

Financial Assistance and Non-Discrimination Policy

- I. Policy: Uninsured and Underinsured Individuals receiving medically necessary care and exhibit financial need according to the Federal Poverty Guideline are eligible to receive financial assistance.
The Guidance Center (TGC) does not discriminate in the provision of health care services to an individual because the individual is unable to pay for services, the payment will be made under Medicare or Medicaid, or based upon the individual's race, color, gender, age, national origin, disability, religion, gender identity, or sexual orientation.
- II. Purpose: The Financial Assistance Program policy, in accordance with federal and state regulatory guidelines, ensures financial assistance is available for Individuals unable to meet their financial obligations based upon their care need.
 - a. Definitions:
 - i. Amounts generally billed (AGB): For each hospital, the AGB Percentage is a percentage derived by dividing the sum of all claims for Medically Necessary services provided at such Hospital paid during the Relevant Period by all private health insurers as primary payors, together with any associated portions of these claims paid by insured individuals in the form of co-pays, co-insurance or deductibles. The AGB Percentage is calculated by January 31 and is effective until the next annual calculation. The calculation shall comply with the "look-back method" described in Treasury Regulation §1-501(r)-5(b) (1) (B).
 - ii. Bad Debt: A balance no longer deemed collectable.
 - iii. Elective: Service deemed by a physician to be non-emergent and safe for delay.
 - iv. Federal Poverty Level (FPL) : The minimum amount of gross income required to sustain a family as determined by the United States Department of health and Human Services.
 - v. Medically Necessary Services: Medical care required to ensure the well-being of the patient as defined by generally accepted medical practice. TGC's Flat Rate: TGC's provides flat rate self-pay fees for specific services to uninsured Individuals.
 - vi. Family size and income: The total number of individuals in the household who are financially supported by the patient and the total gross household income of all such members, including wages, salaries, self-employment earnings, unemployment benefits, Social Security income, pension benefits, child support, alimony, and other sources of income, with eligibility determined solely in accordance with the Federal Poverty Level (FPL) guidelines.
- III. Eligibility: To be eligible for consideration, an applicant must be an uninsured or underinsured patient receiving medically necessary care and exhibit financial need in accordance to the Federal Poverty Guideline (FPL) are eligible to receive financial assistance.
 - a. To be eligible for consideration, an applicant must earn:
 - i. Less than 200% of the FPL.
 - b. TGC's flat rate fees and co-pays are not eligible for consideration.
 - c. Eligible balances will be adjusted according to the FPL calculation based upon household number and income. In the event that the patient receives a tiered discount under this policy, the patient will not be billed more than the amounts generally billed for care, calculated using the Amounts Generally Billed method as described in applicable IRS regulations.
 - i.

- d. This policy is communicated via the following:
 - i. TGC's website;
 - ii. The guarantor billing statement;
 - iii. Available throughout the covered facilities and upon request without charge via mail;
 - iv. Customer Service team members.

Procedures:

1. Charges for all emergency or other medically necessary services provided by entities covered by this policy are eligible for financial assistance consideration, excluding elective care. Care provided by physicians not employed by The Guidance Center are not eligible for financial assistance consideration under this policy.
2. Encounters for which a third party is liable for care are not eligible for consideration. If the third party does not accept liability for the cost of the services, the applicant may reapply.
3. The Financial Assistance Applications are not processed if received after the 240th day after the first bill to the individual for the most recent episode of care. If an application is received within that time but after the encounter has been sent to bad debt, the account will be recalled to the hospital to review and act on the application in accordance with this policy.
4. Financial Clearance (FC) can be done prospectively, concurrently, and retrospectively.
 - a. Prospective and Concurrent Review:
 - i. Individuals are reviewed for the ability to pay by Patient Access Services (PAS) after confirmation from clinical staff that the patient has received an appropriate medical screening examination by a qualified medical professional, and either
 - o no emergency medical condition exists or;
 - o if an emergency medical condition exists, such condition has been stabilized as defined by the Emergency Medical Treatment and Active Labor Act. The hospital will not delay or deny emergency medical care to an individual on the condition that an individual submit information to determine whether the individual qualifies for third-party coverage or financial assistance for the care being delayed or denied.
 - ii. The financial clearance process will be performed in accordance with the procedural requirements outlined in the job aids indicated in the reference section of this policy.
 - b. Retrospectively, the Revenue Cycle staff review requests for assistance submitted post discharge.
 - c. If the patient is unable to meet his or her financial obligation for care, the FC reviews the patient for eligibility for Arizona Medicaid (AHCCCS).
 - i. If the proof of income indicates it is in excess of the limits for AHCCCS eligibility, the financial assistance process may continue without completing the AHCCCS application.
 - ii. If the patient has AHCCCS or other insurance coverage, the financial class is changed on the encounter and financial clearance is concluded.

