BLACK RIVER HEALTH

POLICY TITLE: Financial Assistance Program (FAP)	**PAGE:** 1 of 6
DEPARTMENT(S) AFFECTED: Organization-Wide	**EFFECTIVE DATE:** 05/06/2025
RESPONSIBLE DEPARTMENT/COMMITTEE: Finance	
POLICY OWNER: Finance & Revenue Cycle Director	**POLICY NUMBER:** 700-0113
APPROVED BY: CFO	**REVIEW TERM:** 36 Months

PURPOSE:
To define the proper policy and procedure for determining and granting community care write-offs and self-pay discounts to patients who are unable to pay for the services received from Black River Health.

POLICY STATEMENT:
Black River Health (BRH) is committed to excellence in providing high-quality healthcare while serving the diverse needs of those living within our service area. As a not-for-profit charitable hospital, BRH acknowledges that, in some cases, individuals and their immediate families may not have the ability to pay for services rendered to them. BRH is dedicated to the view that emergency and other non-elective medically necessary care should be accessible to all, regardless of ability to pay. It is the policy of BRH to apply a Community Care write-off if it has been determined that all other avenues of payment have been exhausted and that the patient has no other means of making payment on the account. Community Care write-offs are granted at the discretion of BRH upon consideration of certain guidelines. Eligible individuals may not be charged more than amounts generally billed for emergency or other medically necessary care. **Appendix A** defines the Amounts Generally Billed Methodology (AGB).

This policy covers the patients and residents whom all Black River Health departments serve. Individuals are expected to cooperate with Black River Health's Community Care process.

Financial assistance needs do not consider age, gender, sex, race, color, social or immigrant status, national origin, disability, sexual orientation, gender identity, or religious affiliation.

Self-pay patients are defined as patients who have no health insurance coverage because they are either not eligible for insurance coverage or the services are not covered by a health insurance policy or state, government, liability, or workers' compensation program.

The Community Care Program is advertised to patients on the Black River Health website. A dunning message is also listed on the back of BRH statements, and information is included in the final notices sent by the Extended Business Office. A fillable application is available at https://blackriverhealth.com/financial-assistance

Signage shall be prominently displayed in Black River Health's patient waiting rooms with language stating, at a minimum, "no one will be denied access to services due to inability to pay; there is a discounted/sliding fee schedule available based on family size and income."

GENERAL GUIDELINE:
Community Care write-offs are available to eligible persons residing in our primary and secondary service areas who require medically necessary treatment but are unable to pay for these services. Eligibility for Community Care shall be extended to those persons whose family income does not exceed the current Community Services Administration poverty guidelines. **(See Attachment #1-Community Care Discount Table)** Persons whose income is less than 200% of the guidelines will be considered for complete forgiveness of their outstanding bills. Persons whose income is greater than 200%, but not more than 400% of the guidelines, shall be eligible for a Community Care discount as shown in Attachment 1. The remaining balance may be set up on a payment plan. In addition to income level evaluation as outlined above, the amount of patient responsibility will not exceed 25% of annual household income.

Community Care write-offs shall be considered only after a careful review of the patient's accounts by the Patient Financial Advocate(s) (PFA). Coverage considerations will be based solely on income and family size for patients whose income is less than 200% of the Community

Services Administration poverty guidelines. For patients whose income exceeds 200% of the Community Services Administration poverty guidelines, Community Care will be considered only after it has been determined that no third-party reimbursement is available. A signed Financial Assistance Application **(See Attachment #2)** shall be completed by the Community Care candidate and returned to the BRH Patient Financial Advocate for review. A free application can be completed by contacting one of our Patient Financial Advocates, or a fillable application is available at https://blackriverhealth.com/financial-assistance. Patient Financial Advocates are available by appointment only to assist patients with completing the application.

Legal dependents shall be identified as such based on whether or not they are claimed as dependents on the most recent income tax return and/or reside in the residence. Gross income reported on the Financial Application shall include all household income and shall require supporting documentation (i.e., three (3) most recent pay stubs, W-2 forms, Unemployment Compensation forms, etc.). If a Community Care candidate indicates that no income has been earned, a denial for Unemployment Compensation from Workforce Development may be requested. If the application is returned without sufficient proof of income or if other requested documentation has not been provided, he or she shall be contacted by telephone or letter to discuss other evidence of income that may be available. If the requested information is not received within 60 days of contact, community Care approval may be denied for failure to cooperate in completing the application.

BRH recognizes the fact that there may be instances in which a Community Care candidate's income exceeds the guidelines shown above, but their expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burden. A Community Care write-off may be appropriate for these individual circumstances.

