InterMedical HOSPITAL OF SC	**Charity Care Policy**
	Chapter: Administration — Release Date: March 2014

POLICY

It is the policy of InterMedical Hospital of SC, Inc. (the "IMH") to provide care to all patients regardless of ability to pay. The hospital shall allocate resources to identify charity cases and provide uncompensated care based upon the information submitted at the time of application for charity care by the patient or their representative or through the use of other criteria-based methods to determine charity eligibility.

This policy provides information about how IMH's charity care program is structured, how eligibility is determined and how the application process works. You'll find an application and instructions at the end of this policy.

Charity adjustments may be applied to approved accounts for uninsured patients based on the patient's total gross family income and the patient's willful cooperation in applying for Medicaid or other available coverage.

In order to ensure the funds for uncompensated care are not abused and will be available for those in need within the hospital's service area (county listing attached), IMH will make reasonable attempts to assist eligible candidates to become covered under any available assistance programs in the community.

IMH proactively makes reasonable efforts to determine whether a patient is eligible for financial assistance before engaging in any collection activities.

GOVERNANCE

The Charity Care Policy is administered by the Accounting Department with authority and approval from the IMH Board.

DEFINITIONS

Family Unit Size is defined as the applicant (patient, if applicable), spouse, and all legal dependants as allowed by the Federal Government. If patient/applicant is a minor, the family unit will include parent(s)/legal guardian(s) and all household dependents as allowed by the Federal Government.

Family Unit Income is defined as gross income for all members of the family unit for the last three months or the last calendar year, whichever is the lesser amount. Examples of income are retirement, veteran's administration, workers compensation, sick leave, disability compensation, welfare, social security retirement (SSI not included in income determination), alimony, child support, stock/certificate dividends, interest, or income from property.

Medically Indigent is defined as an uninsured person who is not eligible for other health insurance coverage such as Medicare, Medicaid, or other private insurance. Those that are "medically indigent" make too much to qualify for Medicaid but too little to purchase health insurance or health care.

Uninsured patients are defined as patients without third party insurance coverage for health services.

SCOPE/PROCEDURE

The calculation of the discount for uninsured patients qualified for a charity care adjustment will be based on our Medicare reimbursement rate. This discount will be updated annually when new Medicare rates are received.

Uninsured patients (i.e. those patients without third party coverage for health care services) qualify for a charity adjustment on a sliding scale as follows:

- Family income of 150% or less of the Federal Poverty Guidelines qualifies for a 100% charity adjustment, which means that their services are free.
- A family income between 151%-185% of the Federal Poverty Guidelines qualifies for an adjustment based on the Medicare reimbursement rate plus an additional 40%.
- A family income between 186%-235% of the Federal Poverty Guidelines qualifies for an adjustment equivalent to the hospital's Medicare reimbursement rate plus an additional 20%.
- A family income between 236%-300% of the Federal Poverty Guidelines qualifies for an adjustment equivalent to the hospital's Medicare reimbursement rate.

  Example of the calculation: If a patient's gross charges for services are $1,000, the charges will be discounted to the Medicare reimbursement ($1,000*26.22%=$262.20). The patient with an income of 236%-300% of the Federal Poverty Guidelines would be responsible for $262.20.

The calculation of the discount for insured patients qualified for a charity care adjustment will be based on the Federal Poverty Guidelines for indigent and charity classification. This discount will be updated annually based on any changes to the Federal Poverty Guidelines.

The insured patients (i.e. those patients with third party coverage for health service but family income is 200% or less of the Federal Poverty Guidelines) qualify for a charity adjustment on a sliding scale as follows:

- Family income of 125% or less of the Federal Guidelines qualifies for a 100% charity adjustment, which means that their patient liability will be zero.
- A family income between 126%-175% of the Federal Poverty Guidelines qualifies for an 80% adjustment of their patient liability.
- A family between 176%-200% of the Federal Poverty Guidelines for a 70% adjustment of their patient liability.

Example of the calculation: If a patient's gross charges for services are $1,000, the insurance company pays $500, and the contractual adjustment is $200, the patient liability is $300. The patient with an income of 175% of the Federal Poverty Guidelines would be responsible for $60 ($300*20% = $60), the patient liability with an 80% discount.

CATASTROPHIC PROVISION

Insured patients or uninsured patients who are not eligible for charity and the patient's responsibility exceeds 25% of the annual gross family income may qualify for a catastrophic charity adjustment of up to 75% of the patient's account.

ELIGIBILITY CRITERIA:

1. Charity care is secondary to all other financial resources available to the patient. Insured Patients are eligible for charity if their family income is 200% or less of the Federal Poverty Guidelines and they meet all other criteria. Patients who are insured and their family income is more than 200% of the Federal Poverty Guidelines are ineligible for the charity program but will be considered under the catastrophic provision should the remaining balance for which they are responsible exceed 25% of the family's annual gross income.
2. Determination of eligibility of a patient for charity care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status, or marital status.
3. Patient care that is cosmetic, experimental, or deemed to be non-reimbursable by traditional insurance carriers and governmental payors shall not be considered eligible for charity care under the Charity Care Program. The hospital will make an effort to notify the patient in advance of the lack of eligibility of such care under the Charity Care Program.
    a. Charity care will be provided to uninsured patients when net available assets are not sufficient and gross family income is between 0 and 300 percent of the Federal Poverty Guidelines adjusted for family size.

b. Charity care will be provided to insured patients when net available assets are not sufficient and gross family income is between 0 and 200 percent of the Federal Poverty Guidelines adjusted for family size.

