GRAND VIEW HOSPITAL
Sellersville, PA

FINANCIAL ASSISTANCE POLICY

POLICY

Grand View Hospital (GVH) grants consideration to each individual patient regarding his or her ability to pay for emergency and medically necessary health care.

SCOPE OF POLICY

This Policy shall cover emergency and medically necessary health care services provided by all GVH service lines. Patients residing within GVH's primary and secondary geographic service areas as defined on Schedule A (attached) are eligible for Financial Assistance in the form of a discount from charges as outlined in Schedule B (attached). Those persons residing outside of the GVH primary and secondary service areas are eligible for Financial Assistance in the form of a discount from charges in accordance with Schedule C (attached).

DEFINITIONS

Financial Assistance means either: (1) free care provided to patients who are uninsured/underinsured for emergency and medically necessary service and who have family incomes not in excess of 200% of the Federal Poverty Level. (See attached Schedules B & C); or (2) discounts from charges afforded patients who are uninsured/underinsured for the relevant service and who have family incomes in excess of 200% but not exceeding 500% of the Federal Poverty Level. (See attached Schedules B & C.)

Uninsured/Underinsured Patient means an individual who lacks adequate health care insurance coverage through: (a) a third party insurer, (b) an ERISA plan, (c) a Federal or State Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), (d) Workers' Compensation, (e) Medical Savings Account or other coverage for all or any part of the pertinent bill, including claims against third parties covered by insurance to which a GVH entity is subrogated (if and when such payment is actually made by such insurance company).

PUBLIC NOTICE OF POLICY

Notification concerning the existence of GVH's Financial Assistance Policy (Exhibit 5) shall be posted on the GVH website and within the hospital and its service line sites which patients seek to obtain services, as well as provided to patients at the time of their registration for services. An abbreviated statement of notice will also be printed on the self pay inpatient and outpatient statements. Upon request, a copy of the pertinent policy will be made available in a reasonably timely manner by the staff of the Patient Financial Services Department. Patients will also be informed about the Financial Assistance Policy (FAP) in oral communications regarding any amounts due.

ELIGIBILITY DETERMINATION

For registered inpatient and outpatients, the Patient Financial Services Department will also screen accounts where the total charges may be reasonably anticipated to exceed $2,000.00 in order to identify patient eligibility for Financial Assistance. This review and screening will occur both prospectively, at the time of admission or provision of services, and also during the course of patient account billing and insurance follow-up.

Consideration of patient eligibility for Financial Assistance may also occur upon the request of the patient or guarantor.

The Patient Financial Services staff will discuss the policy's potential applicability to the circumstances of that patient or prospective patient. Patient Financial Services staff will assist in obtaining government sponsored healthcare coverage and explain other payment options as appropriate.

APPLICATION PROCESS

Once a patient or prospective patient is identified as potentially being eligible for Financial Assistance, the Patient Financial Services staff will provide to the patient or guarantor a notice of possible qualification for Financial Assistance (Exhibit 1) along with a Financial Assistance Application (Exhibit 2) and Documents Checklist (Exhibit 3). In order for a formal determination of Financial Assistance eligibility to be made, it is necessary for the patient (or guarantor) to provide any and all information being requested, including, but not limited to, demographic and financial information, as well as information documenting income resources, financial assets, and household expenses. The hospital will hold all such financial information in confidence and will use it only for the purpose of evaluating a patient's eligibility for Financial Assistance. The Patient Financial Services staff will provide assistance to those patients needing aid to complete the Financial Assistance Application and the Documents Checklist. Sign and Language Interpreters will be provided as warranted in accordance with Grand View Hospital Policy. GVH and any third party vendor utilized by GVH to collect past due accounts will suspend any collection actions during the application process.

The financial resources of a parent or guardian may be considered in determining the Financial Assistance eligibility of a patient who is a legal dependent.

Patients who do not provide adequate information necessary to completely and accurately assess their financial situation will be deemed ineligible to receive Financial Assistance discounts; however, this will not be a precondition to the timely provision of emergency and medically necessary treatment. See Exhibit 3A for the letter sent to applicants providing incomplete data. Collection of amounts due from patients ineligible for Financial Assistance shall be handled pursuant to the GVH policy on collections.

