy in order to manage financial resources in a responsible manner and to assist patients in need.

The Financial Assistance Program policy applies to DCMC and any substantially related entities of DCMC. Services eligible under the DCMC financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:

A. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a patient's condition.

B. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.

C. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as "covered items or services."

D. Services of providers employed by DCMC are covered under this policy. Please see Appendix C for a full list of providers included.

Services not eligible for financial assistance include the following:

A. Elective procedures not medically necessary, as well as services typically not covered by Medicare or defined by Medicare or other health insurance coverage as not medically necessary.

B. Lasik Surgery, Acupuncture, Cardiac Scoring, Contacts/Glasses, Cosmetic Surgery/ Plastic Services, Hearing Aides, Orthodontics, Dental Services, Optometry, and cash only retail services.

C. Services received from care providers not employed by DCMC (e.g. private and/or non – DCMC medical or physician professionals, ambulance transport, etc.) Patients are encouraged to contact these providers directly to inquire into any available assistance and to make payment arrangements. See Appendix C for full listing of providers not covered under this policy.

D. Medically necessary services provided to patients out-of-network as defined by their insurers

Policy:

Financial Counseling

A. Patient Financial Services and or their designees are responsible for assisting patients and their families in determining eligibility and applying for federal, state and local insurance programs and/or for the Financial Assistance Program. If applicable, referral for debt counseling is made. Information will be made available at all patient access locations, including the emergency departments.

B. A financial assistance application is used to collect and document the patient's insurance and financial status. The standard application form is reviewed as needed, but at least annually, by Vice President of Revenue Cycle or designees to ensure it encompasses all necessary information to process the application. Any changes to the standard application form are communicated to DCMC for immediate implementation and distribution.

C. Patient cooperation is necessary for determination of eligibility in the DCMC Financial Assistance Program.

D. Irrespective of eligibility for financial assistance under this Financial Assistance Program policy, all uninsured patients are provided an uninsured discount at the time of billing. This discount will be an administrative adjustment, not a charity adjustment. DCMC will determine if the patient is able to qualify for a higher discount level, but at no point will the adjustment be less than 25% of the gross charges. Current uninsured discount amounts are published in Appendix A of this policy and reviewed on a yearly basis by the Patient Financial Services office (PFS) for appropriateness. In the event a patient is later approved for a charity adjustment, the corresponding uninsured discount adjustment will be reversed, and the amount will be applied to a charity write-off.

E. DCMC will have colleagues or delegates available to assist patients in understanding the Financial Assistance Program and other assistance programs available from third parties.

Eligibility Criteria

Financial assistance will be extended to uninsured and underinsured patients, or a patient's guarantor, who meet specified criteria, as defined below. These criteria will assure that this financial assistance policy is consistently applied across DCMC. DCMC reserves the right to revise, modify or change this policy as necessary or appropriate.

A. Nondiscrimination. Financial assistance under this policy is available without regard to the patient's race, color, creed, national origin, age, disability, handicap status, health care condition, sexual orientation or marital status.

B. Residency Restrictions. Patients seeking financial assistance are required to seek appropriate medical care in the medical facilities closest to their actual residence. In the event appropriate treatment is not available in their community, the patient may be pre-approved for medically necessary services under the DCMC Financial Assistance Program. To determine residency, DCMC requires valid state-issued identification, a utility bill received within the last 60 days, a lease agreement, a vehicle registration card, a voter registration card or mail addressed to the patient from a local, state or federal government entity or immigrant letter of support.

C. Excluded Services. Patient care, which is not medically necessary, including elective, cosmetic, or other care deemed to be generally non-reimbursable by traditional insurance carriers and government payers shall not be considered eligible for financial assistance.

D. Minor Children/Divorced Parents. For the minor children of divorced parents, when both parents/legal guardians are responsible parties, information regarding both parents will be required to complete a Financial Assistance Application. However, if after reasonable efforts, circumstances prevent the applicant from obtaining financial information for all responsible parties, information from responsible parties residing in the same household of the minor child/children will be used to make the determination.

