GUTHRIE COUNTY HOSPITAL

An Affiliate of UnityPoint Health

FINANCE

Sliding Fee Discount Program

RESPONSIBLE INDIVIDUAL: Revenue Cycle Manager
CONTRIBUTORS: CFO, Billing

PURPOSE

To make available discount services to those in need.

POLICY

This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured).

Guthrie County Hospital (GCH) and GCH Clinics (GCH and Clinics) will offer a Sliding Fee Discount Program to all who are unable to pay for their services. GCH and Clinics will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

PROCEDURE

The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** GCH AND CLINICS will notify patients of the Sliding Fee Discount Program by:
    - Payment Policy Brochure will be available to all uninsured patients at the time of service.
    - Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
    - An explanation of our Sliding Fee Discount Program and our application form are available on GCH's website.
    - GCH AND CLINICS places notification of Sliding Fee Discount Program in the hospital and clinic waiting areas.

2. All patients seeking healthcare services at GCH AND CLINICS are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

3. **Request for discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will be made available for all GCH AND CLINIC visits. Information and forms can be obtained from the Front Desk.

4. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Revenue Cycle Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided, and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided healthcare services.

5. **Alternative payment sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s), federal and state programs. Residents of the state of Iowa are required to first apply for Presumptive Eligibility before applying for the Sliding Fee Discount Program.

6. **Completion of Application:** The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize GCH AND CLINICS access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two-week time period, his/her application will be re-dated to the date on which s/he supplies the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

7. **Eligibility:** Discounts will be based on income and family size only. GCH AND CLINICS uses the Census Bureau definitions of each.
    a. **Family** is 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.
    b. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, 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.**

8. **Income verification:** Applicants must provide current proof of income which includes but is not limited to the following:
    a. Most recent income tax return or W-2
    b. Two most recent pay stubs with year-to-date totals

c. Most recent unemployment check
d. Proof of other household income (Social Security, pension, etc.)
e. Bank statements showing direct deposit

Self- declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to GCH AND CLINICS's CEO or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

9. **Discounts:** Those with incomes at or below 100% of poverty will receive a full 100% discount. 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.

10. **Nominal Fee:** Patients receiving a full discount will be assessed a $10 nominal charge per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

11. **Waiving of Charges:** In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by GCH AND CLINICS's CEO, CFO, or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).

12. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with GCH AND CLINICS. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

13. **Covered Services:** The sliding fee discount program only applies to medical services provided by GCH AND CLINICS. It does not apply to services rendered by independent physicians or practitioners that are not employed by GCH AND CLINICS. This includes

but is not limited to visiting specialists, Anesthesiologists, Radiologists, and Pathologists.

14. **Billing and Collections:** A minimum of three statements will be mailed to the patient regarding the balance due. If the patient is not enrolled in the Sliding Fee Discount Program, a copy of the program application will be sent to the patient after the third statement has been sent. If the patient fails to contact GCH AND CLINICS within 60 days of receiving the program application, GCH AND CLINICS will presume this is an uncollectible account. At this point in time, GCH AND CLINICS reserves the right to turn all delinquent accounts over to collections.

15. **Payment Plans:** Patients that have been accepted for the Sliding Fee Discount Program may qualify to set up monthly payments to pay off their balance. The payment plans offered to patients are interest free. A schedule is below outlining the balance due and the maximum length of a payment plan in months.

Balance Due		Months
$0	$100	2
$101	$200	4
$201	$300	6
$301	$400	7
$401	$500	8
$501	$800	10

Balance Due		Months
$801	$1,200	14
$1,201	$1,600	18
$1,601	$2,200	24
$2,201	$2,600	27
$2,601	$3,200	32
$3,201	$3,600	36

16. **Refusal to Pay:** If two monthly payments are missed consecutively or a total of 3 payments are missed during the duration of the established payment plan, the patient will be eliminated from the Sliding Fee Discount Program and all discounts on the patient's account will be reversed. The patient will be notified in writing of their removal from the Sliding Fee Discount Program. This notification will include the new balance due and instructions to contact the GCH AND CLINICS Billing Department to establish a payment plan. Failure to contact GCH AND CLINICS within 60 days of written notification of removal from the Sliding Fee Discount Program will constitute a refusal to pay. At this stage, GCH AND CLINICS reserves to right to turn all delinquent accounts over to collections.

17. **Record keeping:** Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Revenue Cycle Manager's Office, in an effort to preserve the dignity of those receiving free or discounted care.
    a. Applicants that have been approved for the Sliding Fee Discount Program will be logged in a password protected document on GCH AND CLINICS shared

directory, noting names of applicants, dates of coverage and percentage of coverage.

b. The Revenue Cycle Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials will also be logged.

18. **Policy and procedure review:** Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CEO and/or Comptroller. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

19. **Budget:** During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue. Board approval for Sliding Fee Discount Program will be sought as an integral part of the annual budget.