Patients currently eligible for Medical Assistance will be deemed indigent and may qualify for full Financial Assistance for outstanding claims for dates of service up to 180 (one hundred eighty) days prior to their Medical Assistance eligibility date. Additional information may be required to determine the exact date of eligibility for retrospective Financial Assistance.

Applications for Financial Assistance falling outside of established guidelines and involving extraordinary circumstances may be considered with the documented approval of the Senior Vice President/Chief Financial Officer.

Patients may reapply at anytime if their original application is denied and they feel their financial circumstances have changed.

All applicant encounters will be entered into the patient accounting or billing system and all application documentation will be scanned to the patient's account or maintained in a paper file.

PARTICIPATION

Patients qualifying for Financial Assistance may be granted a discount from charges of up to a 100%. Patients who are extended Financial Assistance in the form of a discount from charges of less than 100% will be afforded written notification of the level of discount to be provided, with the pertinent GVH bill being adjusted to reflect any such discount (Exhibit 4). Payment terms will be discussed and agreed upon with the patient or guarantor.

Collection of amounts due from patients receiving Financial Assistance shall be handled pursuant to the GVH policy on collections.

CALCULATION OF FINANCIAL ASSISTANCE DISCOUNT

GVH personnel will utilize the Financial Assistance Calculation Worksheet (Exhibit 6) to calculate the level of discount to be afforded an uninsured/underinsured patient based upon the patient's household income, family size, financial assets and household expenses. GVH shall use the GVH Financial Assistance Calculation of Financial Responsibility (Schedules B & C) when determining the level of Financial Assistance discounting to be provided the uninsured/underinsured patient. Ten percent of the applicant's Net Asset Value, as determined during the application process, shall be credited as income when determining Financial Assistance eligibility and the granting of any related Financial Assistance discount.

Patients who qualify for a Financial Assistance discount will be responsible for the lesser of the calculated patient responsibility amount due or the comparable Medicare rate for the services provided. GVH will annually apply the "Look-Back" methodology which utilizes the Medicare fee for service population to determine the amounts generally billed (AGB) as a percentage of charges. This percentage will then be applied to the Financial Assistance account.

The calculation year for the AGB will be January 1 through December 31 and the AGB percentage will be updated by January 31 of the following calendar year.

When a patient fails to qualify strictly on income guidelines, then monthly household and monthly medical expenses will be reviewed and considered by the Patient Financial Services staff. Fifty percent (50%) of documented household monthly expenses up to a maximum of $2,000.00 per month will be considered in determining eligibility. One hundred percent (100%) of monthly medical expenses will be considered by Patient Financial Services staff in determining eligibility.

ACCOUNTABILITY

GVH will review the Financial Assistance policy at least annually when the new Federal Poverty income limits are published. Annual audits will be completed to verify that applications are being handled fairly, respectfully, and consistently. The Financial Assistance policy will be reviewed annually with the Patient Financial Services staff and training needs will be addressed and provided as necessary.

Schedule A

GVH PRIMARY SERVICE AREA (16 Zip Code Areas)

18915	Colmar
18917	Dublin
18041	East Greenville
18054	Green Lane
19438	Harleysville
19440	Hatfield
18927	Hilltown
19446	Lansdale
18932	Line Lexington
18073	Pennsburg
18944	Perkasie
18951	Quakertown
18076	Red Hill
18960	Sellersville
18964	Souderton
18969	Telford

GVH SECONDARY SERVICE AREA (19 Zip Code Areas)

19504	Barto	18930	Kintnersville
18913	Carversville	18934	Mechanicsville
18914	Chalfont	18936	Montgomeryville
19426	Collegeville	19454	North Wales
18036	Coopersburg	18942	Ottsville
18901	Doylestown	18070	Palm
18923	Fountainville	18074	Perkiomenville
19435	Frederick	18955	Richlandtown
18056	Hereford	19473	Schwenksville
		19492	Zieglerville