the missing documentation or make arrangements to pay the bill within the later to occur of (i) 30 days from the date of notice or (ii) 120 days after the first bill to the individual for the most recent episode of care.

- Patient/Guarantor has 30 days to provide missing information or documentation;
 - Failure to respond to missing information or documentation request within 30 days may result in denial.
- vi. Under no circumstances will a determination that an individual is not eligible for assistance under this policy be based on information that there is reason to believe is unreliable, incorrect or obtained from the individual under duress.
 - vii. The patient/guarantor is notified of approval or denial of application in writing:
 - o Financial Assistance less than 100% requires an established payment plan to remain in good standing;
 - o Assistance is applicable to all current outstanding balances excluding elective cosmetic procedures for 6 month postdate of approval;
 - o The patient/guarantor is responsible to notify the Central Business Office of new balances eligible for approved financial assistance adjustment.
- e. Presumed Financial Assistance
- i. Eligibility:
 - o If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance;
 - o Patient had AHCCCS coverage the month preceding and the month post services;
 - o Patient's services are covered under a grant that has exhausted funding;
 - o Patient is incarcerated and the care is not the financial responsibility of the local, state, or federal institution;
 - o Patient provides an invalid social security number;
 - o AHCCCS covered Individuals who exceed maximum allowable days;
 - o Deceased;
 - o Bankruptcy.
 - ii. Presumed Financial Assistance is by encounter only and cannot be used for future balances.
- f. Exception/Financial Assistance Committee:
- i. Individuals/Guarantors requesting exceptions can appeal an outcome by escalation to the Financial Assistance Committee.
 - ii. The Financial Assistance Committee is comprised of the Executive Director of Revenue Cycle, Controller, Director of

Patient Financial Services, and Clinical Department Director for the affected areas of care.

- iii. Committee findings are documented and mailed to the patient/guarantor.
- iv. Remaining balances after committee findings require an established payment plan to remain in good standing.

	Poverty Level	0-100%		101-125%		126 - 150%		151-175%		176 - 200%	
	Percent Discount	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
	Family Size	Minimum Fee		20% Pay		40% Pay		60% Pay		80% Pay	
INCOME	1 person	\$0	through \$15,960	\$15,961	through \$19,950	\$19,951	through \$23,940	\$23,941	through \$27,930	\$27,931	through \$31,920
	2 people	\$0	through \$21,640	\$21,641	through \$27,050	\$27,051	through \$32,460	\$32,461	through \$37,870	\$37,871	through \$43,280
	3 people	\$0	through \$27,320	\$27,321	through \$34,150	\$34,151	through \$40,980	\$40,981	through \$47,810	\$47,811	through \$54,640
	4 people	\$0	through \$33,000	\$33,001	through \$41,250	\$41,251	through \$49,500	\$49,501	through \$57,750	\$57,751	through \$66,000
	5 people	\$0	through \$38,680	\$38,681	through \$48,350	\$48,351	through \$58,020	\$58,021	through \$67,690	\$67,691	through \$77,360
	6 people	\$0	through \$44,360	\$44,361	through \$55,450	\$55,451	through \$66,540	\$66,541	through \$77,630	\$77,631	through \$88,720
	7 people	\$0	through \$50,040	\$50,041	through \$62,550	\$62,551	through \$75,060	\$75,061	through \$87,570	\$87,571	through \$100,080
	8 people	\$0	through \$55,720	\$55,721	through \$69,650	\$69,651	through \$83,580	\$83,581	through \$97,510	\$97,511	through \$111,440
	Add this amount for each additional family member										
											\$5,680

5. Re-determination: The sliding fee will be offered for one year or until such time that the applicant's financial situation changes. It is the applicant's responsibility to report all changes of financial situations promptly.