E. Asset Test. Available assets of patients will be considered in determining eligibility for financial assistance under the Financial Assistance Program. Patients with significant assets are generally ineligible under the Financial Assistance Program. For purposes of this provision, significant assets are assets, other than excluded assets, with a value in excess of 300% of the Federal Poverty Guidelines.

F. Financial Assistance will be offered to eligible underinsured patients, providing such assistance is in accordance with insurer's contractual agreement. Financial assistance is typically not available for patient co-payment or balances after insurance in the event that a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Out of network balances may be reviewed on a case by case basis.

    1. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account, will be expected to utilize account funds prior to being granted financial assistance.

    2. DCMC reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of DCMC.

G. Other Resources. Financial assistance provided by DCMC under this policy is secondary to all other third parties and financial resources available to the patient.

This includes, but is not limited to:

1. Group or individual medical insurance plans
2. Employee benefit plans
3. Worker's Compensation plans
4. Medicaid, State or County Medical programs
5. Other state, federal or medical programs
6. Third parties adjudged to be legally liable for a patient's medical expenses (e.g. auto accidents or personal injury claims)
7. Any other persons or entities that have a legal responsibility to pay for the medical services
8. Crime Victims Fund (if applicable)
9. Medical care cost covered by government programs of other countries

Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy. Patients, or patient's guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial received within the previous six (6) months of applying for DCMC financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.

Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by DCMC as possible sources of payment for care, may be denied financial assistance.

Availability of Financial Assistance

A. Patients who meet the eligibility criteria above may be eligible for financial assistance.

B. Following a determination of eligibility, an eligible patient may not be charged more than AGB for emergency or other medically necessary services.

C. The look-back method is used to determine AGB. More detail on the calculation of AGB can be found in Appendix D. Members of the public may readily obtain the AGB percentage and a description of the calculation in writing and free of charge by visiting www.dcmedical.org, contacting Patient Financial Services; or making an in-person request at DCMC. Contact information is provided in Appendix B.

Guidelines for Determination of Financial Assistance

A. Eligible uninsured and underinsured patients may qualify for financial assistance according to the family income and Federal Poverty Guidelines, as detailed in

Appendix A.

B. For uninsured patients, the financial assistance will apply to gross charges (the DCMC billed charge). For underinsured patients, the financial assistance will apply only to the amount the patient is personally responsible for paying, after insurance and other third-party payer reimbursements and/or payments have been applied.

C. DCMC will consider the following circumstances and other similar circumstances in evaluating applicants who do not otherwise qualify for financial assistance under this Financial Assistance Program.

    1. Catastrophic medical debt is defined as medical debt more than 20% of the annual income of the patient's family. All DCMC medical debt in excess of the 20% would be adjusted off to financial assistance upon notice from the patient and verification by DCMC colleagues.

    2. The time frame calculation for the annual income cap will be based on a 12-month period from the most recent date of medical services.

Application Process for Financial Assistance Program

A. All patients (or their legal guardians) desiring consideration for the Financial Assistance Program should apply for assistance prior to or at the time of admission or prior to discharge, if possible. Patients will also be allowed to apply for consideration under the Financial Assistance Program prior to account placement at a bad debt collections agency, pursuant to the Code Section 501(r) Requirements. DCMC may request an account to be returned from a bad debt collection agency if a patient is approved for financial assistance provided the account was sent to a bad debt agency within the twelve months prior to the date of application approval date.

B. The instructions required to complete the FAP application will be furnished to patients, their legal guardians, or any persons authorized to act on behalf of the patient. DCMC will provide access to colleagues or delegates to assist patients/legal guardians in understanding the criteria for eligibility and how to fill out the FAP application.

