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Principle:

To define the proper policy and procedure for determining and granting community care write-offs and self-pay discounts.

Concept:

As a not-for-profit charitable hospital, Fort HealthCare, Inc. (FHC) recognizes that certain responsible individuals will not have the ability to pay for services rendered to them or their immediately family. Fort HealthCare defines “family” as including any spouse, ancestors, children, grandchildren, great grand-children, and spouses of children, grandchildren, and great grandchildren.

It is FHC’s policy to apply a Community Care write-off after completing an evaluation of the patient’s financial status. Community Care write-offs are granted by FHC upon careful consideration of certain guidelines. Persons whose income is at or up to 200% of the FPL (Federal Poverty Level) are encouraged to seek services through Rock River Community Clinic (RRCC). This facility provides free health care services up to 200% of the FPL.

Individuals are expected to cooperate with Fort HealthCare’s Community Care process. This may include applying for additional resources on the Community Care Application. In cases when a patient appears eligible for financial assistance, but no evidence is available, Fort HealthCare may use outside agencies to determine and assist with eligibility. This is not applicable for persons whose income is at or up to 200% of the FPL.

Self-pay patients are defined as patients who have no health insurance because they are not eligible for insurance coverage or the services are not covered by a health insurance policy or state, government, liability or workers compensation program.

Fort HealthCare will provide care of emergency medical conditions to individuals regardless of their ability to pay. Eligible individuals may not be charged more than amounts generally billed for emergency or other medically necessary care. Appendix A defines the Amounts Generally Billed (AGB) methodology.

Financial Assistance need does not consider age, gender, sex, race, color social or immigrant status, national origin, disability, sexual orientation, gender identity or religious affiliations.

This policy covers all of Fort HealthCare departments including Fort Medical Group physician clinics. Refer to the attached Appendix B for specific coverage.

The Community Care Program will be advertised to patients on the Fort HealthCare website and social media platforms. In addition, signage will be prominently displayed in Fort HealthCare’s patient waiting areas with language that states, at a minimum, “no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available based on family size and income”.

General Community Care Guidelines:

1. Community Care write-offs are available to eligible persons residing in our primary and secondary service areas requiring medically necessary treatment, but who are unable to pay for these services. Eligibility for Community Care shall be extended to those persons whose family income does not exceed current Community Services Administration poverty guidelines (see **Attachment #1 – Community Care Discount Table**). Persons whose income is at or up to 200% of the guidelines will be considered for complete forgiveness of their outstanding bill. Persons whose income is greater than 200% of the guidelines, but not more than 400% of the guidelines, shall be eligible for Community Care on a reduced basis. FHC will automatically adopt the most recent Federal Poverty Guidelines within 30 days of its release by the Federal Government.



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- Community Care write-off shall be considered only after a careful review of the patient’s accounts. For patients whose income is at or up to 200% of the Community Services Administration poverty guidelines, coverage consideration will be based solely on income and family size. For patients whose incomes exceeds 200% of the Community Services Administration poverty guidelines, Community Care will be applied to all eligible patient balances after insurance and third-party payments and contractual adjustments. A signed **Financial Questionnaire** (see **Attachment #2**) shall be completed by the Community Care candidate either by returning the free questionnaire sent by a FHC Patient Financial Counselor or completed online at www.forthhealthcare.com. An appointment may be made with our Patient Financial Advocate to assist completing the application at no charge.

Legal dependents shall be identified as such, based on whether or not they are claimed as dependents on the most recent income tax return and/or reside in residence. Gross income on the questionnaire shall include all household income and shall require supporting materials (i.e., most recent tax returns, 3 most recent pay stubs, W-2 forms, unemployment compensation forms, letters from employers, etc.). If a Community Care candidate indicates that no income has been earned, a copy of a letter from the Department of Workforce Development denying unemployment compensation may be requested. Also requested may be a copy of a letter verifying that Medicaid benefits have been denied (no Medicaid letter/application required for persons whose income is at or up to 200% of FPL). If the Community Care candidate has not yet applied for Medicaid or insurance thru the Marketplace, he or she will be required to do so before the application will be processed. If the Community Care candidate returns the questionnaire without sufficient proof of income or if other information has not been provided, he or she shall be contacted by telephone or letter to discuss other evidence of income they have available. If requested documents/information is not submitted within 60 days of contact, community care approval may be denied for failure to cooperate to complete the questionnaire.

