


ACHC.BO.0160 – Financial Assistance

	Business Office	Policy # ALL.ACHC.BO.0160
	ACHC.BO.0160 – Financial Assistance	Effective: 06/01/2012
		Last Reviewed/Revised: 12/01/2022
		Superseded Policy #

1. SCOPE

Acadia Healthcare Co., Inc., including all subsidiaries, affiliates, facilities, and their personnel.

2. PURPOSE

To determine qualifications for financial assistance.

3. POLICY

It is the company's policy to provide financial assistance based on federal poverty guidelines to patients with no health insurance or other state or federal health assistance or for whom the out of pocket expenses are significant, All financial assistance will be provided based on established protocols and completion of the Financial Disclosure Form (Attachment A) and supporting documentation.

4. PROCEDURE

As stated in policy ACHC.BO.0140 Insurance Verification, all facilities must perform verification of benefits for each patient and each potential payer prior to or upon admission. If an admission occurs after normal business hours, the verification must be performed no later than the next business day. This Insurance verification process should be completed to identify any potential resources for the patient's medical services, whether federal or state governmental health care program (e.g. Medicare, Medicaid, state or local government agency, Champus, Medicare HMO, Medicare secondary payer), private insurance company, or other private, non-governmental third party payer source.

Financial assistance is not considered to be a substitute for personal responsibility. It is the responsibility of the patient/responsible party to actively participate in the financial assessment process and provide timely, accurate information, as requested. This requested information may include information concerning actual or potentially available health benefits such as COBRA coverage or Medicaid/state or local government agency coverage, Failure to provide accurate and timely information may subject the patient/responsible party to a denial of financial assistance.

Self-pay/Uninsured Patients

All self-pay/uninsured patients (no current insurance coverage) will be requested to pre-pay for all services at time of admission/registration. Each facility must have a self-pay deposit schedule based on various estimated lengths of stay and the facility's established self-pay rate. This deposit schedule should be used to estimate the upfront payment that is required for self-pay patients.

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If the patient is unable to pre-pay for services, the patient will be financially assessed during the pre-admission or admission process. The Financial Counselor, or designated Business Office staff member, will then meet with the patient and request that Attachment A - Financial Disclosure Form be completed. This form must be completed verbally or in person before the Equifax reporting tool can be utilized.

As stated in further detail in ACHC.BO.0150 Financial Counseling policy, the Financial Counselor or Business Office Representative will meet with each patient or guarantor expected to have an out-of-pocket liability to discuss payment arrangements and facilitate the completion of the Financial Disclosure Form.

Financially or Medically Indigent Patients

Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in this policy. Financial Indigence can be determined by the verification of Medicaid eligibility for the dates of service. Financially and medically indigent patients are defined in further detail in the definitions found at the end of this policy.

If the patient is unable to pay estimated out-of-pocket expenses, the patient will be financially assessed during the pre-admission or admission process in accordance with ACHC.BO.0150 Financial Counseling policy. During the counseling session, the Patient Responsibility Worksheet (Attachment A -Policy ACHC.BO.0150 Financial Counseling) will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated liability.

During the financial counseling process, the facility may reasonably determine that COBRA coverage is available to the patient. In these cases, the patient will provide the facility with information necessary to determine the monthly COBRA premium by completing the Application for COBRA Assistance (Attachment D). If the facility determines that the patient is financially unable to pay the COBRA premiums the facility may decide to pay the COBRA premium on behalf of the patient/responsible party. Payment of any COBRA premiums must be approved by the facility CEO and CFO prior to payment.

Determining Qualification for Financial Assistance

The Patient Responsibility Worksheet along with the Financial Disclosure Form will be reviewed by the Business Office Director (BOD) and facility CFO. These completed forms are required for the qualification of patients for financial assistance.

The BOD or Financial Counselor is responsible for ensuring the completion of the Financial Disclosure Form by the patient/responsible party during the financial counseling process to evidence their ability to pay. All supporting documentation should be attached to the Financial Disclosure Form such as insurance verifications, bank statements, proof of income and Equifax.

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The BOD or Financial Counselor must verify the assets and income of the patient/responsible party during the qualification process. The facility must have at least one form of documentation from the list below in order to verify and analyze the information received on the Financial Disclosure Form to determine financial assistance available for a patient/responsible party.

Documentation for income verification must be provided to the facility within 30 days of discharge for the patient/responsible party to be eligible for financial assistance. To complete Income Verification, the facility must have one of the following:

- Most Recent Income Tax Return
- Most Recent Paystubs (must span 4 weeks or 30-day period)
- Social Security Statement of Earnings
- SSI Disability Benefit Letter or Current Bank Statement showing Monthly Deposit
 - SSI Income via Direct Express is acceptable when a bank statement is unavailable.
- Unemployment Vouchers (must span 4 weeks or 30-day period)
- Letter from a Third Party Source such as a Shelter, Mission or Group Home confirming Financial Status

Equifax can be used to further analyze patient's financial status for medically indigent patients but cannot be the primary source of data in the qualification process. Income verification documentation is the primary method in which financial assistance will be determined. There are no exceptions to this documentation requirement to receive financial assistance.