C. The patient and/or responsible party may complete and return the FAP application during the Application Period.

D. When considering a FAP application, DCMC may request the patient first pursue other sources of payment, including but not limited to Medicaid, county or state medical assistance, Crime Victims' fund, Supplemental Social Security Income or Disability Income (SSI or SSDI), or other third-party payers as appropriate. If the patient is unwilling to pursue other potential third-party payment sources in a timely manner, the patient will be considered ineligible under the Financial

Assistance Program and DCMC will not consider the patient's request for financial assistance.

E. The patient (or their legal guardians) must disclose financial information, as identified in this Financial Assistance Program policy and/or the FAP application that DCMC considers pertinent to the determination of the patient's eligibility for financial assistance.

F. If requested by DCMC, patients (or their legal guardians) requesting financial assistance must authorize DCMC to make inquiries of employers, banks, credit bureaus, and other institutions for the purpose of verifying information DCMC requires in order to determine eligibility for financial assistance.

G. The completed FAP application must be accompanied by legible and accurate photocopies of the following documents, as needed, for purposes of verifying eligibility:

    1. Complete IRS tax returns for the most recently completed calendar year of all responsible parties;
    2. Payroll check stubs or other documentation of monthly income sources reflecting income of all responsible parties for at least the three months prior to the application;
    3. Written verification from public assistance agencies, such as Medicaid or county medical, reflecting denials for eligibility (upon request) and as appropriate; and
    4. Written verification of denial for unemployment or worker's compensation benefits (upon request and as appropriate).

H. Income will be annualized, when appropriate, based upon documentation provided.

I. Confidentiality of information will be maintained for all who seek and/or receive assistance under the DCMC Financial Assistance Program, as required by DCMC policies and federal and state laws. Copies of all supporting documents will be kept with the application form until destroyed in accordance with DCMC policies and federal and state document retention laws.

J. Patient Financial Services or designated representatives may interview the patient or responsible party and request a completed FAP application to determine the need and eligibility for charity.

    1. DCMC may request documentation of the information requested to verify eligibility for financial assistance and to complete the processing of the application.
    2. If DCMC determines that any material documentation or information submitted is untrue or falsified, the application for the Financial

Assistance Program will be denied. DCMC will not reconsider an application if representatives of DCMC determine that the applicant has intentionally misrepresented material information related to eligibility criteria or documentation.

K. Accounts returned by the collection service due to the debtor's lack of income or assets will qualify for charity status due to their inability to pay or being deemed medically indigent by the independent collection service. In addition, patients for whom DCMC receives discharge confirmation of Chapter 7 bankruptcy through a Federal Bankruptcy Court will also qualify for 100% charity.

Presumptive Eligibility

A. Presumptive eligibility under the Financial Assistance Program may be granted if evidence of a patient's inability to pay for medically necessary services is provided by the patient or through other sources available to DCMC. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write-off of the account balance. Presumptive eligibility may be determined on the basis of individual circumstances that may include:

1. Homelessness
2. Deceased with no estate
3. Mental incapacitation with no one to act on patient's behalf
4. Medicaid eligibility, but not on date of service or for non-covered services
5. Incarceration in a penal institution
6. Enrollment in the following assistance programs for low-income individuals:
    a. Temporary Assistance for Needy Families (TANF)
    b. Wisconsin Department of Health Services Housing Assistance Progra m
7. Enrollment in one or more of the following programs with criteria at or below 200% of the current Federal Poverty Guidelines:
    a. Participation in Women, Infants and Children programs (WIC)
    b. Supplemental Nutrition Assistance Program (SNAP) eligibility
    c. Low Income Home Energy Assistance Program (LIHEAP)
    d. Wisconsin Home Energy Assistance Program (WHEAP)
    e. Enrollment in an organized community-based program providing access to medical care that assesses and documents limited

low-income financial status as criteria

f. Receipt of grant assistance for medical services

B. DCMC may use external programs to verify patients' ability to pay. If a patient is determined to be unable to pay for their medically necessary services via these external programs, the accounts will be adjusted off to charity. See "Presumptive Eligibility" (above).

