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<b>Author(s):</b>	Jennifer Grayson, Director of Revenue Integrity		
<b>Owner:</b>	VP of Revenue Cycle		

<b>Scope:</b>
Renown Health and its affiliated entities, including Renown Regional Medical Center, Renown South Meadows Medical Center, and Rehabilitation Hospital, adopt the following policy and procedure.
<b>Policy Statement:</b>
Renown Health (“Renown”) is committed to providing emergency services, quality medically necessary healthcare to all patients regardless of age, sex, sexual orientation, race, religion, disability, veteran status, national origin and/or ability to pay.
<b>Definition of Terms:</b>
<ol style="list-style-type: none"> <li>1. FAP - Financial Assistance Program</li> <li>2. FPG - Federal Poverty Guidelines</li> <li>3. FPL - Federal Poverty Level</li> <li>4. Guarantor – Individual financially responsible for a patient’s account</li> <li>5. Hospital-Specific Amounts Generally Billed (AGB):  For each Hospital, a percentage derived by dividing the sum all claims for Medically Necessary services provided at such Hospital paid during the Relevant Period by Medicare fee-for-service and all private insurances as primary payers, together with any associated portions of these claims paid by Medicare beneficiaries or insured individuals in the form of co-payments, co-insurance, or deductibles, by Usual and Customary Charges for Medically Necessary Services. (Total Reimbursement ÷ Total Charges = Hospital Specific AGB Percentage) See Treasury Regulation 1-501r5(b)(1)9B</li> </ol>

These Policies and Procedures are guidance for the Organization. The Organization recognizes there may be specific facts and/or circumstances that warrant a departure from a specific policy provision. Nothing herein is intended to override an employee’s ability to use good judgment in such circumstances.

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**6. Medically Indigent:**

Are persons who do not have health insurance and who are not eligible for other health care coverage, such as Medicaid, Medicare, or private health insurance.

**7. Medically Necessary:**

Means those services required to identify or treat an illness or injury that is either diagnosed or reasonable suspected to be Medically Necessary taking into account the most appropriate level of care. In order to be Medically Necessary, a service must:

- a. Be required to treat an illness or injury
- b. Be consistent with the diagnosis and treatment of the patient's condition;
- c. Be in accordance with the standards of good medical practice;
- d. Not be for convenience of the patient or patient's physician; and
- e. Be the level of care most appropriate for the patient as determined by the patient's medical condition and not Guarantor's financial or family situation.

8. Gross Charges – Charges that have not been discounted.

9. Actions in the event of nonpayment of an individual self-pay account are described in the Billing and Collection Self Pay Policy (Renown.SPC.005)

**Procedure:**

**1. Notification of Program**

- a. Guarantors will be offered a FAP brochure and/or application.
- b. Guarantors can request a FAP application or plain language summary at any admitting location, patient financial assistance office, or the business office.
- c. Guarantors can find a plain language summary and FAP application at <https://www.renown.org/interact/paying-for-your-care/financial-assistance-program/>

**2. Referral**

- a. Uninsured guarantors will be identified as early as possible when no other payment source is available and referred to the FAP.
- b. Referrals can be made anytime a guarantor expresses a financial hardship and wishes assistance (up to one year after service or up to 240 days after collection activities have commenced, whichever is later). Exceptions may be requested and require approval from the VP of Revenue Cycle or above.
- c. Information pertinent to FAP referrals should be made prior to any planned procedure and at time of service.

### 3. Application

- a. Referred guarantors will be provided a FAP Letter and Application. (Appendix B & C)
- b. Multiple accounts may be submitted for review on a single FAP Application.
- c. Assets exempt from financial consideration include the residence where a guarantor and/or guarantor's family resides, automobiles needed to transport all working parties to and from work, bank accounts with less than two months of income, and retirement accounts with less than \$50,000.
- d. Financial documentation requested in the FAP Letter to the Guarantor and the Application must be returned in order for an Application to be considered complete.
- e. If a guarantor needs assistance in completing the FAP application, they can contact a Financial Assistance Specialist at 775-982-4110 or toll free at 855-951-6871 or at the Business Office at 775-982-4130 or toll free at 866-691-0284 or on-line at Renown.org.
- f. Applications not completed within 30 calendar days of issuance will be denied.

### 4. Copayment

- a. All guarantors are required to make a financial contribution towards their bill. Guarantors are subject to a co-pay amount based on their specific Federal Poverty Level. Federal Poverty Levels are determined by HHS.
  - i. Co-Pay Table

FPL%	Co-Pay
<100%	\$25.00
150%	\$75.00
200%	\$150.00
250%	\$200.00
300%	\$250.00
350%	\$300.00
400%	\$350.00

- b. Guarantor co-pay amounts are to be paid in full at time of FAP application approval based on stated income.
  - i. If approval is granted by the FAP Supervisor or above, payments can be delayed to a maximum of 90 days after submission.
  - ii. Application approval will be applied to all prior services that meet FAP

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- criteria as well as all future guarantor financial responsibility that meets FAP criteria for 6 months from the date of the approval. Renown Patient Financial Assistance must be notified of any changes in income or household size during the 6-month approval period to maintain eligibility.
- iii. If application is denied, Financial Assistance Specialist will contact patient with information regarding payment arrangement.

