Boyd Healthcare Services
olicy & Procedure
Revised May 2012
Revised December 2012
Revised June 2018
(Combines and replaces previous Boyd Cares Program and Uninsured Patient Discount Policies)

PATIENT FINANCIAL ASSISTANCE POLICY

PURPOSE: To outline the process for Boyd Healthcare Services' (Boyd or the Hospital) Financial Assistance Program. Boyd will work to promote the health and well-being of the citizens of the community, and will provide care to patients for healthcare services provided by the hospital and its rural health clinics regardless of financial condition. Illinois resident patients who are uninsured (without *any* health insurance or coverage) may qualify for an uninsured patient discount in accordance with IL Compiled Statues (210 ILCS 89/ Hospital Uninsured Patient Discount Act). A patient may also qualify for financial assistance under the Boyd Cares Program who demonstrate the inability to pay and do not meet the qualifications of the Uninsured Patient Discount Act.

POLICY: Patients requiring financial assistance are those who qualify for discounts under the Illinois Uninsured Patient Discount Act and those who demonstrate the inability to pay (Boyd Cares Program), versus the unwillingness to pay (bad debt). The financial status of each patient should be determined so that an appropriate determination as to the eligibility of financial assistance can be made.

1. Financial assistance includes services provided to:
    a. Uninsured patients who qualify for discounts under the Illinois Uninsured Patient Discount Act.
    b. Patients that qualify for the Boyd Cares Program:
        a. Uninsured patients who do not meet the qualifications or deadlines required by the Illinois Uninsured Patient Discount Act.
        b. Patient's annual household income is less than 200% of the Federal Poverty Level.

2. Boyd will provide notification of the Patient Financial Assistance Program by:
    a. Posting signs in the registration area;
    b. In person; or
    c. On hospital bills delivered in the mail

3. The Financial Assistance Program (Program) is intended solely for the benefit of the patient and his or her family living within the same household as dependents. The Program also does not relieve third parties of liability for payment.

4. No refunds will be paid to a patient or guarantor approved for financial assistance on payments paid towards account balances.

5. Presumptive Eligibility will be used to outline the criteria Boyd will use to determine if a patient is eligible for hospital financial assistance without further scrutiny by the Hospital. Presumptive eligibility does not mean that patients automatically qualify for free care; rather that the patient is eligible for consideration of financial assistance eligibility without having to complete a full financial need application. Boyd will use the following criteria for presumptive financial need eligibility:

    a. Homelessness;
    b. Deceased with no estate;
    c. Mental incapacitation with no one to act on patient's behalf; or
    d. Medicaid eligible, but not on date of service or for non-covered service.

6. Uninsured Patients - Illinois Uninsured Patient Discount Act:

A. This Program covers Illinois resident not covered by any third-party insurance plan, including high deductible plans, workers' compensation, accident liability insurance, etc.

B. Patients who may be eligible for coverage under public programs such as Medicaid may be required to first apply to those programs prior to being considered for discounted services under the Uninsured Patient Discount Act. Thomas H. Boyd Memorial Hospital shall require patients to apply for Medicaid coverage to be eligible for the uninsured patient discount.

C. Boyd will provide a discount from its charges to any eligible IL resident uninsured patients who applies for a discount and has annual family (household) income of 300% or lower of the federal poverty level (FPL) for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter. Boyd shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 125% of the federal poverty income guidelines.

D. Proof of Illinois residence must be provided through ONE of the following:
   a. A valid state-issued ID
   b. A recent residential utility bill
   c. Lease agreement
   d. Vehicle registration card
   e. Voter registration card
   f. Mailed addressed to the uninsured patient at an IL address from a government or other credible source
   g. A statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or
   h. A letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility

E. Proof of income eligibility shall require ONE of the following acceptable forms of documentation for each source of household income:
   a. Copy of the most recent tax return
   b. Copies of the most recent pay stubs, or W-2 and 1099 forms (Preferred)
   c. Written income verification from an employer if paid in cash
   d. Other reasonable form of third party income verification as deemed acceptable by the hospital.

