FACILITY: Tower Health at Home		
MANUAL: Tower Health at Home		**FOLDER:** General
TITLE: Patient Financial Assistance		**DOCUMENT OWNER:** VP, Nursing & Operations
DOCUMENT ADMINISTRATOR: Sr. VP, Chief Nursing Officer		**KEYWORDS:**
ORIGINAL DATE: August 2019	**DATE OF REVIEW:** 7/2026	**REVISION DATE(S):** 10/2020, 10/2021, 1/2024, 4/2026, 7/2026

SCOPE:
Applies to Tower Health at Home

PURPOSE:
To ensure standard procedures are established and practiced throughout Tower Health at Home in reference to identifying and consistently assisting patients in need of financial assistance. Tower Health at Home is designated as a charitable organization under Internal Revenue Code (IRC) Section 501(c) (3). In compliance with IRC Section 501(r), it is required to establish and widely publicize the organization's financial assistance policy. The intention of the policy is to identify and serve patients in financial need, as well as to create an increased awareness of the availability of financial assistance throughout the Health System and community.

POLICY:
As part of Tower Health at Home's mission of providing compassionate, accessible, high-quality, cost-effective healthcare to the community, there is recognition that not all patients have an equal ability to pay for medical services. Tower Health at Home shall widely publicize the availability of financial assistance to the community through the agency website, brochures and engagement with community advocacy groups. Agency staff will educate patients and families in reference to available resources and will provide assistance with the financial assistance application and approval process to ensure all patients continue to have the opportunity to access the care they need.

DEFINITIONS:
A. Amounts Generally Billed (AGB): Section 501(r)(5)(A) requires the organization to limit amounts charged for medically necessary care provided to individuals eligible for assistance under the organization's FAP (FAP-eligible individuals) to not more than the amounts generally billed to individuals who have insurance covering such care. AGB is calculated using the prospective method based on Medicare fee for service rates.

B. Federal Poverty Guidelines (FPL): These guidelines are published annually in the Federal register and are utilized to determine a baseline for the poverty level. The Department of Health and Human Services publishes this statistical information.

C. Financial Assistance: Healthcare provided to patients without the expectation of payment for services, in whole or in part, as determined by a patient's financial inability to pay.

D. Guarantor: The individual who is legally and financially responsible for payment of a patient's bill.

E. High Dollar Services: For purposes of this policy, high dollar services are defined but not limited to services being generated by high-cost departments, such as hospice and therapy services.

F. Household Composition: Determined by the tax household size. Household size includes Patient/Spouse and any biological or adopted children under the age of 18 years old.

G. Household Income: Income of those residing in the household, includes but not limited to wages, interest, dividends, social security benefits, veterans' benefits, pensions and spousal income. For the purpose of eligibility of financial assistance, examples of income which are excluded are temporary assistance for needy families (TANF) benefits, supplemental nutrition assistance program (SNAP) benefits, low-income home energy assistance program (LIHEAP) benefits, and weatherization benefits.

H. Medicaid: A joint federal and state program that assists with medical costs for some people who have limited income and resources.

I. Medically Necessary Services: Healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

J. Presumptively Eligible Patients: Patients who are presumed to be eligible for financial assistance based on life circumstances such as homelessness, zero income, or previous eligibility for financial assistance programs.

K. Underinsured Patients: Patients who have insurance coverage which results in high patient financial responsibility toward payment of their medical bills.

L. Uninsured Patients: Patients who have no insurance coverage available for their medical needs.

PROCEDURE:

A. Creating awareness of the Patient Financial Assistance option.

A.1. The current Financial Assistance Policy (FAP), Application(s) and Plain Language summary (PLS) are available in English and in the primary language

of populations with limited proficiency in English (LEP) that constitutes the lessor of 1,000 individuals or 5% of the community served by THAH's primary service area.

- The FAP, Applications(s) and PLS are available on-line at https://towerhealth.org/locations/home-health-and-hospice/tower-health-home financial-assistance

A.2. Information about charges, including the plain language summary of the Financial Assistance policy, is included in the Patient Admission Booklet provided to each patient. This easy-to-read summary of the financial assistance program includes contact information for Tower Health at Home employees who will assist the patients with the application process.

A.3. Patient billing statements for Tower Health at Home services contain guidance and direction on the availability of the financial assistance program.

A.4. Tower Health at Home will work closely with advocacy programs in the community.The availability of Tower Health at Home financial assistance policy is shared with those agencies.

B. Identifying patients in need of Financial Assistance for medically necessary services.

B.1. As a result of the Tower Health at Home patient financial services verification-of- coverage process, there will be the opportunity to identify uninsured patients and underinsured patients. Tower Health at Home financial counseling resources will assist these patients with the Medicaid application process.

B.2. Patients who are denied Medicaid coverage, or who are screened and determined to not meet the Medicaid coverage criteria, will be considered for the Patient Financial Assistance program.

B.3. Tower Health at Home patient financial services will utilize available eligibility resources to determine insurance coverage and benefits available to all patients. For scheduled patients, the verification of coverage will take place prior to a patient's admission for all high dollar services.