For patients whose income exceeds 200% of the Community Services Administration poverty guidelines with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement, or a Flexible Spending Account will be expected to use these funds prior to being approved for financial assistance.

Upon review of a completed Financial Assistance Application (FAA), a Patient Financial Advocate will make a recommendation for Community Care. Recommendations below $5,000 will be approved by the Director of Finance and Revenue Cycle. The Chief Finance Officer or Chief Executive Officer will approve amounts greater than $5,000. Once Community Care is approved, the individual will receive written notice from Black River Health, Inc., along with a current statement reflecting the new adjusted balance due.

If partial Community Care is approved, the individual will be contacted by a Patient Financial Advocate to establish an approved payment plan for the remaining balance. If an individual fails to follow through on their established payment plan, Black River Health, Inc. reserves the right to submit the balances to a collection agency.

BRH recognizes that certain patients may be unable to comply with or unresponsive to the traditional FAP application process. To remove barriers for these patients and improve community benefits, BRH may utilize an electronic screening process before bad debt assignment after all other funding sources have been exhausted. The information returned via the electronic screening process will constitute adequate documentation under BRH's FA policy, and the patient's eligibility through this process will receive the most generous financial assistance discount and will not be assigned to bad debt. Presumptive Eligibility is for a finite period of time and covers very specific types of services and patients. Individuals eligible for a presumptive eligibility discount will not be

asked or required to submit an FAA form. For example:

A. The individual is homeless;
B. The individual is deceased and has no known estate able to pay hospital debts;
C. The individual is incarcerated for more than two (2) years;
D. The individual is currently eligible for Medicaid but was not eligible at the time of service;
E. The individual who received services not covered by Medicaid;
F. The individual is eligible to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act by the State;
G. Individuals who are declaring bankruptcy:
H. Individuals with out-of-state Medicaid for whom we are not providers and are unable to bill for services;
I. Medicaid eligible applicant application completed;
J. SLMB-Medicare patients; Senior Care- no application needed.

If an application is denied, a letter explaining the reason for the denial will be sent to the applicant, along with a contact number for a PFA. In the event a patient feels an incorrect determination was made, they may file an appeal. The patient will be asked to document the factors that would change the result.

Catastrophic care discounts will be applied per policy. Patient liability is capped at an amount that is not greater than 25% of annual gross income per service.

The "Application Period" is the period during which BRH must accept and process an application for Financial Assistance under this policy. The "Application Period" begins on the date the care is provided and ends on the 240th day after BRH provides the first post-discharge billing statement.

Financial Assistance applications will be accepted for open dates of service. Patient balances that have been sent to collections are not eligible for Financial Assistance.

Financial Assistance applications that have been approved will be determined eligible for 90 days unless there is a change in income.

The eligible individual will not be charged more than the amounts generally billed for emergency or other medically necessary care.

BRH, at any time, with the approval of the BRH Board of Directors, may revise the criteria established in determining eligibility for Financial Assistance.

SELF-PAY GUIDELINE:

BRH limits the amount charged for any emergency or other medically necessary care it provides to a Financial Assistance eligible individual to not more than the amount generally billed to individuals with insurance coverage. BRMH uses the "look-back" method to determine AGB and is reviewed annually. **(See Appendix A)**

Individuals without health insurance coverage will receive a self-pay discount but are required to pay for services in advance or at the time of service where appropriate.

Registration and pre-registration processes promote the identification of individuals in need of financial assistance. PFA will make the best effort to contact all self-pay inpatients during the course of their stay or at the time of discharge.

SERVICES NOT COVERED BY FAP:

A. Services deemed not medically necessary or elective by the examining physician
B. Charges in litigation
C. An unpaid account that has been placed with a collection agency

This list is not all-inclusive.