C. Patients who were determined to be eligible for the Financial Assistance Program retain eligibility for a period of up to twelve (12) months from the date of approval. At the end of twelve (12) months, the patient is responsible for reapplying for eligibility under the Financial Assistance Program.

Asset Exclusion

DCMC may exclude the following assets listed below from the net available household asset computation without affecting eligibility for the Financial Assistance Program.

A. A home that is the primary residence

B. Personal property for use in the home

C. Vehicle(s) up to a combined value $15,000 with value based on the current blue book appraisal amount (excludes motor homes)

D. Liquid assets including cash, savings, stocks, bonds etc. up to $1,000 for one person; $2,000 for two people; and $500 for each additional person in the household.

E. Any funds set aside in a retirement account as defined by the Internal Revenue Service

F. Other assets directly related to the earnings and livelihood of the household may be exempt if deemed necessary and reasonable to the continued ability to earn a livelihood by DCMC.

G. Nursing home or assisted living monthly payments.

Communication of the Financial Assistance Program to Patients

A. Notification about financial assistance availability from DCMC shall include the following:

1. Paper Copies: The Financial Assistance Program policy, the FAP application, and the plain language summary will be available upon request and without charge, both by mail and in public locations in the hospital facilities of the Local Systems, including, at a minimum, in the emergency room (if any) and admissions areas.

2. Intake and Discharge: The plain language summary and the FAP

application will be offered to patients during the registration, post-registration, or discharge processes.

3. Signage: The availability of the Financial Assistance Program shall be advertised on poster-sized signage located in Emergency Department, Admissions, Outpatient, and waiting room areas. A toll-free phone number will be included.
4. Internet: The Financial Assistance Program policy, the FAP application, and the plain language summary will be widely available on the DCMC web site (www.dcmedical.org)
5. Patient Statements: Each bill, invoice or other summary of charges shall include with it, or on it, a prominent statement that he/she may apply for consideration under the Financial Assistance Program, including the telephone number for Patient Financial Services and a direct web site address where copies of the Financial Assistance Program policy, the FAP application, and the plain language summary may be obtained.
6. Translations: DCMC will make available translations of the Financial Assistance Program, the FAP application, and plain language summary in the language spoken by limited English proficiency language groups that constitute the less of 1,000 individuals or five percent (5%) of the community served by DCM or the population likely to be affected or encountered by DCMC.
7. Community Outreach: DCMC will take measures to notify and inform members of the community about the Financial Assistance Program.

B. A Financial Assistance Program application can be made on behalf of the patient by a concerned party (subject to privacy laws), including but not limited to:
    1. Patient or guarantor
    2. Faith community leader or representative
    3. Personal physician or other health care professionals
    4. Any member of the DCMC staff or medical staff
        a. Examples include physicians, nurses, financial counselors, social workers, case managers, chaplains and religious sponsors.

BILLING AND COLLECTIONS PROCESS

As described below, DCMC will make reasonable efforts to determine whether a patient is eligible under this Financial Assistance Program for financial assistance before it engages in an ECA.

Processing of Financial Assistance Program Applications

Except as provided below, a patient may submit a Financial Assistance Program application at any time during the Application Period, which is generally 240 days from the date of the first post-discharge bill as defined in Section III. Determinations of eligibility for financial assistance will be processed based on the following general categories.

A. Presumptive Eligibility Determinations. If a patient is presumptively determined to be eligible for less than the most generous assistance available under the Financial Assistance Program (for example, the determination of eligibility is based on an application submitted with respect to prior care), DCMC will notify the individual of the basis for the determination and give the patient a reasonable period of time to apply for more generous assistance before initiating an ECA.