GRAND VIEW HOSPITAL
SELLERSVILLE, PA

Schedule B

CALCULATION OF FINANCIAL RESPONSIBILITY
FINANCIAL ASSISTANCE DETERMINATION

For Patients Residing in GVH's Primary or Secondary Service Areas

HOUSEHOLD INCOME	Household Size								Patient Responsibility % of Charges Due
	1	2	3	4	5	6	7	8	
Household income ≤ 200% of HHS Poverty Income	$23,340	$31,460	$39,580	$47,700	$55,820	$63,940	$72,060	$80,180	0%
Household income ≤ 300% of HHS Poverty Income	$35,010	$47,190	$59,370	$71,550	$83,730	$95,910	$99,999	$99,999	5%
Household income ≤ 400% of HHS Poverty Income	$46,680	$62,920	$79,160	$95,400	$99,999	$99,999	$99,999		10%
Household income ≤ 500% of HHS Poverty Income	$58,350	$78,650	$98,950	$99,999	$99,999				20%

*Income Guidelines as Published in the Federal Register on January 14, 2014

GRAND VIEW HOSPITAL
SELLERSVILLE, PA

Schedule C

CALCULATION OF FINANCIAL RESPONSIBILITY
FINANCIAL ASSISTANCE DETERMINATION

For Patients Residing outside of GVH's Primary or Secondary Service Areas

HOUSEHOLD INCOME	Household Size								Patient Responsibility % of Charges Due
	1	2	3	4	5	6	7	8	
Household income ≤ 200% of HHS Poverty Income	$23,340	$31,460	$39,580	$47,700	$55,820	$63,940	$72,060	$80,180	0%
Household income ≤ 300% of HHS Poverty Income	$35,010	$47,190	$59,370	$71,550	$83,730	$95,910	$99,999	$99,999	10%
Household income ≤ 400% of HHS Poverty Income	$46,680	$62,920	$79,160	$95,400	$99,999	$99,999	$99,999		20%

*Income Guidelines as Published in the Federal Register on January 14, 2014

Exhibit 1

[date]

[name]
[street]
[city, state, zip code]

Dear [name]:

Based upon our review/your request and consistent with our Financial Assistance Policy, your account has been identified as one that may qualify for reduction of the balance owed.

In order for Grand View Hospital to fully evaluate your eligibility under this policy, it is necessary that you complete and return the enclosed application, along with the information requested. Grand View Hospital requires your cooperation with this request as incomplete applications will not be considered. Grand View Hospital staff is available to assist you with this process and can also assist you in determining eligibility for any government programs.

Please forward all requested information to the Hospital Patient Financial Services Department within the next 30 days. Our office is open every day, except holidays as follows:

Monday through Friday:	8:30 a.m. to 4:45 p.m.
Saturday & Sunday:	8:00 a.m. to 4:15 p.m.

If you have any questions or concerns, please feel free to contact us.

Sincerely,

[name]
Patient Financial Services Department
(215) 453-4608

Enclosures

Exhibit 2

GRAND VIEW HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for financial assistance.

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Social Security Number: _____

Street Address: _____

City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____

Current Health Insurance Company Name: _____

Policy Number: _____ Group Name/Number: _____

Household Members

Please attach additional sheets of paper if household has more than eight members.

	Name:	Relationship:	Age:
1.	_____	Self	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Monthly Household Income

Wages/Salaries *(Before Taxes):* _____ Pensions: _____

Social Security: _____ Other Disability: _____

SSI: _____ Cash Assistance: _____

Unemployment Compensation: _____ Worker's Compensation: _____

Child Support: _____ Spousal Support: _____

Veteran's Administration (VA) Benefits: _____

Other Unearned Income *(includes Trusts, Interest/Dividends, etc.):* _____

_____

_____

Household Countable Resources

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit: _____ Stocks or Bonds: _____

Trust Fund: _____ Savings Account: _____

Checking Account: _____ Savings Certificates: _____

U.S. Saving Bonds: _____ Christmas or Vacation Club: _____

Health Savings Account (HSA) Funds: _____

Other *(Please Explain):* _____

Monthly Household Expenses

Please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment of income downward. Lower-than average expenses will not result in an adjustment of income upward.