## 5. Eligibility Criteria

- a. The FAP may not be used for cosmetic or bariatric procedures, fertilizations, Same Day or Package Price procedures, or any other non-medically necessary procedures. Exceptions may be requested and require approval from the VP of Revenue Cycle or above.
- b. All screenings will be based on the guarantor's financial status at the time of application.
- c. Guarantors must meet the following criteria:
  - i. Uninsured Guarantors are required to apply for government assistance/Insurance.
  - ii. Insured guarantors are required to apply for government assistance.
  - iii. Applicants will be assigned a FPL using the national FPG matrix documented in Appendix A.
  - iv. Guarantors with a household FPL  $\leq 600\%$  will be considered for the FAP program.
    - 1) Discounts will be provided based on FPL and assets.
    - 2) Guarantors approved for the FAP will not be responsible for more than the hospital-specific AGB. Eligible patients will be responsible for the lesser of the co-pay based on the specific Federal Poverty Level or the hospital specific AGB.
    - 3) The AGB will be calculated after each fiscal year. The final regulations of Section 501(r)(5) allow a hospital facility to take up to 120 days after the end of the 12-month period used to calculate the AGB percentage(s) to begin applying its new AGB percentage(s).
    - 4) For questions regarding the AGB calculation, patients may contact our Self Pay Contact Center at:
      - i. Phone: 775-982-4130
      - ii. In Person: 850 Harvard Way, Reno, NV 89502

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- v. Guarantors eligible for assistance programs (i.e. food stamps, welfare, etc.), or who are deemed medically indigent may not be required to complete a FAP application in order to be considered for the program. In such cases, state and local data sources representing indigence or credit evaluation tools may be used as sources to approve a guarantor for FAP. In no case will these sources be solely used to disqualify an applicant.
- vi. Guarantors who are determined to be homeless or with no documentation to establish indigence, deceased guarantors with no estate, either single, divorced, or widowed may be considered for FAP on a case by case basis without application. In such cases, state and local data sources representing indigence or credit evaluation tools may be used as sources to approve a guarantor for FAP. In no case will these sources be solely used to disqualify an applicant.
- vii. A payment, denial, or benefit summary from any payer source must be secured prior to final determination of FAP eligibility.

## 6. Determination

- a. Determination of eligibility of FAP and the charitable adjustments to be applied once approved are based on the guarantor's Federal Poverty Level, as defined by the Health and Human Services Department.
- b. All Guarantors are required to make a financial contribution towards their bill. Less the Co-Pay amounts listed in Co-Pay Table in Item 4.a.i of this policy, the charitable adjustment percentages based on Federal Poverty Level are determined as follows:
  - 1. FPL 0-99% = 100%
  - 2. FPL 100 - 249% = 80 - 99%
  - 3. FPL 250 – 350% = 72 – 79%
  - 4. FPL 350 – 400% = 31 – 72%
  - 5. FPL 400 – 500% = up to 50% with approval from Director of Revenue Integrity
  - 6. FPL 500 - 600% = up to 40% with approval from VP of Revenue Cycle
  - 7. FPL > 600% = not eligible for charitable adjustments for FAP
    - 1. Guarantors with FPL greater than 600% will be encouraged to make other payment arrangements with the Self-Pay Services Department.
    - 2. Terms of payment arrangements may be subject to VP of Revenue Cycle approval.
- c. Approval or denial notification is sent to the patient. If FAP application is denied, Financial Assistance Specialist will contact the Guarantor with information regarding payment arrangement options.

## 7. Billing

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- a. The basis for calculating amounts charged to patients is initiated by clinical documentation based on healthcare services rendered. Based upon that documentation, charges are applied automatically, or by clinical chart review staff. In most instances, Health Information Management coding specialists also review the account for coding purposes as well. Once all charges are captured, validated, and a claim is generated with final balance due for the account, the Financial Assistance application can then be processed.
- b. Guarantors will be billed for remaining balance based on determination according to Renown's Self Pay Billing and Collection Guidelines.
  - i. A copy of these guidelines may be requested by contacting a Financial Assistance Specialist at 775-982-5747 or toll free at 855-951-6871 or Business office at 775-982-4130 or toll free at 866-691-0284 or on line at Renown.org
- b. Guarantors who have made payments towards outstanding balances that are in excess of the adjustment amounts approved for FAP will be processed according to the Renown Health Refunds and Credit Balances Policy, RENOWN.PRB.005.

**8. Exclusions:**

- a. FAP does not apply to charges deemed not medically necessary.
- b. Guarantors with FPL > 600-1000% will be evaluated by either the Director of Revenue Integrity and/or VP of Revenue Cycle for applicable charitable adjustments, or possible payment arrangements on a case by case basis.
- c. Medicare beneficiaries may qualify for Medicare Bad Debt under Renown Medicare Bad Debt Policy.