B. Incomplete FAP Applications. In the case of a patient who submits an incomplete FAP application during the Application Period, DCMC shall notify the patient in writing about how to complete the FAP application and give the patient a reasonable opportunity to do so (not to be less than 30 days from the date of notification of incomplete application). During this time, the standard billing process will continue, but any pending ECAs shall be suspended, and the written notice shall (i) describe the additional information and/or documentation required under the Financial Assistance Program or the FAP application that is needed to complete the application, and (ii) include appropriate contact information.

C. Complete FAP Applications. In the case of a patient who submits a complete FAP application during the Application Period, DCMC shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

D. Deferring or Denying Care. Excluding any services provided to a patient as emergency care, DCMC may defer or deny, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the Financial Assistance Program. The patient will be offered a FAP application and/or the Financial Assistance Plain Language Summary indicating that financial assistance is available for eligible patients and stating the deadline, if any, after which DCMC will no longer accept and process an application submitted (or, if applicable, completed) by the patient for the previously-provided care at issue. This deadline shall be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided.

Financial Assistance Program Determination Notification

A. Determinations. Once DCMC determines the final balance owed by the patient

AND a completed FAP application is received on a patient's account, DCMC will notify the patient, patient's legal guardian, and/or responsible party in writing of the final determination within forty-five (45) calendar days. The notification will include a determination of the amount for which the patient and/or responsible party will be financially accountable, if approved for less than 100% financial assistance. If the application for the Financial Assistance Program is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

B. Refunds. DCMC will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the Financial Assistance Program, unless such excess amount is less than $5.00.

C. Reversal of ECA(s). To the extent a patient is determined to be eligible for financial assistance under the Financial Assistance Program, DCMC will take all reasonably available measures to reverse any ECA taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the individual, lift any levy or lien on the individual's property, and remove from the individual's credit report any adverse information reported to a consumer reporting agency or credit bureau.

Appeals

A. The patient and/or responsible party may appeal a denial of eligibility for financial assistance by providing additional information to the Patient Financial Services within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Patient Accounts Manager and/or the Chief Financial Officer for a final determination. If the final determination affirms the previous denial of financial assistance, written notification will be sent to patient, legal guardian, and/or responsible party.

B. If an appeal is filed within fourteen (14) calendar days of final determination, any collection efforts will be suspended pending the final outcome of the appeals process.

ADMINISTRATION

Reporting Requirements

A. DCMC should be able to provide the following upon request:

1. Financial Assistance Program Application
2. Presumptive Eligibility criteria accepted

3. Count of applications submitted (complete and incomplete)
4. Count of applications approved (including number approved using presumptive eligibility)
5. Count of applications denied
6. Dollar amount of financial assistance provided (year-to-date)

Policy Administration

A. Services provided as a result of an accident are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, DCMC will pursue and collect the balance owed from the third-party payer.

B. This policy shall be supervised by the Patient Financial Services Manager (or another colleague designated by the CFO, or Vice President of Revenue Cycle) who shall be responsible for administering the program, assuring that determinations for financial assistance meets the requirements of this policy, and notifying the patient and/or responsible party of the final determination. Any application from family members, friends or associates should be referred to the Patient Financial Services Manager or similar position at DCMC.

C. Other circumstances may compellingly show that full payment of outstanding medical expenses could cause serious social and/or financial hardship to the patient or the household. These circumstances may warrant an exceptional financial assistance reduction to be considered on a case by case basis.

D. The preceding guidelines are set forth in establishing the Financial Assistance Program. DCMC may modify these guidelines at any time consistent with existing law. DCMC reserves the right to approve or deny a financial assistance application received at its discretion. In implementing this Policy, DCMC management shall comply with all other federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to this Financial Assistance Program policy.

Definitions:

For purposes of this policy, the terms below are defined as follows:

A. **Assets**: Property of all kinds, real and personal, tangible and intangible, that is legally applicable to, or subject to, the payment of the patient's debts, including, but not limited to, cash on hand, checking and savings accounts, vehicles, mineral rights, stocks, mutual funds, lines of credit and any other investments; provided, however, that "income," as defined herein, shall not be included in determination of

assets.