4. The financial obligations that remain once the charity payment has been applied must be satisfied according to the Self Pay Payment Plan Guideline attached.
5. A patient who does not qualify for charity care, but whose patient responsibility incurred for medical care at IMH, even after payment by third-party payers, significantly exceeds the patient's ability to pay the balance in full (25% or more of the patient's gross income, considering all assets and resources) may be considered for a catastrophic charity adjustment.

ELIGIBILITY DETERMINATION

1. Charity eligibility can be determined once a completed application has been received along with **ALL** supporting documentation or through other criteria-based methods to determine charity eligibility. Should documentation not be applied or should the application remain incomplete, charity will **NOT** be granted. In these instances, the account(s) will be noted as uncooperative and will be subject to the normal account flow process of self pay collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys as appropriate.
2. Patient should provide proof of residency. Listed below are examples of acceptable proof of residence:
    a. County property tax assessment statement.
    b. Utility bill showing current county address.
    c. Rent receipt(s) showing evidence of county of resident.
    d. County food stamp letter.
    e. Voter registration cared.
    f. South Carolina driver's license.
    g. Senior Citizen picture I.D. with local residence address.
3. Cases for consideration may be requested by the patient, the patient's family, the patient's physician, hospital personnel who have been made aware of the financial need of the patient, or recognized social agencies.

4. In instances where charity eligibility has been determined through the use of other criteria-based methods, a member of the Case Management/Billing team will follow up with the patient directly to assist the patient in providing the paperwork required for charity approval.
5. Following the initial request for charity care, the hospital will pursue other sources of funding, including Medicaid and/or state programs. If a patient refuses to pursue any other source of funding, the patient will be ineligible for the Charity Care Program. All outstanding accounts will be notated as uncooperative and will be subject to the normal account flow process of self collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys if appropriate.
6. Forms and instructions will be furnished to the responsible party when charity care is requested, when need is indicated, or when financial screening indicates potential needs. Refusal to complete the forms will result in denial of charity care and will subject the account to the normal escalation process including self pay collection statements and outsourcing to bad debt collection agencies as well as debt collection attorneys.
7. The responsible party will be given fifteen (15) business days or a reasonable time as required the person's medical condition to complete the required forms and furnish proof of income and assets.
8. Designations of charity care, while generally determined at the time of application, may occur at any time prior to judgment upon learning of facts that would indicate financial need. If a responsible party pays a portion or all of the charges related to medical care and is subsequently found to have met the charity care criteria at the time of application, the amount that will be eligible for charity care will be the balance due on the patient's account at the time of reapplication.
9. Approval for charity is granted for periods of six (6) months. If it has been longer than 6 months since an application and financial documentation have been supplied to IMH, a new application and required documentation must be provided for reconsideration of charity care.
10. If the patient/responsible party's financial situation changes after charity has been approved and awarded, IMH reserves the right to reverse their decision at the discretion

of the Accounting Manager in accordance with the President/CEO. Examples include but are not limited to payouts from court settlement, lottery, etc.

APPLICATION PROCESS

1. All patients desiring consideration under the IMH program must apply for assistance in writing disclosing financial information that is considered pertinent to the determination of the patient's eligibility for charity care. Persons requesting assistance will be given a Charity Care Application Form. The patient will authorize the hospital to make inquiries of employers, banks, credit bureaus, and other institutions for the purpose of verifying statements made by the patient in applying for assistance.
2. When returned, the financial statement shall be accompanied by one or more of the following types of documentation as needed for purposes of verifying income:
    a. Payroll check stubs for the last three months.
    b. IRS tax return forms from the most recently completed calendar year.
    c. Forms denying unemployment or worker's compensation benefits.
    d. Income shall be annualized, when appropriate, based upon documentation provided and upon verbal information provided by the patient. This process will take into consideration seasonal employment and temporary increases and/or decreases of income.
3. All applicants supporting documentation, and communications will be treated with proper regard for patient confidentiality, IMH will exercise reasonable care to maintain supporting documents with the application form.
4. Additional information may be requested to complete the application.

PUBLIC RELATIONS

IMH will make concerted efforts to promote the Charity Care Program. The program is promoted through educational material provided directly to all patients upon admission and on the hospital web site. In addition, information regarding the Charity Care Program is provided on a periodic basis to physician offices, human service agencies, and other community organizations.

NOTIFICATION

1. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care.
2. Signage indicating the hospital's participation in charity care shall be conspicuously posted in public areas of the hospital and on the hospital web site.
3. The hospital will make reasonable efforts to notify the patient of the final determination within fifteen (15) working days of receipt of financial statement with related documented materials (proof of income, etc.). The notification will include a determination of the amount for which the responsible party will be financially accountable. Denials will be written and include instructions for reconsideration.

APPEALS PROCESS

The responsible party may request reconsideration of eligibility for charity care by providing additional verification of income or family size to the Accounting Manager within thirty (30) calendar days of receipt of notification. Accounting Manager or President/CEO will review all requests for reconsideration and will make the final determination. If the determination affirms the previous denial of care, written notification will be sent to the patient/guarantor.

NON-PAYMENT PROCESS

In the event of non-payment by a patient for their portion of their account, the hospital or its representative will send three collection letters before sending the account to a collection agency. The collection agency will continue collection activities, which may include reporting to the credit bureau and the use of bad debt collection attorneys when appropriate.