**References/Regulations:**

Treasury Regulation 1-501r5(b)(1)9B

Annual Update of the HHS Poverty Guidelines: 85 FR 3060 Doc. 2020-00858

Federal Poverty Level

<https://www.federalregister.gov/documents/2020/01/17/2020-00858/annual-update-of-the-hhs-poverty-guidelines>

BILLING CODE 4150-05-P

Nevada Medicaid Manual – Medical Necessity Section 103.1

[http://dhcfnv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/Medicaid\\_Services\\_Manual\\_Complete.pdf](http://dhcfnv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/Medicaid_Services_Manual_Complete.pdf)

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Medicare Bad Debt Policy

RENOWN.CBO.109

Refunds and Credit Balances Policy

RENOWN.PRB.005

Adjustments to Accounts Receivable Policy

RENOWN.CBO.024

Patient Billing and Collection Guideline Policy

REOWN.SPC.005

## Appendix B - Financial Assistance Program Application Letter

**Guarantor Account:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Dear Guarantor:

Attached is an application for the Financial Assistance Program offered by Renown Health. This program is for individuals who feel they may need assistance in fulfilling their financial obligation for medical services.

### **Requirements:**

The purpose of the Financial Assistance Program is to provide assistance to guarantors who do not qualify for Federal, State, or County assistance and have no reasonable means to pay their liability. If you have not already applied directly to these agencies, you may contact for a Guarantor Financial Assistance Specialist for assistance in applying by calling 775-982-4110.

- ✓ All items on the application must be completed in full.
- ✓ A co-payment of \$\_\_\_\_\_ to be determined based on prescreen is required at the time you submit your application. Payment will be applied to any outstanding balances regardless of application approval
- ✓ Proof of Income and Expenses (attach copies):
  - Prior Year Filed **Tax Forms** (1040 forms and corresponding schedules)
  - Last 4 months of Pay Stubs and/or other **Source of Income** (social security, unemployment, child support, alimony, etc.)
  - Last 4 months of **Bank Statements** (include linked accounts; all pages)
  - Last 4 months of **Mortgage or Rent** Receipts
  - Last 4 months of statements from any **Other Asset Accounts** (i.e. Retirement funds (401k, 403b, 503b, IRA, etc.) insurance policies, investments, life insurance distribution, legal settlement funds, etc.)
- ✓ You must have proof of application and denial for assistance through your county's Social Services and State Welfare programs
- ✓ A Trans Union Credit Report will be run to verify all information as presented on the application for Financial Assistance funds

After all supporting documentation has been submitted, you will be notified in writing or by phone of the final determination of your eligibility. Please update us if your address or phone numbers changes.

If you have any questions regarding the Financial Assistance Program, please contact a Financial Assistance Specialist at Renown Health by calling 775-982-5747.

**Renown Regional Medical Center**  
850 Harvard Way T-6  
Attn: Medical Financial Hardship  
Reno NV 89502



## PATIENT INFORMATION

**IMPORTANT:** Please read and complete the entire form before signing. The information you provide must be accurate for proper processing.

**Pt. Account No:**

**Date of Birth:**

**Date of Application:**

NAME OF PATIENT	DATE OF ADMISSION		
NAME OF RESPONSIBLE PARTY (Guarantor)	SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	
ADDRESS	RELATIONSHIP TO PATIENT	HOW MANY PEOPLE RESIDE IN HOUSEHOLD	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE	
HOW LONG THIS EMPLOYMENT	OCCUPATION		
SPOUSE'S NAME	SOCIAL SECURITY NUMBER	OCCUPATION	HOW LONG THIS EMPLOYMENT
SPOUSE'S EMPLOYER	EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER
NAME OF CLOSEST RELATIVE		RELATIONSHIP	
ADDRESS		PHONE NUMBER	

### GUARANTOR INFORMATION:

1. REAL PROPERTY :	ADDRESS:		
2. CASH ON HAND:			
3. BANK/CREDIT UNIONS/TRUST REFERENCES AND ACCOUNTS:			
NAME	ADDRESS	TYPE & ACCT NUMBER	BALANCE
4. INSURANCE POLICIES:			
NAME	TYPE & POLICY NUMBER		VALUE
5. STOCKS/BONDS:			
DESCRIPTION			VALUE
6. BUSINESS OWNERSHIP:			
NAME & ADDRESS	TYPE OF INTEREST HELD		VALUE
7. VEHICLES:			
DESCRIPTION			VALUE
8. DEEDS OF TRUST, NOTES:			
9. MISCELLANEOUS:			
10. ARE YOU ELIGIBLE FOR COUNTY OR STATE WELFARE? IF SO, DESCRIBE BASIS OF ELIGIBILITY	<input type="checkbox"/> YES	<input type="checkbox"/> No	

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I ALSO AUTHORIZE RENOWN HEALTH TO OBTAIN INFORMATION NECESSARY FOR VERIFICATION OF MY FINANCIAL POSITION.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
Date

Appendix C - Financial Assistance Program Application