Final approval of the financial assistance offered to the patient will be determined by the facility management (CFO/CEO) based on their review of the completed Patient Responsibility Worksheet, the completed Financial Disclosure Form and documentation required for verifying income and assets of the patient/responsible party.

Approval and Recording of Financial Assistance

Financial or medical indigence (categorized as charity or indigent care on the facility general ledger) must be identified prior to the patient's discharge and must be logged on the Charity Log within the month identified. Charity Adjustments will be written off in the patient accounting system no later than the end of the month following discharge with the exception of insured patients which can be adjusted at the time of the remittance advice posting. Facilities involved in a joint venture with a non-profit organization must be aware of the different guidelines for the time period in which a patient may qualify for charity care and follow the agreed upon policy.

Upon identifying a self-pay 100% charity patient at admission — enter the self-pay payer in the patient's account so that a self-pay contractual will post. Indigent accounts pending Medicaid approval should not be immediately written off as Charity. Patients who are in process of being qualified for Medicaid eligibility should be included in the Medicaid Pending Financial Class and contractualized at the Medicaid reimbursement rate. If it is determined after discharge that the patient is not eligible for Medicaid coverage, however the patient meets indigent criteria for the facility, move the account to financial class "SX" for self-pay charity and process the patient's account balance (gross charge less Medicaid contractual) for a charity adjustment.

SAN JOSE BEHAVIORAL HEALTH DISCOUNT SCALE 2022

Income Level	% of Discount on Total Charges
Equal to or less than 133% of FPG	100%
133% - 150% of FPG	75%
150% - 200% of FPG	50%
200% - 400% of FPG	25%
Greater than 400% of FPG	0%

Definitions:

Equifax is one of the largest sources of consumer and commercial data in the world and has been providing business solutions using advanced analytics and the latest technologies for over 100 years.

Financial Assistance also known as Charity Care or Discount is defined as a reduction in the cost of health care services granted to patients based on their capacity to pay their estimated liability.

Financially Indigent is defined as those patients who are accepted for medical care who are uninsured with no or a significantly limited ability to pay for the services rendered. These patients are also defined as economically disadvantaged and have incomes at or below the federal poverty guidelines. An individual may also be classified as "categorically needy" by proof of entitlement to some state or federal government programs such as SSI, Food Stamps, Aid to Families with Dependent Children (AFDC), or Medicaid for which entitlement has been established, but for which coverage may not be available for the specific type or level of service.

Medically Indigent is defined as those patients who incur severe or catastrophic medical expenses but are unable to pay and/or payment would require substantial liquidation of assets critical to living or would cause undue financial hardship to the family support system.

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As noted in Accounting Policy #115.00 — Administrative, Denial, and Charity Care Adjustments, the following approvals are required for any Administrative or Charity Care patient account adjustment.

- BOD/CFO approval is required for financial assistance up to \$5,000.
- Additional approval by CEO is required for financial assistance greater than \$5,000 with Divisional CFO approval being required above \$10,000 as stated in Policy #115.00 — Administrative, Denial, and Charity Care Adjustments.

A form letter provided, Notification of Determination of Eligibility for Financial Assistance (Attachment B) can be used as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

All documentation for financial assistance must be maintained in the patient financial file. The amount of financial assistance will only be applied after recovery from all third party payers has been verified, Reductions in revenue deemed financial assistance shall not result in a credit balance or a refund situation.

Method for the Calculating of the Amount of Financial Assistance (Discounts)

This method is intended to illustrate a sliding scale. It should be used as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and determination of any financial assistance,

This method uses the Federal Poverty Guideline (FPG) Schedule. This schedule can be accessed from the internet by putting the following data in your web browser —

<https://aspe.hhs.gov/poverty-guidelines> , For San Jose Behavioral Health in the State of California scale is 100% discount up to 400% FPG. First, find the number of the guarantor's dependents under the column labeled "Family Size". Then, locate the guarantor's gross annual income on the same row as the Family Size. In most cases, the guarantor's income will fall between two percentage categories (much like the tax schedule individuals use each year in determining how much they owe the government).

- With this information, determine the discount percentage based on the discount scale included herein. Example: Mr. Jones is uninsured and has met the criteria for the financially indigent. According to his federal income tax return, Mr. Jones earned \$35,000 and has 4 dependents. Mr. Jones's total charges are \$20,000. In this example, Mr. Jones's income level is 139% of the FPG and would therefore be eligible for a 50% discount of \$10,000. Mr. Jones will be responsible for the remaining balance of \$10,000.

5. REFERENCES

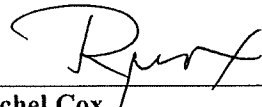
Attachments:

- Attachment A — Financial Disclosure Form
- Attachment B — Notification of Approval/Denial for Financial Assistance
- Attachment C — Charity Log
- Attachment D – Charity Log
- Attachment D – Application for COBRA assistance

Related Policies:

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| ACC-115.00 | Administrative, Denial, and Charity Care Adjustments |
| ACHC.BO.0150 | Financial Counseling |
| ACHC.BO.0140 | Insurance Verification |

APPROVAL:



Rachel Cox
San Jose Behavioral Health CFO

Date: 12/01/2022