F. The Illinois Uninsured Patient Discount Act requires that charges in excess of $300 for any one inpatient admission or outpatient encounter shall be discounted to 135% of cost as determined by Worksheet C Part I of the Medicare Cost Report.
   a. The Hospital shall use all combined charges in excess of $300 and will not exclude from the discounted services calculation individual accounts that may be less than $300.
   b. Individual accounts $300 or less shall not be eligible for the uninsured patient discount; however, may still qualify for the Hospital's Boyd Cares Program described later in this policy.

G. Amounts Generally Billed: Patients will not be charged more for emergency or medically necessary hospital services than the Amounts Generally Billed (AGB) to insured patients. For these purposes, the allowed amount includes both the amount to be reimbursed by the insurer and the amount (if any) the individual is personally responsible for paying in the form of co-payment, co-insurance, or deductible. The Hospital uses the lookback method to calculate AGB based on actual billed claims paid to the Hospital by Medicare, Medicaid and private health insurers paying claims to the Hospital. The AGB percentage will be calculated annually by dividing the sum of all claims that have been paid full during the prior 12 month fiscal year

period by the sum of all gross charges for those claims. This resulting percentage will be applied to the uninsured individual's gross charge to reduce the bill. A revised percentage will be calculated and applied subsequent to the release date of the audited financial statements performed annually.

H. Each individual hospital can collect up to a maximum of 25% of the family's annual gross income in the 12-month period which begins on the date of service for which eligibility is first determined. Patients with substantial assets are excluded from the 25% limit.

I. The Hospital will provide the patient the ability to apply for discounted services for up to 60 days from the date of service. Patients not applying within 60 days shall forfeit the uninsured patient discount, however may apply for eligibility under the Boyd Cares program described below.

J. The Illinois Uninsured Patient Discount Act requires the patient to supply third party verification of income and assets within 30 days of request, or else risk forfeiture of the discount. Patients not supplying the required information within 30 days shall forfeit the uninsured patient discount and may apply for eligibility under the Hospital's Boyd Cares program.

6. Boyd Cares Program (Charity):

A. The Boyd Cares Program (Boyd Cares) covers uninsured patients who do not meet the qualifications or deadlines required by the Illinois Uninsured Patient Discount Act and have a household income would cause the applicant to be less than 200% of the Federal Poverty Level.

B. Such patients qualifying for the Financial Need Discount Program shall be eligible for discounts according to the following scale:

< 125% of poverty level	Full financial need write-off
126% to 150% of poverty level	75% financial need write-off w/ 25% of balance due from patient
151% to 175% of poverty level	50% financial need write-off w/ 50% of balance due from patient
176% to 200% of poverty level	25% financial need write-off w/ 75% of balance due from patient
> 200% of poverty level	No financial need write-off w/ 100% of balance due from patient

C. Proof of income shall require ONE of the following acceptable forms of documentation for each source of household income:
   a. Copy of the most recent tax return
   b. Copies of the most recent pay stubs, or W-2 and 1099 forms (Preferred)
   c. Written income verification from an employer if paid in cash
   d. Other reasonable form of third party income verification as deemed acceptable by the hospital.

D. To qualify under the Boyd Cares program, completed applications must be turned in to the Financial Counselor within 120 days of service.

7. A single application form is used for the Uninsured Patient Discount and Boyd Cares programs. Separate determination forms will be utilized to examine the applicant's eligibility under each program.

8. Boyd will provide notification of approval or denial of financial assistance to the patient based on completed application.

9. The maximum amount that may be collected in a 12 month period under the financial assistance policy is 25% of the patient's family income, and is subject to the patient's continued eligibility under the financial assistance policy.

