



TITLE: FINANCIAL ASSISTANCE

REPLACES:

EFFECTIVE DATE: 02/2018

I. **PURPOSE:** OU Health provides financial assistance for qualifying patients who receive emergency or other medically necessary care from OU Health. Medically necessary emergency care will not be delayed or withheld based on the patient's ability to pay. OU Health is committed to providing health services and understands that in some cases the patient will not be able to pay for the services received.

II. **DEFINITIONS:**

- a. "Ability to Pay Score" means a score will be provided through a product designed to identify patients that have limited or no ability to pay for services performed.
- b. "Amounts Generally Billed" (AGB) means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. AGB percentage means a percentage of gross charges that a hospital uses to determine the AGB for any emergency or other medically necessary care it provides to an FAP eligible individual.
- c. "Application Period" means the time period in which an individual may apply for financial assistance. The Application Period ends on the 240th day after OU Health mails or electronically provides the individual with the first billing statement for the care, but may be extended by OU Health upon extraordinary circumstances.
- d. "Elective Services" means services or procedures that are non-emergent and non-medically necessary.
- e. "Extraordinary Collection Action (ECA)" is defined in the OU Health Billing and Collection Policy.
- f. "Federal Poverty Guidelines" are determined by the Department of Health and Human Services and published in the Federal Register.
- g. "Medically Necessary Care" means healthcare services or supplies which meet all of the following requirements: (i) ordered by a physician and appropriate and necessary for the symptoms, diagnosis, or treatment of the medical or mental health condition; (ii) provided for the diagnosis or direct care and treatment of the medical or mental health condition; (iii) meet the standards of good medical practice within the medical and mental health community in the service area; (iv) not primarily for the convenience of the patient or a provider; and (v) the most appropriate level or supply of service that can safely be provided.
- h. "Underinsured" means insured patients whose out-of-pocket medical costs would pose a financial burden to the patient due to deductibles, out-of-pocket maximum requirements, limited benefit plans, or non-contracted insurance plans.

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- III. POLICY:** As part of its mission, OU Health has developed a fair and consistent process for the review and completion of requests for financial assistance for patients of OU Health in need of financial assistance. Generally, eligibility for financial assistance is determined by comparing the patient's total household income to the Federal Poverty Guidelines as established by the Department of Health and Human Services on an annual basis. This Policy also serves to meet the requirements set forth in state and federal laws, including Internal Revenue Code section 501(r). This policy will supersede all other Financial Assistance Policies.

OU Health shall determine eligibility for financial assistance based on an individual determination of financial need in accordance with this Policy, and shall not take into account a patient's age, gender, race, immigrant status, sexual orientation, religious affiliation, or whether or not the patient has health coverage.

In accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, OU Health is prohibited from engaging in any actions that discourage individuals from seeking emergency medical care, such as demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, of emergency medical care without discrimination.

IV. ELIGIBILITY CRITERIA:

All patients will be eligible to apply for financial assistance during the Application Period. Financial assistance is only available for emergency or other medically necessary services and does not cover Elective Services. This Policy covers services billed through OU Health at its facilities. Not all services provided within OU Medicine are provided by OU Health employees and therefore may not be covered by this Policy. Professional services rendered by non-employed physicians, which includes but is not limited to physicians in the emergency room, pathology, radiology, and anesthesiology, are not covered by this policy. These professionals will bill separately for these professional services. Physicians employed by OU Health are covered under this Policy. A full list of covered and non-covered providers can be found in Appendix "A" of this Policy. This list is available online at www.oumedicine.com.

OU Health will take into account each patient's income level, family size, assets, or other resources available to the patient or patient's family and amount of hospital charges when determining eligibility for financial assistance. This method allows for a fair and accurate way to assist patients who may need financial assistance. Full financial assistance will be granted based on the individual's ability to pay. Eligible individuals include patients who do not have insurance and patients who have insurance but are underinsured.

OU Health uses a financial assistance eligibility guideline that is based on the Amounts Generally Billed and the published Federal Poverty Guidelines for the current calendar year. Financial assistance eligibility guidelines will be maintained at OU Medical Center, 1200 Everett Drive, Oklahoma City, OK 73104. Financial assistance guidelines will be updated annually in accordance with the Federal Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

V. MEASURES TO PUBLICIZE THE FINANCIAL ASSISTANCE PROCESS:

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Copies of the Financial Assistance Policy, the Plain Language Summary, and the Financial Assistance Application will be widely publicized and can be obtained in the following manner:

1. **Online** at the OU Medicine website, www.ouhealth.com.
2. **By telephone** at OU Health Customer Service, 1-888-472-0040.
3. **By mail** at OU Health Customer Service, PO Box 269070, Oklahoma City, OK 73126
4. **On posted signs, paper copies, and brochures** located in the emergency departments, admitting areas, and business offices of all OU Health facilities, in languages that are appropriate for the hospital's service area.
5. **In person** through financial counselor visits, as necessary, with patients at OU Health facilities, at registration desks, and discussions by designated staff, when appropriate.
6. **In billing statements**, a phone number for inquiries about financial assistance will be included.