- FHC recognizes the fact that there may be instances in which a Community Care candidate’s income exceeds the previously mentioned guidelines, but their expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burden. A Community Care write-off may be appropriate for these individuals.
- Patients with tax-advantaged, personal health accounts such as Health Savings Account, a Health Reimbursement Arrangement or Flexible Spending Account will be expected to use these funds prior to being approved for financial assistance.
- Upon review of a completed Financial Questionnaire, a Patient Financial Counselor will make a recommendation for Community Care. Recommendations below \$5000 will be approved by the Director of Revenue Cycle and approvals for \$5000 and above will be approved by the Senior Vice President – Finance & Strategic Development or President/Chief Executive Officer. Once Community Care is approved, the individual will receive written notice from FHC and a current statement reflecting the new adjusted balance due.
- If partial Community Care is approved, the individual will be contacted by a Patient Financial Counselor to establish an approved payment plan for the remaining balance. If an individual does not follow through on their payment plan, FHC reserves the right to submit the balances to a collection agency.
- Fort HealthCare has reviewed RRCC’s charity care policy and procedures and determined their process is substantially similar to Fort HealthCare’s. FHC will use RRCC’s collected data to process RRCC referrals for FHC’s charity care write-offs.



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8. FHC recognizes that some patients will be unable to comply with or be unresponsive to traditional FAP processes; and in effort to remove barriers for these patients and improve community benefits, FHC may utilize an electronic screening process prior to bad debt assignment after all other funding sources have been exhausted; and that the information returned via this electronic screening will constitute adequate documentation under FHC’s policy; and the patient’s eligibility through this process will receive the most generous financial assistance discount and will not be assigned to bad debt. Transunion Consumer Credit Report will be reviewed. Presumptive care is for a finite period of time and covers very specific types of services and patients. For example:
- a. Patients who are incarcerated for more than 2 years
 - b. Patients that do not live in the area and will most likely never return
 - c. Patients that are here illegally and have no access to health insurance
 - d. Homeless
 - e. Medicaid eligible, but not on the date of service
 - f. Deceased with no estate

Individuals eligible for a presumptive eligibility discount will not be asked or required to submit a Community Care application.

9. If a patient feels an incorrect determination was made, they may appeal. The patient will be asked to document the factors that would change the result.
10. Community Care applications will be accepted for open dates of service. Patient balances older than 240 days from date of service which have been sent to collections are not eligible for FAP. Community Care approvals will be good for one calendar year and not automatically extend to future services provided by Fort HealthCare, Inc. but may be reviewed annually.
11. Applications for recently unemployed patients or guarantors will be held for 3 months with the intent that the applicant will be re-employed in the near future. At the end of the 3 months, the applicant will need to provide an update on their employment status. The status will be reviewed by FHC and a decision will be made to extend the hold or process the application.
12. FHC may at any time, with the approval of the FHC Board of Directors, revise the criteria determining eligibility for financial assistance.
13. The eligible individual will not be charged more than the amounts generally billed for emergency or other medically necessary care.

General Self-Pay Guidelines

1. Eligible individuals will be expected to pay the equivalent of Amounts Generally Billed for qualified medically necessary services as determined by their qualified medical provider.
2. Individuals residing outside of the primary or secondary service areas without insurance will receive a self-pay discount but are required to pay for services in advance or at the time of service where appropriate.
3. The Self-Pay discount of 68% will automatically be applied once the Business Office determines the account meets the above criteria and all charges have been posted to the date of service.
4. The Self-Pay discount will be reviewed each year to ensure the correct percentage.



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Services not covered by FAP

Generally, care that is emergent or medical necessary will be eligible for discount. Community Care and Self-Pay write-off/discounts will not apply to the following types of services provided by Fort HealthCare:

1. Services deemed not medically necessary by the examining physician
2. Services deemed retail in nature (e.g., hearing aids and elective hearing tests, allergy testing/injections, dermatology light booth therapy)
3. Fertility and infertility treatments and procedures (including birth control)
4. Missed appointment charges
5. Bariatric Services
6. An unpaid account(s) over 240 days that we have placed with a collection agency
7. Charges in litigation
8. Experimental or investigational procedures including clinical trials and studies
9. Cosmetic-type services

This list is not all inclusive. Please consult a Business Office Associate for specific services.

