

Beloit Health System Beloit Health System Charity Care Benefit

Upon patient request, it is the policy of Beloit Health System to consider an Uncompensated Care adjustment if all other avenues have been exhausted and the patient shows there is no other means of making payment on the account. All uninsured patients shall be granted an automatic "Uninsured Patient Discount" equal to the Hospital's current average managed care contractual allowance. Uncompensated Care adjustments are granted at the discretion of Beloit Health System upon consideration of the following guidelines:

Uncompensated Care adjustments are available to eligible persons requiring medical treatment but who are unable to pay for hospital services. Eligibility for uncompensated care shall be extended to those persons whose family income does not exceed 150%*** of the current Community Services Administration poverty guidelines. Persons whose income is greater than the guidelines, but not more than 3 times*** the guidelines, shall be eligible for charity care on a reduced charge basis.

The following are excluded from consideration for charity care adjustments: Cosmetic procedures, hearing aids, sterilization procedures, reversals of sterilization procedures, bariatric procedures, Restor, Toric, and Crysta lens procedures, and most elective procedures. Other exclusions include: Services found to be unnecessary or disallowed by government or third party payers, accounts pending settlement from a liability claim, DME, and Home Health. Some elective cases may be considered upon attestation by the procedural physician that the condition being addressed is eminently life and/or limb threatening. This is subject to review by Utilization Review in consultation with the Department Chair and Vice President of Medical Affairs for approval.

All applications for Financial Assistance must be received within 180 days of the service date.

An Uncompensated Care adjustment shall be considered only after a review of the patient's accounts and a determination has been made that no third-party reimbursement is available. An Uncompensated Care Application may be completed in person with the assistance of a Credit Consultant, or it may be sent by mail accompanied by a letter of explanation from the Credit Consultant.

The Uncompensated Care Application shall be completed in full, including the patient's name, address, telephone number, occupation, employer, and names of spouse and legal dependents. (Legal dependents shall be identified as such based on whether or not they are claimed as dependents on the most recent income tax return.) Also included shall be the household income for the last three months as well as the last twelve months. The income reported must

include all wage earners in the household excluding minors. (Patients who are claimed as dependents on another individual's income tax return must report income of the other individual(s) as well as their own.) Verification of earnings must be proved by submitting any or all of the following: income tax returns, pay stubs, W-2 forms, unemployment compensation forms, or letters from employers. If the patient indicates that no income has been earned, a copy of a letter from the Social Services Department denying unemployment compensation may be requested. Also requested may be a copy of a letter verifying that Public Aid benefits have been denied. If the patient has not yet applied for Public Aid, he or she should be encouraged to do so. If the patient returns the application without sufficient proof of income, or if other information is missing or incomplete, he or she shall be contacted by the Hospital Credit Department to obtain the information. Approval may be denied for failure to complete an application.

Patients who are employed (or patients who are the spouse or dependent of an employed individual) must show proof that group health insurance benefits were not available from the employer. Patients who have chosen not to enroll in an available group health plan shall be denied Uncompensated Care benefits.

Upon review of the Uncompensated Care Application, the Credit Consultant shall request the completion of a financial questionnaire. The same income information outlined previously shall be included for the entire household. Expense information should also be documented, including copies of any bills, loans, leases, and mortgage payments available. Upon completion of the questionnaire, eligibility shall be determined by comparing total income and total expenses.

Upon completion of one or both of the above-mentioned applications or questionnaires, the Credit Consultant shall determine eligibility. All completed forms shall be submitted to the Patient Accounts Manager for approval. If the application receives partial approval, the amount owed by the patient shall be indicated in the appropriate location. Also indicated on the form shall be 100% approvals or denials. In cases of partial approvals or denials, the patient will be responsible for payment within 45 days from the date the form is returned to the patient. Thereafter, routine collection procedures shall be followed. If the patient is not able to make payment in full within 45 days, payment arrangements may be made in accordance with the Beloit Health System Payment Plan Policy/Procedure.