TITLE: Financial Assistance and Charitable Care	
POLICY NUMBER: FIN-302	**REPLACES:** 14-006-1192 14-011-0695 14-011-0503 14-011-0912 14-011-0220 14-011-0821 GOV-FIN-302
ORIGINAL EFFECTIVE DATE: 05/30/2003	**VERSION EFFECTIVE DATE:** 02/21/2025
SCOPE: Rogers Behavioral Health System, Inc., Rogers Memorial Hospital, Inc., and all subsidiaries and affiliates of both corporations. Policy terms may vary for employees governed under a collective bargaining agreement.	**AUTHOR(S)/REVIEWER(S):** Vice President of Revenue Cycle, Executive VP of Foundation, Legal Services, Compliance **APPROVER(S):** Chief Financial Officer

PURPOSE/SUMMARY:

Rogers' policy is to provide emergency behavioral health care to stabilize patients, regardless of their ability to pay. Rogers' staff are prohibited from engaging in actions that discourage individuals from seeking emergency medical care, such as demanding that emergency patients pay before receiving treatment or permitting debt collection activities in areas of the facility where such activities could interfere with the provision, without discrimination, of emergency medical care.

DEFINITIONS:

Bad Debt: The financial liability incurred by persons who are able but unwilling to pay all or some portion of the medical bills for which they are responsible.

Emergency Care: Care provided to stabilize a medical condition where the patient presents an imminent threat to themselves or others.

Federal Poverty Guidelines (FPG): One measure of poverty within the United States; also referred to as "federal poverty level (FPL)." The FPG are released annually by the U.S. Department of Health and Human Services (HHS) and are used to determine financial eligibility for federal programs and benefits.

Financial Assistance: The cost of providing free or discounted care to individuals who cannot afford to pay, and for which Rogers ultimately does not expect payment; also referred to as "charity care."

Guarantor: An individual or any other entity that agrees to be or is legally responsible for payment to Rogers for services provided to a patient.

Medically Necessary Care: Services or supplies that are determined by Rogers to be consistent with the illness or condition of the patient and the most appropriate supply or level of service that can safely be provided.

Presumptive Eligibility Determinations: Rogers may use previous eligibility determinations and/or information from sources other than the individual, including approval in state/federal income-based programs (i.e. Medicaid), to determine eligibility for financial assistance.

POLICY:

Rogers Behavioral Health System, Inc. (collectively with all of its affiliates and subsidiaries, "Rogers") is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, or are otherwise unable to pay for medically necessary care based on their individual financial situation. Rogers will provide, without discrimination, care for emergency behavioral health conditions to individuals regardless of their eligibility for financial assistance or on the basis of race, color, creed, national origin, religion, sex, sexual orientation, disability, source of income, marital status, military service, or any other classification protected by federal, state or local laws.

This policy applies to all emergency and medically necessary care provided by all Rogers' hospitals and clinics and includes all technical and professional charges.

ELIGIBILITY

Eligibility criteria for financial assistance are:

A. Services are emergent and/or medically necessary and provided by Rogers;
B. The patient/guarantor is an established Rogers patient and has had a permanent residence in the United States of America for at least one year;
C. The patient/guarantor has not opted out of using insurance to pay for treatment and has complied with all coordination of benefit (COB) requirements;

D. The patient/guarantor is uninsured, the care provided is not covered by insurance plan, or the patient has a high deductible or coinsurance balance and there would be a financial hardship to pay the full out-of-pocket expenses; and,
E. The patient's/guarantor's annual household income is 0% - 300% of the Federal Poverty Guidelines.

Financial Assistance for individuals and families will be calculated as a percentage of total eligible charges according to the following schedule:

Percentage of Federal Poverty Guidelines	Percentage of Financial Assistance
0-200%	100%
201-250%	50%
251-300%	25%

Eligibility is contingent upon patient cooperation with the application process including written permission for Rogers to check consumer credit information.

All Rogers hospitals will keep records of the number of patients receiving financial assistance and the amount of money provided as financial assistance and will comply with all related reporting and/or filing requirements set forth in law, including without limitation the annual filing of an Uncompensated Health Care Service Plan as required by Wisconsin law.

LIMITATIONS
Rogers locations reserve the right to reverse financial assistance adjustments and pursue appropriate reimbursement or collections. This may occur as a result of a variety of reasons including, but not limited to, newly discovered information such as insurance coverage or pursuit of a personal injury claim related to the services in question.

Rogers' financial assistance does not include all costs that may be associated with behavioral health services. Items or services that may not be included in the financial assistance program include, but are not limited to, transportation, lodging, prescriptions, food, medical equipment, ancillary testing, and pharmacy supplies.

Applications must be received within 240 days of the first patient statement and may need to be renewed for each admission or every 240 days. This is a balance-forgiveness program and does not apply to prior payments.

Residential, Inpatient, Partial Hospitalization, and Intensive Outpatient Services
Applications may be submitted any time after admission but can only be processed after the patient is discharged, all insurance companies or other payors have completed processing of the claim, all payments or denials have been posted to the account, and the patient/guarantor has a balance.

