

SVMC Financial Assistance Program Eligibility Policy

I. POLICY:

Southwestern Vermont Medical Center (SVMC) will:

- Treat all patients equitably, with dignity, with respect and compassion.
- Serve the emergency and health care needs of everyone, regardless of a patient's ability to pay for care.
- Assist patients who cannot pay for part or all the care they receive.
- Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep the hospital's doors open for all who need care in the community.

SVMC will render financial assistance to persons with a demonstrated inability to pay regardless of race, color, gender, immigration status, sexual orientation, or religious affiliations. Financial Assistance represents medical services provided to a person for which the hospital has no expectation of receiving full payment. Financial Assistance eligibility may include an amount the patient or household is expected to pay, in addition to an amount which is written off.

SVMC recognizes that it will be necessary to identify patient's that are uninsured, underinsured, ineligible for government programs or otherwise unable to pay and establish the amount of financial assistance to be rendered for medically necessary care based on their individual financial situation. It is the policy of SVMC to follow the federal poverty household guidelines to determine eligibility for financial assistance. Individuals eligible for SVMC's financial assistance program will not be charged more than amounts general billed to patients that have insurance. The discount provided to individuals eligible for financial assistance will be consistent with the average discount provided to Vermont Medicaid. This discount is calculated using the look back method taking previous year total Medicaid Charges minus Payments to determine Medicaid contractual allowance and then dividing by Medicaid charges to calculate the Medicaid discount. Based on this calculation the minimum discount granted to eligible patients under this policy is 65%.

SVMC will not impose extraordinary collection actions, such as reporting to credit bureau, for patients without first making reasonable efforts to determine whether patient is eligible for Financial Assistance. For information on the steps SVMC will take to inform patients of the financial assistance policy and collection activities we may pursue, please see SVMC Billing and Collections policy. This policy can be found online at <http://svhealthcare.org/patients-visitors/billing-insurance/>, or can be requested by phone by calling the SVMC billing department at 802-447-4500.

Length of eligibility for Financial Assistance will be reviewed every six months for patients who receive wages from employment or have income that may fluctuate to determine if a change in status has occurred. Patients who receive Social Security and pensions that do not change are granted for 1 year.

Covered Providers

This policy covers hospital services performed by SVMC and professional services provided by SVMC medical providers. You may receive services at SVMC from Radiology Associates of Bennington, Anesthesiology Associates or other private physicians in the community. These providers are separate entities and services are billed separately. These physician groups are not required to follow SVMC's Financial Assistance policy.

II. PROCEDURES:

Eligibility Criteria for Routine Determinations:

SVMC will use the following criteria to determine if a patient qualifies for Financial Assistance:

1. The patient's gross household income/assets do not exceed 400% of the current year Federal Poverty Income Guidelines (see Chart A). The number of dependents and others in the household must be taken into account in making this determination.
 - "Patient's household income and/or assistance" includes all funds received by all members of the patient's household for the 12 month period prior to receiving services at SVMC.
 - "Household" is defined as all dependents who live in the same residence as the patient and/or guarantor. A patient's household includes the patient, spouse, dependent children and unmarried couples with a mutual child living together.
 - A "dependent" is defined as a person who can be claimed by the guarantor and/or patient as a dependent on their federal tax return.
 - Examples of "Assets" include cash, savings, checking, CDs, stocks/bonds, secondary homes. For the purposes of qualifying for Financial Assistance, assets in excess of 100% of the FPL will be considered in determining eligibility.
 - Patient's primary residence and automobile(s) are not considered in determining eligibility.
2. The patient has no medical insurance, liability or other third-party coverage that will pay for the services the patient received at SVMC. All insurance guidelines/plan provisions must have been followed including obtaining necessary referrals/authorizations and staying within your plans specified provider network.
 - The financial assistance determination will be rescinded should the patient subsequently receive medical, liability or third-party coverage that will pay for the services.
3. Uninsured patients are required to apply for Medicaid or insurance through the Health Exchange in order to be considered for assistance.
 - SVMC does reserve the right to request a copy of the Medicaid Denial of Assistance if proof of income appears to be within the Medicaid Eligibility Guidelines or income cannot be verified.
 - Exceptions to this requirement may be approved by Director of Revenue Cycle or Chief Financial Officer for good cause on a case by case basis.
4. Patients must reside in the SVMC service area unless care was a medical emergency. The SVMC service area includes: Bennington (VT), Windham (VT), Rensselaer (NY), Washington (NY) and Berkshire (MA) counties where SVMC is the closest hospital to the patient's home or place of work.
5. Services must be medically necessary.
 - Services Eligible for Financial Assistance:
 - Emergency or Urgent Medical Services.
 - Elective medically necessary services for patients who meet program guidelines.
 - Services not eligible for Financial Assistance:
 - Cosmetic, Infertility and other elective procedures and services that are not medically necessary.
 - Services where an Advanced Beneficiary Notice (ABN) was signed.
 - General Dentistry.
 - Services reimbursed directly to the patient by an insurance carrier or third party.

- Non-emergency care that may be covered by an insurance carrier at another provider, but are not covered at SVMC.

6. Financial Assistance applications must be received within 240 days of the patient's first billing statement for services.