Mortgage/Rent: _____ Property Taxes: _____

Insurance: _____ Auto Loan: _____

Credit Cards (*Total*): _____ Water: _____

Gas: _____ Oil: _____

Electric: _____ Telephone: _____

Child Support: _____ Spousal Support: _____

Health Savings Account (HSA) Contributions: _____

Other (*Please Explain*): _____

Monthly Medical Expenses

Insurance Premiums: _____ Equipment: _____

Doctors' Visits: _____ Prescriptions: _____

Other (*Please Explain*): _____

Exhibit 3

GRAND VIEW HOSPITAL

Verification of Income, Countable Resources & Household Expenses

Please attach proof of income from the past 30 days, your monthly household expenses, and current resources to this application. Please verify all income, expenses and resources listed in Exhibit 2. If you are unable to verify some or all of your income, expenses or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income, expenses or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

Income and Resources

- ❑ Pay stubs or letters from employers, listing wages before taxes.
- ❑ Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- ❑ Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- ❑ Documentation of other sources of income.
- ❑ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- ❑ Health Savings Account (HAS) and other dedicated account statements.
- ❑ Checking and Savings account statements.
- ❑ Copy of Health Insurance Card(s), if applicable.

Expenses

- ❑ Bills or statements for any expenses you have listed.

Certification

Please sign and return the completed application with the items listed above.

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of financial assistance.

Signed: _____ Dated: _____

Exhibit 3A

[Date]

[Name]
[Street]
[City, State, Zip Code]

Dear [Name]:

Thank you for your application for financial assistance.

We are unable to complete your application with the information provided.

In order for us to make a determination of eligibility, we need the following information:

[1]

[2]

Please forward this information to the Patient Financial Services Department as soon as possible.

Your application for financial assistance will be closed if this formation is not returned within 30 days.

If the requested information is not received, your account(s) will be returned to our normal collection process and you will be expected to pay in full. Accounts not paid in full could be referred to a collection agency and may be reported to a credit reporting agency.

Please call Patient Financial Services at 215-453-4608 with any questions.

Sincerely

Coordinator
Patient Financial Services
215-453-4608

Exhibit 4

[date]

[name]
[street]
[city, state, zip code]

Dear [name]:

We have reviewed your application for Financial Assistance and have determined that your present financial situation does/does not qualify you for reduction or forgiveness of your hospital balance due. Please note that physician charges are not included. The following represents the calculation of payment due Grand View Hospital:

Total Charges for Services	_____
Less: Payments Received	(_____)
Outstanding Balance	_____
Amount of Reduced Charges or Forgiveness of Balance Due	_____
Amount Generally Billed	_____
Adjusted Balance Due from Patient	_____

Failure to pay the adjusted amount due will result in your account(s) being returned to GVH's normal collection activity including referral to a collection agency and to a credit reporting agency. Please contact our Patient Financial Services Department at the phone number below if you have any questions or to arrange payment terms of the adjusted balance due.

Sincerely,

[name]
Patient Financial Services Department
(215) 453-4608

Exhibit 5

GRAND VIEW HOSPITAL

FINANCIAL ASSISTANCE

Grand View Hospital is proud of its mission to provide quality care to the communities which we serve, 24 hours a day, 7 days a week, 365 days a year.

If you do not have health insurance or worry that you may not be able to pay for part or all of your care, we may be able to help. Grand View Hospital provides financial assistance to patients based on their income, assets, and financial needs. In addition, we may be able to help you apply for insurance coverage through the State Medical Assistance Program or to work with you to arrange a manageable payment plan.

For more information, please contact Hospital Patient Financial Services at 215-453-4608. We will treat your questions and any information you provide us with confidentiality and courtesy.

GVH

Exhibit 6

Grand View Hospital
Financial Assistance Calulation Worksheet
For Hospital Use Only

Patient Name:	
Account Number:	

A) Number in Household	0
B) Annual Income	$0.00
C) Net Assest Value	$0.00
D) Net Assest Value times 10%	$0.00
E) Eilgible Household/Medical Expenses	$0.00
F) Total (B plus D minus E)	$0.00
G) Financial Assistance Discount % (Exhibit B or C)	
H) Total Charges	$0.00
I) Financial Assistance (G times H)	$0.00
J) Patient Liability (H minus G)	$0.00
K) Medicare Rate/AGB Rate	$0.00
L) Final Patient Pay Lesser of (J) or (K)	$0.00