Actions That May Be Taken In the Event of Non-Payment:

Fort HealthCare will inform all patients at the time of service that they may qualify for discounted fees. Fort HealthCare will send 4 statements to each eligible individual with progressively stronger language in attempt to collect outstanding balances. The statements will include invitations to eligible persons to contact a Patient Financial Counselor in the event they are unable to pay the balances due.

During the period in which Fort HealthCare is sending the 4 statements, Fort HealthCare may 1) try to call the eligible person to discuss methods in which the individual will satisfy their outstanding balances (including encouragement to apply for Community Care) and/or, 2) may seek a credit check from a credit agency.

After the 4th statement or 120 days after the date of the Guarantor’s first post discharge billing statement, Fort HealthCare will enlist the assistance of a collection agency in the collection of the outstanding balances. The collection agency will attempt to contact the eligible person via mail or phone to collect on this debt and provide notice of ECA (Extraordinary Collection Action). If payment is not made, the agency will provide notice 30 days prior to intent to do one or all of the following: 1) report adverse information about the eligible individual to a consumer credit reporting agency or credit bureau, 2) place a lien on an eligible individual’s property, 3) file a small claims suit, or 4) garnish an individual’s wages.

Financial Assistance applications will be accepted by agency if (a) within 240 days from date of first post-discharged bill or (b) if later, 30 days from the date of ECA notification. If an individual submits an application, all ECA actions will be suspended while the application is being reviewed. If the application is incomplete, FHC will contact the individual by mail or phone. If missing or incomplete information is not received within 60 days from date of contact, the application will be denied, and collection activity will resume.

FHC has entered into a legally binding written agreement to refer debt to FHC’s Collection Agency to ensure no ECAs are taken to obtain payment for care until “reasonable efforts” have been made.

It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for “Reasonable Efforts” will have been made. If a statement is sent to a patient or guarantor, and mail is returned as undeliverable, FHC will attempt to find a correct address. If the correct address cannot be found, FHC will attempt to contact the patient or guarantor by



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phone at the number listed by the patient or guarantor. If efforts to communicate with the patient or guarantor fail, accounts will be sent to a collection agency.

Patients are informed of financial assistance options thru hospital employees, Patient Financial Services employees, signage and FHC website. Brochures and patient bills also include information about financial assistance. Spanish versions of the application and financial assistance policy are available. Copies of our Financial Assistance Policy and Billing and Collection Policy, which describes the actions that FHC may take in the event of nonpayment, are provided free upon request.

Appendix A

Amounts Generally Billed (AGB) Calculation:

FHC has adopted the “Look Back Method” to determine the AGB calculation. We based this on the previous fiscal year’s claims allowed for all medical care, including emergency and other medically necessary care for Medicare and all private insurers divided by total gross charges for FHC. All services provided under FHC (including physician offices and clinics) will use the same discount percentage.

Appendix B

Providers and Services covered under Fort HealthCare’s Financial Aid policy:

- Applies to all Fort Memorial Hospital departments and services;
- Applies to all Fort HealthCare physician clinics; Note: this includes all Rural Health Clinics (FHC Integrated Family Care Clinic, FHC Whitewater Clinic, FHC Jefferson Clinic, FHC Johnson Creek Clinic, FHC Center for Women’s Health Clinic, and FHC Internal Medicine and Pediatrics Clinic)

Providers and Services not covered under Fort HealthCare’s Financial Aid Policy

(Please refer to the individual providers for their specific financial aid options.)

Associated Pathology	University of Wisconsin Laboratories
Southern WI Emergency Assn (SWEA)	United States Drug Testing Laboratories, Inc.
SSM/St. Mary’s Hospital – Madison, WI	Ariosa Diagnostics, Inc.
Associated Pathologists, S.C.	Aspira Labs
Wisconsin Diagnostic Laboratories	Versiti Blood Center
Labcorp	Physician offices and clinic located within FHC service area and are affiliated with FHC.
Mayo Clinic Laboratories	Referrals made by FHC providers to providers outside FHC service area.
Wisconsin State Laboratory of Hygiene	Aegis Laboratory Services