VI. METHOD FOR APPLYING OR OBTAINING FINANCIAL ASSISTANCE:

1. A determination of whether a patient qualifies for financial assistance may be initiated by the patient, an OU Health representative, an external agency, or an interested party on behalf of the patient. A patient will be considered a financial assistance patient at the time sufficient information has been obtained to verify the patient's inability to pay for needed medical services. Patients identified as possible financial assistance cases will be offered the financial assistance packet. This packet includes a copy of the Financial Assistance Policy and associated Plain Language Summary, Billing and Collection Policy, and Financial Assistance Application. They will also be provided information on filling out the paperwork, additional documentation needed, and the required submission process.
2. Any patient who wishes to be considered for financial assistance must fully cooperate and comply with eligibility requirements for any federal and/or state program for which they may be qualified.
3. Outstanding balances that are owed by a patient as a result of a deductible, coinsurance, or where the insurance benefits have been exhausted may qualify for financial assistance support if the patient meets the eligibility requirements. Patients with insurance must cooperate with any insurance claim submission and exhaust their insurance or potential insurance coverage before becoming eligible for financial assistance.
4. In order to be evaluated for financial assistance, it is the responsibility of the patient to complete an OU Health Financial Assistance Application and provide supporting documents. The completed application must be submitted to OU Health Customer Service Center, Patient Account Service, ATTN: Research and Correspondence Dept. PO Box 269070, Oklahoma City, OK 73126.

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Documentation may include:

- a) Federal/state tax return from the most recent calendar year, which includes adjusted gross income, and/or supporting W-2s or 1099s.
- b) Employer pay stubs.
- c) Written documentation from income sources.
- d) Copies of all bank statements for the past three months.

Failure to provide these documents may result in a denial of financial assistance. If the patient is unable to provide the requested documentation, the patient will be required to provide a detailed explanation as to why.

- 5. Patients may also be screened through a third party vendor for financial assistance eligibility. Additionally, patients may qualify for financial assistance based on an Ability to Pay Score when the patient is unable to fully complete the application or provide some or all the necessary supporting documentation.
- 6. All patients must be individually approved for financial assistance even if another family member was previously approved.
- 7. The process of application review, approval or denial, and patient notification of decision should not take more than thirty (30) days from the date that the completed application is received with all supporting documentation, or the account is final billed whichever is later. An OU Health financial counselor, designated business office representative, or executive with the authority to offer financial assistance will review individual cases and make a determination of financial assistance that may be offered. All patients that request financial assistance will receive a letter stating if the patient was approved or denied for financial assistance. The letter will be mailed using the best available contact information provided by the patient. Approval of financial assistance is valid for 12 months. However, the patient is required to notify OU Health of any subsequent changes in income or Federal Poverty Level during that time period.

OU Health retains the right to require any patient to reapply if new information pertaining to any change in their income level becomes available that may change the patient's eligibility for financial assistance.

- 8. In the event a completed Financial Assistance Application is received during the Application Period, OU Health will suspend any Extraordinary Collection Actions (ECAs) while it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this Policy. In the event an incomplete Financial Assistance Application is received during the Application Period, ECAs will be suspended for no more than thirty (30) days while OU Health provides written notice to the patient that ECAs may be initiated or resume if the Financial Assistance Application is not completed. Collection activity will resume in the following situations: (i) a partial

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adjustment occurs, (ii) the patient fails to cooperate with the financial assistance process, or (iii) the patient is not eligible for financial assistance.

9. OU Health staff will uphold the confidentiality and individual dignity of each patient. All application information and supporting documentation will be maintained in accordance with the Health Information Portability and Accountability Act and the OU Health Records Retention Policy.

VII. BASIS FOR CALCULATING FINANCIAL ASSISTANCE:

1. Patients eligible for OU Health financial assistance will be charged less than full charges (gross charges). If meeting the requirements of this Policy, patients with income from all sources up to 200% of current Federal Poverty Guidelines will qualify for 100% discount of their Hospital service.
2. Catastrophic assistance may be available for patients who do not otherwise qualify under the Financial Assistance Policy if the patient has a balance due to OU Health that exceeds their ability to pay. Catastrophic assistance is defined as a patient that has medical or hospital bills after payments by all third parties that exceed 25% of the patient's total reported annual household income and the patient is unable to pay the remaining bill. To begin the financial assistance process, a Financial Assistance Application should be submitted.
3. Patients that qualify will not be charged more than Amounts Generally Billed (AGB) for emergency or medically necessary care. The Prospective Method based on Medicare rates will be used to determine AGB.