B.4. Tower Health at Home Internal/External Collections policy outlines the process by which Tower Health at Home will charge and bill uninsured patients and pursue the collections of outstanding balances. The uninsured rate is 70% of AGB and is applied at the time an initial payment is made. The Internal/External Collections policy is available online on the THAH website, and a paper copy can be obtained, free of charge, by emailing THAHBilling@towerhealth.org or calling 610-378-0481.

C. Determining eligibility for Financial Assistance

C.1. Patients who are seeking or have received any medically necessary services and who demonstrate the inability to pay for services, will be considered for the financial assistance policy.

C.2. The assistance can be used for direct patient care services only, except for Hospice medical supplies, DME, and covered medications when no other reimbursement source is available.

C.3 The maximum number of approved visits per patient per month should not exceed 12 visits. Services are capped at 20 visits total. Any request which exceeds monthly or total visit caps must approved by the Vice President of Nursing and Operations.

- At start of care, the authorization for visits will include all discipline and will be noted in the EMR for staff reference. Visits will be manually tracked to ensure that visit caps are not exceeded.

C.4 Patients visiting the United States with the intent of receiving non-emergent care are not generally eligible for financial assistance.

C.5 Patients will be requested to provide verification of household income along with the names of people residing in the household, as a requirement of the application process. This information is utilized in determining where the household falls within the Federal Poverty Level Guidelines (FPL). The following (where applicable) must be provided for each member of the household for income verification:

- Current pay stubs or written verification from employer
- W-2's and/or 1099's
- Form approving or denying unemployment or worker's compensation
- Written verification from public welfare agencies or any governmental agency of the individual's income
- Self-employed provide complete tax forms from most recent filing, including Schedule C
- Most recent bank statements for all open accounts (for asset verification only)

C.6. An allowance amount is assigned to each FPL category and is calculated using the assigned percentage of the Medicare-Fee For-Service Rate. For patients above 400% of the FPL, the uninsured rate applies.

FPL Category	Allowance	Maximum patient payment per
= < 200% FPL	100% financial assistance allowance	$0
between 201% up to 250%	90% allowance on MCR FFS	$300
between 251% up to 300%	80% allowance on MCR FFS	$500
between 301% up to 350%	70% allowance on MCR FFS	$1,000
between 351% up to 400%	50% allowance on MCR FFS	$2,000

C.7. While it is ideal to initiate the process as soon as possible, patients are eligible to request consideration for financial assistance within 240 days from the first patient statement date.

C.8. Patients determined eligible for financial assistance will be charged less than gross charges for any non-medically necessary care provided by Tower Health at Home.

C.9. Decisions pertaining to eligibility for financial assistance will be made within 14 days of receipt of a complete financial assistance application. Incomplete applications will be reviewed and attempts to contact the patient/guarantor for additional information will be made. A confirmation letter will be sent to the patient describing the outcome of the decision. Revised billing statements will take into consideration any excess payments made by the patient in determining the amount due.

C.10. When financial assistance is approved, the confirmation letter will also serve as a means of specifying time frame covered by the financial assistance determination. Approved financial assistance applications are good for one (1) year from the initial date of service.

C.11. If financial assistance is not approved, letters will be sent describing the reasons for the decision, as well as information about who should be contacted for other payment options and how to appeal the decision.

C.12. Patients or guarantors who disagree with the outcome of the financial assistance eligibility decision will have the opportunity to appeal the decision. Review of the appeal request will be the responsibility of the VP of Nursing and Operations and lead Financial Officer.

D. Presumptive Eligibility

D.1. Patients may be eligible for a discount of the full unpaid balance in the absence of a completed financial assistance application form if the patient meets one of the following:

- Is homeless or resides in low-income subsidized housing
- Is currently eligible for Medicaid (as primary insurance) but was not at date of service OR
- Medicaid benefits are exhausted or charges are for services that are not covered by Medicaid
- Is currently eligible for prescription assistance, SNAP/food stamps or WIC
- Is eligible to receive benefits from a governmental agency as the victim of a violent crime or sexual assault and the treatment is related to the violent crime or sexual assault
- A demonstrated inability to pay for services based on all available assets.

E. Financial Responsibilities and Expectations

E.1. If a patient does not qualify for financial assistance, the following financial responsibilities apply:

- THAH will clearly communicate financial expectations to patients as early as possible in the billing cycle to prevent confusion or hardship.
- Patients are responsible for understanding their insurance coverage and submitting any required documentation.
- Patients are accountable for any self-pay balances, including amounts not covered by insurance or third-party payers.
- Patients with outstanding balances may be required to settle past-due amounts before receiving additional care.
- Tower Health at Home may postpone additional home health or hospice services for patients who repeatedly refuse to make reasonable efforts to pay for their care.

GUIDELINE:

PROVIDER PROTOCOL:

EDUCATION AND TRAINING:

Revenue Cycle team will be responsible for annual education on expectations covered in this policy. New Revenue Cycle employees will be educated as appropriate during their initial orientation.

REFERENCES:

COMMITTEE/COUNCIL APPROVALS:

CANCELLATION:

The content of this document supersedes all previous policies/procedures/protocols/guidelines, memoranda, and/or other communications pertaining to this document.