ATTACHMENTS:
2020 Sliding Fee Schedule
Patient Application for the Sliding Fee Discount Program

INITIAL APPROVAL DATE: 12/2020
REVIEW DATE:
REVISED DATE – MINOR:
REVISED DATE – MAJOR:
DELETION DATE:

GUTHRIE COUNTY HOSPITAL

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Sliding Fee Schedule

	Number of Persons in Family									
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Each Add/l**	**Poverty Level**
Minimum Fee $10.00	$0 $12,760	$12,761 $17,240	$17,241 $21,720	$21,721 $26,200	$26,201 $30,680	$30,681 $35,160	$35,161 $39,640	$39,641 $44,120	$4,480	100%
85% Discount	$12,761 $15,950	$17,241 $21,550	$21,721 $27,150	$26,201 $32,750	$30,681 $38,350	$35,161 $43,950	$39,641 $49,550	$44,121 $55,150	$5,600	125%
70% Discount	$15,951 $19,140	$21,551 $25,860	$27,151 $32,580	$32,751 $39,300	$38,351 $46,020	$43,951 $52,740	$49,551 $59,460	$55,151 $66,180	$6,720	150%
55% Discount	$19,141 $22,330	$25,861 $30,170	$32,581 $38,010	$39,301 $45,850	$46,021 $53,690	$52,741 $61,530	$59,461 $69,370	$66,181 $77,210	$7,840	175%
40% Discount	$22,331 $25,520	$30,171 $34,480	$38,011 $43,440	$45,851 $52,400	$53,691 $61,360	$61,531 $70,320	$69,371 $79,280	$77,211 $97,200	$8,960	200%
No Discount	$25,521 +	$34,481 +	$43,441 +	$52,401 +	$61,361 +	$70,321 +	$79,281 +	$97,201 +	$8,961	>200%

Guthrie County Hospital Sliding Fee Application

This Sliding Fee Discount Program Application is being provided to you for completion so that we can determine if you qualify for discounted medical services.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Sliding Fee Discount Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact the Revenue Cycle Manager at 641-332-2201.

To determine if you qualify for our Sliding Fee Discount Program, please return the following supporting documentation with the completed packet:

- A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- Last two weeks of paystubs with year-to-date totals, or last two months of paystubs without year-to-date totals (if paid in cash without paystubs, provide written verification from employer)
- Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office, etc.
- If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.

❖ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.
❖ NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided. Your completed application and supporting documentation may be submitted to:

- **Hand-delivering to the Front Desk of Guthrie County Hospital at 710 N 12th St Guthrie Center, IA 50115**
- **Mailing to:**
  Guthrie County Hospital
  Attn: Revenue Cycle Manager
  710 N 12th Street
  Guthrie Center, IA 50115

Guthrie County Hospital
Sliding Fee Discount Program Application

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address since _____ Phone # (_____) _____

Marital Status: Single_____ Married_____ Divorced_____ Widow_____

Spouse's Name _____ Spouse's Date of Birth _____

List family members (including parents, patient, and natural or adoptive siblings) living at the above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan.		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

Guthrie County Hospital
Sliding Fee Discount Program Application

I. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed (Y/N) ____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____)_____ Does Employer Offer Health Insurance? (Y/N)_____

Occupation/Position _____ Date of Hire _____

Student (Y/N) _____ Name of School _____ Number of Credits This Semester _____

MOTHLY SALARY:

Gross: $_____ Net: $_____ Hourly Pay: $_____ Hours Worked Weekly: _____

Additional Source(s) of Income (per month):

❑ Other Wages	$_____	❑ Child Support	$_____	❑ Farm Income	$_____
❑ Interest, Dividends	$_____	❑ Retirement	$_____	❑ Self-Employment	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ SSI/Social Security	$_____
❑ Alimony	$_____	❑ Unemployment	$_____	❑ Veterans Benefits	$_____
				❑ Other	$_____

Employment information of spouse (if applicable):

Spouse's Employer _____ Unemployed (Y/N) ____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____)_____ Does Employer Offer Health Insurance? (Y/N)_____

Occupation/Position _____ Date of Hire _____

Student (Y/N) _____ Name of School _____ Number of Credits This Semester_____

MOTHLY SALARY:

Gross: $_____ Net: $_____ Hourly Pay: $_____ Hours Worked Weekly: _____

Additional Source(s) of Income (per month):

❑ Other Wages	$_____	❑ Child Support	$_____	❑ Farm Income	$_____
❑ Interest, Dividends	$_____	❑ Retirement	$_____	❑ Self-Employment	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ SSI/Social Security	$_____
❑ Alimony	$_____	❑ Unemployment	$_____	❑ Veterans Benefits	$_____
				❑ Other	$_____

Guthrie County Hospital
Sliding Fee Discount Program Application

III. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state, or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Guthrie County Hospital. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for the sliding fee discount program, and any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request _____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering to the Front Desk of Guthrie County Hospital at 710 N 12th St Guthrie Center, IA 50115
- Mailing to:

  Guthrie County Hospital
  Attn: Revenue Cycle Manager
  710 N 12th Street
  Guthrie Center, IA 50115

To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application.

OFFICE USE ONLY

Patient Name: _____

VERIFICATION CHECKLIST	YES	NO	N/A
Identification: Driver's License, Employment ID, Passport, etc.			
Income: Prior year tax return, pay stubs, bank statements			
Insurance: Insurance Cards if applicable			

Family Size _____

Patient Income _____ Spouse Income _____ Total Income _____

Poverty Level _____ Discount Available _____

Approved by:_____

Date Approved: _____