VIII. FINANCIAL ASSISTANCE DENIAL:

1. Financial assistance will be denied to the patient if the patient or responsible party is uncooperative, or unresponsive to reasonable efforts, to work with OU Health representatives, or if the patient or responsible party provides false information including information regarding their income, household size, assets, or other resources available that might show financial means to pay for care. Charges for services previously rendered will be billed to the responsible party.
2. If the patient receives a third party financial settlement associated with the care rendered by OU Medicine, the patient is expected to use the full amount of any settlement for current and future care until it is exhausted.
3. Financial assistance is not available to a patient who is a ward/custodial of a local, state or federal government agency as a result of conduct that is in violation of local, state, or federal laws.

IX. FINANCIAL ASSISTANCE OFFERED TO DUALY ELIGIBLE PATIENTS:

Medicare charity will be written off using the Medicare Bad Debt Policy and Procedures currently in place at OU Health.

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X. OVERSIGHT:

THE OU HEALTH BOARD OF DIRECTORS, OR ITS DESIGNEE, IS RESPONSIBLE FOR THE OVERSIGHT OF THIS POLICY. ANY MATERIAL CHANGES TO THE STANDARDS SET FORTH IN THE POLICY MUST BE APPROVED BY THE BOARD PRIOR TO IMPLEMENTATION BY OU MEDICINE.

ATTACHMENTS

Appendix A
Financial Assistance Application

REFERENCES

OUM Billing and Collection Policy, BIL.026

APPROVED BY:

OU Medicine Board of Trustees: October 31, 2017
OUM Board of Directors: 1/23/2018



Appendix A

Physicians/Medical Groups whose services ARE NOT covered under the OUM Financial Assistance Policy:

Excluded

EPMC	Emergency
Resolve	Emergency
HealthFirst	Hospitalist
OU Physicians	Tulsa Facilities

These physicians/medical groups may have their own financial assistance policies. Patients will need to contact the physician/medical group billing office directly to determine availability of financial assistance.



Dear Patient/Responsible Party,

We are providing this application because you may qualify for our ***Financial Assistance Program***.

The attached form only applies to bills of the hospital and its employed physicians. For a list of included physicians please review our Financial Assistance Policy, Appendix A. This form does not pertain to any other medical bills you may have, such as radiology, non-employed physicians, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application.

It is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer Pay Stubs
Written documentation from income sources
Copies of all bank statements for the past three months
Supporting W-2
Supporting 1099's

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

For any assistance in completing the application or to return the completed application in person please see one of our Financial Counselors at the below address

OU Medical Center
711 SL Young Blvd, Suite 100
Oklahoma City OK

OUMC Edmond
1 S Bryant
Edmond Ok 73034

Please allow thirty (30) business days for our review process. We will notify you of our charity determination by letter.

**Remember if you return this form your bill may be
included in our Financial Assistance Program.**

**Mail application and all required documents to:
Patient Account Services
Attn: Research and Correspondence Dept
PO Box 269070
Oklahoma City, OK 73126**



Financial Assistance Application

Name:		Account Number:
Address:		
City:	State:	Zip Code:
Phone:		SSN:

HOUSEHOLD INFORMATION: Please list all members of the household, including patient, spouse and any biological/legally adopted children under 18 years old.

First and Last Name	Relationship to Patient	Age/DOB	Total Gross Income in the 3 Months Prior to the Date of Service	Total Gross Income in the 12 Months Prior to the Date of Service
	Self			

If you have no income, how you are being supported?

Did you have health insurance on the date of service? ☐ No ☐ Yes (Provide card copy with application)

Does anyone in your household have a checking and or savings account? ☐ No ☐ Yes (Value _____)

Does anyone in your household have any other assets? ☐ No ☐ Yes (Type/Value: _____)

For **Income/Assets** listed above, you must provide the following for each member of the household:

- ☐ Employment = paystubs showing gross income for 3 or 12 months prior to the date of service
- ☐ Self Employment = Complete tax forms from most recent filing including Schedule C
- ☐ Social Security/Pension/Disability = Most recent benefit letter
- ☐ Other = Proof of any other income (unemployment benefits, dividends, interest, rental income, etc.)
- ☐ Checking/Savings = Current 30-day statement for each account

By signing this document:

I affirm all the answers on this application are true. Should a subsequent review reveal that any information provided was fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed.

I understand that the information I submit is subject to verification and review by federal and/or state agencies and others as required.

Patient Signature: _____ **Date:** _____

Mail Application and all required documents to:
Patient Account Services
PO Box 269070
Oklahoma City, OK 73126
For inquiries, call Customer Service 888-472-0040