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Original Date <u>11/03/1998</u>			
<u>Committee/Unit Review</u>	<u>Revised</u>	<u>Reviewed/No Changes</u>	<u>Date</u>
J. Nelson, SVP/CFO	X		05/2002
J. Nelson, SVP/CFO	X		05/2005
FHC Board	X		05/2010
FHC Board	X		03/01/2011
FHC Board	X		03/06/2012
FHC Board	X		03/05/2013
FHC Board	X		05/02/2017
FHC Board	X		05/07/2019
FHC Board	X		11/02/2021
FHC Board	X		03/01/2022
FHC Finance Committee	X		04/01/2022
FHC Finance Committee	X		08/24/2023
FHC Finance Committee	X		
FHC Board	X		03/04/2025
FHC Revenue Cycle	X		



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Attachment 1

2026 Community Care Discount Table

- Write off accounts up to 200% of Federal Poverty Guidelines; with sliding-scale out to 400% of FPG
- For accounts where a catastrophic adjustment is appropriate, the discount would be the greater of the % calculation or the difference of the balance of accounts and the total payment plan payments

% of FPG	Discount	Family Size / Household Income							
		1	2	3	4	5	6	7	*8
100%	100%	\$15,960	\$21,640	\$27,320	\$33,000	\$38,680	\$44,360	\$50,040	\$55,720
110%	100%	\$17,556	\$23,804	\$30,052	\$36,300	\$42,548	\$48,796	\$55,044	\$61,292
120%	100%	\$19,152	\$25,968	\$32,784	\$39,600	\$46,416	\$53,232	\$60,048	\$66,864
130%	100%	\$20,748	\$28,132	\$35,516	\$42,900	\$50,284	\$57,668	\$65,052	\$72,436
140%	100%	\$22,344	\$30,296	\$38,248	\$46,200	\$54,152	\$62,104	\$70,056	\$78,008
150%	100%	\$23,940	\$32,460	\$40,980	\$49,500	\$58,020	\$66,540	\$75,060	\$83,580
160%	100%	\$25,536	\$34,624	\$43,712	\$52,800	\$61,888	\$70,976	\$80,064	\$89,152
170%	100%	\$27,132	\$36,788	\$46,444	\$56,100	\$65,756	\$75,412	\$85,068	\$94,724
180%	100%	\$28,728	\$38,952	\$49,176	\$59,400	\$69,624	\$79,848	\$90,072	\$100,296
190%	100%	\$30,324	\$41,116	\$51,908	\$62,700	\$73,492	\$84,284	\$95,076	\$105,868
200%	100%	\$31,920	\$43,280	\$54,640	\$66,000	\$77,360	\$88,720	\$100,080	\$111,440
210%	90%	\$33,516	\$45,444	\$57,372	\$69,300	\$81,228	\$93,156	\$105,084	\$117,012
220%	80%	\$35,112	\$47,608	\$60,104	\$72,600	\$85,096	\$97,592	\$110,088	\$122,584
230%	70%	\$36,708	\$49,772	\$62,836	\$75,900	\$88,964	\$102,028	\$115,092	\$128,156
240%	60%	\$38,304	\$51,936	\$65,568	\$79,200	\$92,832	\$106,464	\$120,096	\$133,728
250%	50%	\$39,900	\$54,100	\$68,300	\$82,500	\$96,700	\$110,900	\$125,100	\$139,300
260%	40%	\$41,496	\$56,264	\$71,032	\$85,800	\$100,568	\$115,336	\$130,104	\$144,872
270%	35%	\$43,092	\$58,428	\$73,764	\$89,100	\$104,436	\$119,772	\$135,108	\$150,444
280%	30%	\$44,688	\$60,592	\$76,496	\$92,400	\$108,304	\$124,208	\$140,112	\$156,016
290%	25%	\$46,284	\$62,756	\$79,228	\$95,700	\$112,172	\$128,644	\$145,116	\$161,588
300%	20%	\$47,880	\$64,920	\$81,960	\$99,000	\$116,040	\$133,080	\$150,120	\$167,160
320%	20%	\$51,072	\$69,248	\$87,424	\$105,600	\$123,776	\$141,952	\$160,128	\$178,304
340%	15%	\$54,264	\$73,576	\$92,888	\$112,200	\$131,512	\$150,824	\$170,136	\$189,448
360%	15%	\$57,456	\$77,904	\$98,352	\$118,800	\$139,248	\$159,696	\$180,144	\$200,592
380%	10%	\$60,648	\$82,232	\$103,816	\$125,400	\$146,984	\$168,568	\$190,152	\$211,736
400%	10%	\$63,840	\$86,560	\$109,280	\$132,000	\$154,720	\$177,440	\$200,160	\$222,880