Routine Outpatient and Recurring Services
Applications may be submitted prospectively for up to twelve months after the date of approval and will need to be resubmitted annually. Uninsured patients eligible for Medicaid must apply to receive financial assistance unless exempted from social security and Medicare taxes as documented on IRS Form 4029 or alternative documentation.

PROCEDURES:
Patients/guarantors may qualify for financial assistance by meeting presumptive eligibility requirements or by submitting a completed financial assistance application. Patients/guarantors can obtain a financial assistance application at no charge electronically at rogersbh.org, in person at any Rogers location, or by mail by contacting Patient Financial Services at 262-303-2180.

Patients/guarantors that want to submit an application or dispute presumptive eligibility requirements must complete and return the application, along with the following documents to process the application:

- Proof of household income (pay stubs for the past 90 days);
- A copy of the three most recent bank statements from all banking institutions of the household;

- A copy of the two most recent tax returns, including all schedules of patient, spouse, or any person who claims the patient as a tax dependent or an IRS Verification of Non-filing letter;
- Verification of loss of income, if applicable; and
- Full disclosure of claims and/or income from personal injury and/or accident-related claims.

A patient's/guarantor's application will be reviewed by a Patient Financial Services representative after receiving a complete financial assistance request or application and all required documentation. Rogers reserves the right to request additional documentation identified in the FAP application before finalizing a request for assistance. Rogers will notify the patient/guarantor about the decision within a reasonable time after a complete request or application has been submitted.

Rogers reserves the right to refer to or rely on external sources and/or other program enrollment resources to satisfy documentation requirements for patients/guarantors. Rogers also uses Experian Health Financial Assistance Screening to systematically identify patients who may be eligible for financial assistance under this policy and reduce administrative burdens.

Patients eligible for financial assistance under this Policy will not be charged individually more than the amount generally billed to individuals who have insurance covering such care (the "AGB") for emergency and medically necessary services. Rogers calculates AGB rates using the "look-back method." This rate is calculated annually by dividing the sum of the amounts of all claims that have been allowed by Medicare Fee-For-Service and all private health insurers that paid claims to Rogers in the previous 12-month period by the number of paid claims for each geographic service location. Uninsured patients not eligible for financial assistance under this policy may be offered a self-pay discount.

Rogers may deny a request for financial assistance for a variety of reasons including, but not limited to, sufficient income, sufficient asset level, patient/guarantor is uncooperative or unresponsive to requests for information despite reasonable efforts to work with the patient to obtain information. An applicant who is denied financial assistance may make a request for an appeal by submitting written notification to the Chief Financial Officer or designee within twenty (20) calendar days and state why he/she disagrees with the reason given for ineligibility.

Rogers will not engage in extraordinary collection actions (ECAs) before it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this policy. Once reasonable efforts have been exhausted, ECAs taken by Rogers or a third-party agency against a patient related to obtaining payment of a bill may include reporting unpaid accounts to consumer credit reporting agencies or credit bureaus, filing judicial or legal action, commencing a civil action against a patient, garnishing of wages, or obtaining judgment liens and executing upon such judgement liens using lawful means of collection. Rogers may begin ECAs at least 120 days after providing the first post-discharge billing statement to a patient. In addition, Rogers will provide the patient with a final written notice indicating the availability of financial assistance, listing potential ECAs that may be taken to obtain payment for care, and giving a deadline after which ECAs may be initiated. Patient Financial Services will be responsible for ensuring that Rogers has made reasonable efforts to determine FAP eligibility before engaging in ECAs. Financial assistance is not to be used as a substitute for bad debt. Only those patients who meet the criteria are eligible for financial assistance relief. Those patients who do not meet the criteria and refuse to cooperate with collection efforts will be pursued to whatever extent deemed necessary for collection and if Patient Financial Services defines as still uncollectible, will be written off to bad debt and referred to a collection agency.

If a collection agency identifies a patient as meeting Rogers's financial assistance eligibility criteria, the patient's account may be considered for financial assistance. Collection activity will be suspended on these accounts and Rogers will review the financial assistance application. If the entire account balance is adjusted, the account will be returned to Rogers. If a partial adjustment occurs, the patient fails to cooperate with the financial assistance process, or if the patient is not eligible for financial assistance, collection activity will resume.

PUBLIC NOTICE

Rogers takes reasonable efforts to fully inform all patients and the public in the communities that the individual Rogers-affiliated sites serve by posting signs in the reception, admission and check-in areas of the Rogers' hospitals and clinics. Written information about Rogers' financial assistance and charitable care policy shall also be made available to patients at admitting or check-in and any time upon request. Rogers will make a copy of this policy, a plain language summary, and the application available by posting it on the website, including the ability to download a copy of the policy, free of charge.

All information regarding a patient's financial assistance application will be kept confidential. Rogers may share patient financial assistance information across our locations for the benefit and ease of administering financial assistance to patients seen at multiple sites. No information will be shared outside of Rogers unless authorized or required by law.

RESPONSIBILITIES:
The Patient Financial Services (PFS) Department is responsible for administering the financial assistance program with oversight by the vice president of revenue cycle.

REFERENCES:
26 CFR § 1.501(r)-4 - Financial assistance policy and emergency medical care policy.

RELATED DOCUMENTS:
Plain Language Summary
Financial Assistance Application