ACTIONS THAT MAY BE TAKEN IN THE EVENT OF NON-PAYMENT

A. Subject to compliance with the provisions of this policy, BRH may take any and all legal actions, including Extraordinary Collection Actions (ECA), to obtain payment for medical services provided.
B. BRH will not engage in ECAs, either directly or by any debt collection agency or another party to which the hospital has referred the patient's debt before reasonable efforts are made to determine whether a patient is eligible for assistance under the FAP(Financial Assistance Program).
C. At least three separate billing statements for collection of Self-Pay accounts shall be mailed to the last known address of each patient prior to the end of the Notification Period; provided, however, that no additional billing statements need to be sent after a patient submits a complete application for financial assistance under the FAP. At least 60 days shall have elapsed between the first and last of the required three mailings.
Note: It is the responsibility of the individual to provide the correct mailing address at the time of service or upon moving.
D. At least one of the billing statements sent during the Notification Period will include a written notice that informs the patient about the ECAs that may be taken if the patient does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline (i.e., the last day of the Notification Period). Such a statement must be provided to the patient at least 30 days before the deadline specified in the statement.
E. At least 30 days before first initiating one or more ECAs, the hospital makes reasonable efforts to orally notify all patients about the hospital's FAP and how the individual may obtain assistance with the FAP application process.
F. ECA's may be commenced as follows:
    1. If the patient fails to apply for financial assistance under the FAP by the last day of the Notification Period and the patient has received the 30-day written notice described in Section E of this policy, then BRMH may initiate ECAs.
    2. If the patient applies for financial assistance under the FAP, and the Patient Financial Advocate of BRH determines definitively that the patient is ineligible for any financial assistance under the FAP (including because the patient was not insured), BRMH may initiate ECAs.
    3. If a patient submits an incomplete application for financial assistance under the FAP prior to the Application Deadline, then ECAs may not be initiated until after each of the following steps has been completed;
        a. Patient Financial Advocate provides the patient with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the Plain Language Summary (PLS).
        b. Patient Financial Advocate provides the patient with at least 30 days prior written notice of the ECAs that BRH may initiate against the patient if the FAP application is not completed or payment is not made; provided, however, that the deadline for completion or payment may not be set prior to the Application Deadline.
        c. If the patient who has submitted the incomplete application completes the application for financial assistance, and the Patient Financial Advocate determines definitively that the patient is ineligible for any financial assistance under the FAP, BRH may initiate ECAs.

d. If the patient who has submitted the incomplete application fails to complete the application by the deadline set in the notice provided pursuant to Section F.3.b. of this policy, then ECAs may be initiated.
e. If an application, complete or incomplete, for financial assistance under the FAP, is submitted by a patient at any time prior to the Application Deadline, BRH will suspend ECAs while such financial assistance application is pending.

G. A letter indicating intent to transfer a Single Patient Account to a collection agency or shall be mailed to the last known address of the patient prior to transfer of a Self-Pay account to a collection agency or the initiation of ECAs.

H. A patient or Representative, who contacts BRH for information concerning any possible financial assistance, shall be provided with information concerning financial assistance available under the FAP.

I. After the commencement of ECAs is permitted under this policy, external collection agencies shall be authorized to report unpaid Self-pay accounts to consumer credit agencies and to file litigation, obtain judgment liens, and execute upon such judgment liens using lawful means of collection; provided, however, that prior approval of a Patient Financial Advocate shall be required before lawsuits may be initiated.

J. BRH may at any time offer a one-time discount for aging accounts.

Patients are informed of financial assistance options through hospital employees, Patient Financial Advocate employees, signage, and the BRH website. Brochures and patient bills also include information about financial assistance. Spanish versions of the application and the Financial Assistance Policy are available. Copies of the BRH Financial Assistance Policy and Billing and Collection Policy, which describe the actions the BRH may take in the event of non-payment, are provided free upon request.

Appendix A

Amounts Generally Billed (AGB) Calculation

BRH has adopted the "Look Back Method" to determine the AGB calculation. It is based on the previous year's claims allowed for all medical care, including emergency and other medically necessary care for Medicare and all private insurers, divided by total gross charges.

ALL BLACK RIVER HEALTH EMPLOYED PROVIDERS ARE COVERED UNDER THIS FINANCIAL ASSISTANCE POLICY AND THE RELATED GUIDELINES.

PROVIDERS RENDERING CARE AT BLACK RIVER HEALTH THAT ARE NOT ON THE MEDICAL STAFF OF THE ORGANIZATION, ARE NOT COVERED UNDER THE FINANCIAL ASSISTANCE POLICY AND THE RELATED GUIDELINES.

ORIGINAL DATE: 3/01/06	**REVIEW/REVISE DATE:** 06/26/2007,07/26/2011, 1/9/14, 1/1/15, 12/16/15, 7/1/16, 09/01/16, 10/19/16, 1/23/17, 4/4/17, 9/1/17, 12/14/17, 8/14/18, 1/18/19, 1/22/19, 1/28/20, 6/25/20; 1/26/21, 3/17/21; 1/25/22, 2/28/23, 08/13/23, 08/23/23, 12/11/23, 5/28/24, 5/6/25
REPLACES POLICY/POLICIES:	
RELATED POLICIES: Private Pay Policy and Procedure; Payment Plan Policy	
REFERENCES: 2025 Federal Poverty Guidelines, WHA Collection and Collection Guidelines	
ATTACHMENTS: Community Care Discount Table, Financial Assistance Application	
PATIENT CARE POLICY GENERAL STATEMENT: Decisions to adopt these guidelines are made by the practitioner based on available resources and by circumstances presented by individual patients. The recommendations in the guideline may not be appropriate for use in all	

circumstances.