*If more than 8 in household/family, add \$5,550 per additional person



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Attachment 2

FORT HEALTHCARE COMMUNITY CARE FINANCIAL QUESTIONNAIRE

To apply for Fort HealthCare’s Community Care program on outstanding balances for persons whose income is determined to be above 200% of the Community Services Administration poverty guidelines, the following information must be furnished. Financial information should include all income for applicant and spouse/co-guarantor. Please complete all areas using “None” where not applicable.

PERSONAL INFORMATION

Applicant’s Name: _____ Date of Birth: ____/____/____
Last First Middle Initial mm dd yyyy

Address: _____
Street City State Zip Code County

Home Telephone Number: (____) _____

Alternate Number: (____) _____

Spouse’s/Co-guarantor’s Name: _____ Date of Birth: ____/____/____
Last First Middle Initial mm dd yyyy

Address: _____
Street City State Zip Code County

Home Telephone Number: (____) _____

Alternate Number: (____) _____

EMPLOYMENT INFORMATION

Applicant’s Employer: _____

Address: _____
Street City State Zip Code

Occupation: _____ Length of Employment: _____

Spouse’s/Co-guarantor’s Employer: _____

Address: _____
Street City State Zip Code

Occupation: _____ Length of Employment: _____



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FORT HEALTHCARE COMMUNITY CARE FINANCIAL QUESTIONNAIRE (continued)

Did you or will you file a tax return for last year? Yes No
 Are you listed as a dependent on someone's tax forms? Yes No

DEPENDENT CHILDREN LIVING IN YOUR HOUSEHOLD

Name: _____	Relationship _____	Date of Birth	<u>mm</u>	<u>dd</u>	<u>yyyy</u>
Name: _____	Relationship _____	Date of Birth	____/____/____		
Name: _____	Relationship _____	Date of Birth	____/____/____		
Name: _____	Relationship _____	Date of Birth	____/____/____		
Name: _____	Relationship _____	Date of Birth	____/____/____		

INCOME

Gross Monthly Income:

Applicant's Wages: \$ _____
 Spouse's Wages: \$ _____
 Social Security Income: \$ _____
 Survivor Benefits \$ _____

Pensions/Other Income:

Veteran Benefits: \$ _____
 Child Support/Maintenance \$ _____
 Pension/Retirement: \$ _____
 Other Income: \$ _____

Are there any adult member(s) of the household who are 18 years of age or older who contribute to the income of the household and incur expenses of the household? Yes No If Yes, how many? _____

Please Submit the Following Documents:

- Most Recent Federal and State Tax Return Denial from Medicaid 3 Most Recent Pay Stubs
- If receiving Social Security, please provide a copy of your bank statement showing the deposit, a recent benefit determination letter or a copy of your check from Social Security.
- If you have no income, please provide a letter of support from the person who is financially assisting you.
- Please include documentation showing proof of any monthly pension or retirement payments.

HEALTH INSURANCE INFORMATION

Do you currently have health insurance?

Yes : Health Insurance Company Name: _____
 No: Have you applied in the Marketplace? Yes: Effective Date: _____ No – if No, Please explain:

List any additional information pertinent to this application:

Preference for Fort HealthCare Monthly Installment Amount: \$ _____



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FORT HEALTHCARE COMMUNITY CARE
FINANCIAL QUESTIONNAIRE *(continued)*

I represent that this statement of my financial condition is true & complete and authorize Fort HealthCare or its agents, to verify the information obtained in this statement and obtain additional information concerning my financial condition and furnish the same to others. I understand that it is a federal crime punishable by fine or imprisonment or both to knowingly make any false statements concerning any of the following information as applicable under provisions of Title 18, United States code, Section 1014. I agree to notify Fort HealthCare in writing, of any changes that materially affects the accuracy of this statement. This statement is the property of Fort HealthCare.

Applicant's Signature

Date

Spouse's/Co-guarantor's Signature

Date