B. **Amounts Generally Billed or "AGB"**: The amounts generally billed for emergency or other medically necessary services to individuals who have insurance covering such care, as further explained in Appendix D.

C. **Application Period**: The period during which a FAP application may be submitted for consideration of Financial Assistance eligibility. The Application Period begins on the date care is provided and ends on the later of the 240th day after the date the first post-discharge statement for the care is provided or either: (i) the date specified in a written notice from DCMC regarding its intention to initial ECAs; or (ii) in the case of a patient who has been deemed presumptively eligible for Financial Assistance less than 100%, the end of the reasonable time to apply for Financial Assistance as described in Section VI.

D. **Charity or Financial Assistance:** The adjustment to charges for free or discounted medical services provided to individuals who meet certain financial criteria.

E. **Colleague or Delegate**: DCMC employees or contractors who will assist patients with the process to apply for financial assistance under this Financial Assistance Program.

F. **Code Section 501(r) Requirements**: The requirements of Section 501(r) of the Internal Revenue Code of 1986, as amended from time to time, and the related Treasury Regulations pertaining to financial assistance, limitations on charges, and billing and collections activities.

G. **Emergency and other medically necessary services:** Emergency medical services provided in an emergency room setting; Health care services for a condition which, if not promptly treated would lead to an adverse change in the health status of an individual; Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and other medically necessary services, all evaluated on a case-by-case basis solely at DCMC's discretion for purposes of application of this Financial Assistance Program.

H. **Extraordinary Collections Actions or "ECAs"**: For purposes of this Financial Assistance Program policy, ECAs are those activities identified under the Code Section 501(r) Requirements, which may include:

    1. Selling an individual's debt to another party, unless the purchaser is subjected to certain restrictions as provided in the Code Section 501(r) Requirements.
    2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    3. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding.

I. **Family**: Defined by the Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return in compliance with Internal Revenue Service rules, then they may be considered a dependent for purposes of the provision of financial assistance.

J. **Family income**: Income is the total annual cash receipts from all sources, before taxes, less payments made for child support which includes, but is not limited to; wages and salaries before deductions, tips, net receipts from non-farm self-employment income, net receipts from farm self-employment, social security payments, railroad retirement, unemployment compensation, workers compensation benefits, veteran's payments, public assistance payments, Supplemental Security Income, Social Security Disability Income, alimony, military allotments, private pensions, government pensions, annuity payments, grants, fellowships, dividends, interest, net rental income, net payments, net gambling or lottery winnings, assistance from outside the household and other miscellaneous sources. Noncash benefits (such as food stamps, housing subsidies and child support) do not count as income.

K. **FAP application**: The information and accompanying documentation that a patient submits to apply for financial assistance under a Financial Assistance Program.

L. **Federal Poverty Guidelines**: The most recent published federal income poverty guidelines for a household as published by U.S. Department of Health & Human Services and updated from time to time. See Appendix A for the most current guidelines.

M. **Guarantor:** An individual, who may or may not be the patient who is responsible for payment of the patient's bill.

N. **Health care services:** Medical services provided to the individual within the DCMC environment, including, but not limited to, medical diagnostic and surgical services as well as room and board; outpatient diagnostic environment, including but not limited to Diagnostic Services, Therapeutic Services and Chronic Support Services inclusive of use of equipment, supplies, and professional services (excluding non-DCMC physicians).

O. **Homelessness**: Indigent, when a person lacks a fixed, regular and adequate residence, and if they sleep in a shelter designated for temporary living accommodations or in places not designated for human habitation.

P. **Hospital facility**: A facility that is required by a state to be licensed, registered, or similarly recognized as a hospital. Multiple buildings operated under a single state license are considered to be a single hospital facility.