Determination Process for Routine Determinations:

1. The patient indicates to any Access Services or Financial Services Representative that they would like to apply for financial assistance.
 - Financial assistance applications can be obtained:
 - Online at <http://svhealthcare.org/patients-visitors/billing-insurance/>.
 - In person at any registration desk at the hospital, SVMC physician practice, or at the SVMC Billing Office.
 - By calling the SVMC billing department at 802-447-4500.
2. A SVHC application for financial assistance is completed with supporting documentation and forwarded to SVHC financial advisor. Supporting documentation shall include:
 - 2 most recent Payroll Stubs or written verification of wage from employer.
 - Prior year Federal and State Income Tax Returns.
 - Business Tax Return (if applicable).
 - 2 months of bank statements including checking, savings and money market.
 - Social security statements.
 - Pension statements.
 - Forms approving or denying unemployment compensation or Worker Compensation, if appropriate
 - Written verification from public welfare agencies or any other government agency, which can attest to the income status for the past twelve (12) months. (if applicable).
3. If the application submitted is incomplete, then the financial advisor will send written notification to the patient of what is still required in order to process the application. If the information is not received within 30 days then the application will be denied. If any extraordinary collection actions have begun they will be suspended until determination is complete.
4. Patients with excessively large account balances that apply and do not qualify but may have extenuating circumstances should be referred to one of the following for review: Refer to "Presumptive Determinations", below.
 - Supervisor of Patient Accounts.
 - Director of Revenue Cycle Management.
 - Chief Financial Officer.
5. If the application is approved, the following actions should occur:
 - The Supervisor of Patient Financial Services or their designee (Patient Financial Advisor) will prepare the necessary paperwork to post the appropriate adjustment to any open accounts within 240 days (from 1st post-discharge billing statement) from receipt of completed application.
 - The Financial Advisor will notify the patient by letter that their request for financial assistance has been approved.
 - All collection activities on FAP eligible accounts will be suspended and any ECA actions will be reversed.

6. If the application is denied, the following actions should occur:
 - The application for financial assistance will be retained on file.
 - The Financial Advisor will notify the patient by letter that their request for financial assistance has been denied.
7. Appeals Process:
 - If SVMC denies partial or total financial assistance then the patient can appeal the decision within 30 days. The patient must write a letter to the Supervisor of Patient Accounts explaining why the original decision should be reconsidered and assistance granted. The letter will be reviewed and a final decision sent to the patient within 30 days.

Eligibility Criteria for Presumptive Determinations:

Known circumstances surrounding a patient's personal situation may support the conclusion that they qualify for financial assistance. In addition, the patient is either unable to apply for financial assistance and/or provide required supporting documentation to make a routine determination of eligibility.

1. Some common, specific scenarios where a patient may be eligible for financial assistance but unable to document it are listed below. This is not an all-encompassing list. Unique situations that are not listed may occur and should be evaluated independently.
 - A patient is a foreign national who was in the area for a limited period of time and appears to have limited means as best we can tell. We can confirm or have a reasonable belief that the patient has returned to their country and it is questionable whether they will return to this area again. Furthermore, they do not qualify for any kind of other assistance program.
 - The patient is deceased. There is no probate filed in the local jurisdiction where the person resided. There may or may not be family we can locate. We have no reason to believe that the patient has assets that would cover the bill (as determined from whatever sources of information available). No assistance programs are available to cover the patient's services.
 - The patient is known to be homeless. They do not have a job and no assets. They do not qualify for any kind of assistance program.
 - The patient is currently eligible for Medicaid.
2. In addition to specific scenarios, there may be other factors that could indicate that a person might qualify for financial assistance. All of these factors assume that the person has no or very limited insurance coverage.
 - Their income is below \$5,000 per annum for each family member in the household.
 - They are a full-time student who is on their own.
 - A large cumulative balance of \$20,000 or more is owed to the hospital.
 - The patient is disabled or unemployed.
 - The patient is elderly and is not on Medicare or had Medicare Part B only.
 - The patient has a serious or debilitating illness or injury that could cause a person who was previously employed to be unable to work for an extended (6 months for more) period.
3. The reasons above are not by themselves are not a definitive reason to grant presumptive assistance, but are an indicator that further review of the patient's circumstances may be warranted. The following individuals are authorized to examine the facts of a potential presumptive financial assistance and make a determination as to whether to approve the write-off:

- \$1 to \$5,000 Supervisor of Patient Accounts.
- \$5,000 to \$10,000 Director of Revenue Cycle.
- Greater than \$10,000 Chief Financial Officer.

III. Communication

- SVMC will provide financial counseling to patient’s about their bills and will make the availability of such counseling widely known.
- SVMC will respond promptly to patient questions about their bills and requests for financial assistance. It is the goal of SVHC to process completed financial assistance applications within 30 days.
- SVMC will use a billing process that is clear, concise and patient friendly.
- SVMC will post information on SVHC’s Financial Assistance Program, including copies of the policy and application on the SVHC website, www.svhealthcare.org.
- SVMC will send a Financial Assistance Application to all self pay patients living in the SVHC service area with their initial bill and notify patients of the Financial Assistance Program on all patient statements.
- SVMC will post information regarding the SVHC Financial Assistance Program in patient registration areas.

Chart A: FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA

Effective January 1, 2018 the income requirements are:

Family Size	< 225% FPL	300%FPL	400%FPL
	100% Discount	75% Discount	65% Discount
1	\$27,315	\$36,420	\$48,560
2	\$37,035	\$49,380	\$65,840
3	\$46,755	\$62,340	\$83,120
4	\$56,475	\$75,300	\$100,400
5	\$66,195	\$88,260	\$117,680
6	\$75,915	\$101,220	\$134,960
7	\$85,635	\$114,180	\$152,240
8	\$95,355	\$127,140	\$169,520
Over 8	Add \$9,720 per person	Add \$12,960 per person	Add \$17,280 per person

Author: A. Mazzariello

Approved by: Stephen Majetich, CFO

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