Q. **Legal guardian**: A recognized legal surrogate for the patient with regard to medical

and financial decisions, who would be authorized under applicable state law to receive confidential health care information on the patient. This includes parents who are legally responsible for their minor children, close family members who are recognized by the patient or applicable state law as having the legal ability to act on the patient's behalf with regard to medical and/or financial decisions, or a legal guardian under applicable state law.

R. **Medically indigent charity care**: Health care services rendered in the absence of sufficient financial resources to cover the costs of care without catastrophic affect upon the individual family, in the absence of catastrophic health care coverage, and to those without third party insurance, which precludes the ability of the individual to pay for services, regardless of income level.

S. **Medically necessary services:** Health care services for a condition which, if not promptly treated would lead to an adverse change in the health status of an individual; Emergency medical services provided in an emergency room setting; Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and medically-necessary services, evaluated on a case-by-case basis at DCMC's discretion.

T. **Patient Financial Services**: The department responsible for managing the Financial Assistance Program at DCMC and each Local System.

U. **Presumptive Eligibility:** Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need.

V. **Responsible party**: The patient or any individual legally obligated to pay for the patient's debts for medical care, excluding third party payers. An adult patient, living in the household of a relative other than a spouse – including an adult, unmarried child living at home – will be considered the "responsible party" for purposes of this policy, without regard to the assets and income of the other relatives living in the household (except a spouse).

W. **Substantially-related entity**: An entity treated as a partnership for federal tax purposes in which a Local System owns a capital or profits interest, or a disregarded entity of which the Local System is the sole member or owner, that provides emergency or other medically necessary services in a hospital facility of a Local System, unless the provision of such care is an unrelated trade or business described in section 513 of the Internal Revenue Code.

X. **Third party payer**: Any financial agent or entity, such as an insurance carrier, HMO, employee benefit plan or government payer, with a legally enforceable obligation to pay for services billed to a patient by DCMC. Responsible parties, as defined herein, are not considered third party payers.

Y. **Underinsured**: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by DCMC.

Z. **Uninsured**: An individual, with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third-party assistance available to cover the cost of a patient's healthcare expenses.

AA. **Uninsured Discount:** Patients with no third-party coverage will be provided an uninsured discount, for eligible services provided by DCMC under this policy, at the time that the undiscounted charges are rendered. DCMC will have this discount applied automatically to uninsured patient balances at the time of billing. Current uninsured discount amounts are published in Appendix A of this policy and reviewed on a yearly basis by Patient Financial Services for appropriateness

Related Policies/Position Statements/Other Source Documents:

- HFMA Patient Friendly Billing Practices
- ACA Regulations Code Section 501 (r)
- Federal Poverty Guidelines
- Credit and Collections Policy PFS-4

The following providers do honor the DCMC financial assistance policy at this time:

- Radiology Associates of the Fox Valley
- HSHS St. Vincent Hospital

Values:

This Policy has been reviewed for support of the Door County Medical Center Values.

Key Words:

Financial assistance, community care, charity, poverty, vulnerable persons

For More Information Contact:

Manager of Patient Financial Services

Responsible Senior Leader:

Chief Financial Officer

Approved by:

Senior Leader Team: 7/25/2017; 10/2/2018; 1/2020; 3/17/2020; 4/20/2021; 3/23/2023; 4/25/2023

Notice:

This information is an accurate state of published Door County Medical Center Policy as of the time of publication. Door County Medical Center adopts the Policy and recommends that the user always check for the latest version in PolicyStat, before any subsequent use.

Attachments

APPENDIX A FAP RC-09-DC 2023.docx

APPENDIX B FAP RC-09-DC 2023.docx

APPENDIX C Covered Providers and Departments.docx

APPENDIX D AMOUNTS GENERALLY BILLED.docx

DCMC FAP Application 1.30.pdf

Approval Signatures

Step Description	Approver	Date
SLT	Sherry Maass: Program Specialist	4/26/2023
	Andy Laluzerne: Chief Financial Officer	3/28/2023
	Ashley Moede: Patient Access Director	3/28/2023