10. The Hospital will forego extraordinary collection actions against an individual before the Hospital has made reasonable efforts to determine whether the individual is eligible for assistance under the hospital organization's

financial assistance policy.

1. The CEO and/or CFO oversees all financing procedures, and directs the authorized personnel who enforce the policies.

12. The Hospital will use the poverty guidelines established by the Department of Health and Human Services in effect at the time of application when reviewing the financial need of patients. The guidelines are used as an eligibility criterion in federal programs and are updated frequently by the federal government. Existing guidelines are updated annually.

13. Failure to complete necessary documentation will result in no discounts awarded under this policy.

14. Financial need applications can be re-evaluated and revoked if it is found that the recipient misrepresented their income, assets or other information on the financial need application.

Administrator: Deborah Cupbell Date: 8-1-18

Financial Officer: Kathryn Garner Date: 8-1-18

Implementation Date: ongoing

BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME ADDRESS		TELEPHONE NUMBER
CITY, STATE, ZIP		MARITAL STATUS
NAME AND ADDRESS OF EMPLOYER		EMPLOYER TELEPHONE NUMBER

FAMILY INFORMATION

SPOUSE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME ADDRESS, IF DIFFERENT THAN ABOVE		TELEPHONE NUMBER
NAME AND ADDRESS OF SPOUSE'S EMPLOYER		EMPLOYER TELEPHONE NUMBER
TOTAL NUMBER IN FAMILY/HOUSEHOLD _____	NAMES AND AGES OF DEPENDENTS (CHILDREN)	

PROOF OF IL RESIDENCY

PLEASE PROOF OF ILLINOIS RESIDENCE (a valid state-issued ID, recent residential utility bill, lease agreement, vehicle registration card, voter registration card, mailed addressed to the uninsured patient at an IL address from a government or other credible source, a statement from a family member of the uninsured patient who resides at the same address and presents verification of residency; or a letter from a homeless shelter, transitional house or other similar facility verifying that the uninsured patient resides at the facility).

PROOF PROVIDED?	☐ YES ☐ NO

PRESUMPTIVE ELIGIBILITY - Uninsured Discount Analysis to be completed if uninsured

DECEASED WITH NO ESTATE	☐ YES ☐ NO		HOMELESS	☐ YES ☐ NO		MEDICAID ELIGIBLE, BUT NOT ON THE DATE OF SERVICE	☐ YES ☐ NO	
MENTAL INCAPACITATION	☐ YES ☐ NO	***IF YOU HAVE ANSWERED YES TO ANY QUESTION IN THIS SECTION, DO NOT PROCEED WITH REMAINDER OF THE FORM, EXCEPT FOR "PATIENT AGREEMENT" ON PAGE 2. IF YOU HAVE ANSWERED NO, PROCEED TO NEXT SECTION.						

MONTHLY FAMILY INCOME

VERIFICATION: Proof of income eligibility MUST BE PROVIDED from the following acceptable forms of documentation for each source of household income: Examples include a copy of the most recent tax return, copies of the two most recent pay stubs, or W-2 and 1099 forms (Preferred), written income verification from an employer if paid in cash, other reasonable form of third party income verification as deemed acceptable by the hospital, benefit statements, court orders, etc.

☐ WEEKLY ☐ MONTHLY ☐ ANNUAL

DESCRIPTION	BALANCE	DESCRIPTION	BALANCE	DESCRIPTION	BALANCE
PATIENT GROSS INCOME		RENTAL INCOME		WORKERS COMP	
SPOUSE GROSS INCOME		ALIMONY/ CHILD SUPPORT		PENSION	
SOCIAL SECURITY		UNEMPLOYMENT		OTHER	
INTEREST/ DIVIDENDS		DISABILITY		OTHER	

TOTAL MONTHLY INCOME AMOUNT: _____

MONTHLY EXPENSES

MONTHLY EXPENSE: SINCE MONTHLY EXPENSES ARE NOT FACTORED INTO THE HOSPITAL'S DETERMINATION OF FINANCIAL NEED ELIGIBILITY, THE PATIENT IS NOT REQUIRED TO SUBMIT OTHER MONTHLY EXPENSE DATA AS PART OF THE APPLICATION PROCESS UNLESS IT BECOMES NECESSARY TO HELP VALIDATE THE APPLICANT'S INCOME.

BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION (Continued)

ADDITIONAL INFORMATION REGARDING FINANCES

VERIFICATION: For verification purposes, please include copies of last two months of the items below.

DESCRIPTION	BALANCE
CHECKING ACCOUNT	
SAVINGS ACCOUNT	

DESCRIPTION	BALANCE
HEALTH SAVINGS/ FLEX SPENDING	
STOCKS / MUTUAL FUNDS	

DESCRIPTION	BALANCE
CERTIFICATE OF DEPOSIT	
OTHER	

LIST OTHER ASSETS OWNED (HOME, VEHICLE, ETC): _____

TOTAL ASSETS VALUE: _____

OTHER INFORMATION

LIST OTHER OUTSTANDING MEDICAL EXPENSES:

PROVIDER: _____ AMOUNT: _____

PROVIDER: _____ AMOUNT: _____

PROVIDER: _____ AMOUNT: _____

ADDITIONAL COMMENTS: _____

PATIENT AGREEMENT

The undersigned applies for financial assistance in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The creator will retain the original or a copy of this application, even if financial assistance is not granted. The undersigned also agrees to allow Boyd to contact any or all of the above references for credit verification, including credit bureaus. The falsification of data may result in the reversal of any financial assistance.

Patient Signature: _____ Date _____

Responsible Party or Spouse Signature: _____

BOYD HEALTHCARE SERVICES
PATIENT FINANCIAL ASSISTANCE APPLICATION (Continued)

**REMAINING PORTION OF APPLICATION WILL BE COMPLETED BY BOYD

ACCOUNT NUMBER(S): _____ ACCOUNT BALANCE(S): _____

UNINSURED DISCOUNT

Uninsured Discount Calculation:

For uninsured patients with income < 300% FPL only

A. Is the patient's family income 125% or less of the Federal Poverty Level? ☐ YES ☐ NO

* If yes, 100% discount to be given, remainder of form can be disregarded.
* If no, complete remainder of section

If A. from above is a "no" response, complete B. - D.:

B. Total uninsured charges:
(accounts with charges > $300) _____

C. Uninsured Discount

([1-(1.35*cost report cost to charge ratio)]	0.255	
Plus additional discount*	0.175	0.43

D. Discount (B * C) _____

*Patients will not be charged more than the Amounts Generally Billed (AGB) to those patients who have insurance. Based on FY17 Cost Report, patients cannot be charged more than 57% of gross charges.

BOYD CARES PROGRAM

Boyd Cares Program/Financial Assistance Calculation:

Family size: _____

Monthly family income (from above): _____

A. Using Sliding Fee Schedule, which discount percentage does the patient qualify? _____

B. Total Charges: _____

C. Boyd Cares/Financial Assistance write-off (A*B): _____

HOSPITAL APPROVAL

Financial Counselor Signature:_____ Date_____

CEO / CFO Approval:_____ Date_____

BOYD HEALTHCARE SERVICES

800 School Street Carrollton, IL 62016 (217)942-6946

2019 SLIDING FEE SCHEDULE

Maximum Annual Income Amounts for each Sliding Fee Percentage Category						
Poverty Level*	**100%**	**101-125%**	**126-150%**	**151-175%**	**176-200%**	**>200-300%**
Family Size	**100% discount**	**100% discount**	**75% discount**	**50% discount**	**25% discount**	**0% discount**
1	$12,490	$15,613	$18,735	$21,858	$24,980	$37,470
2	$16,910	$21,138	$25,365	$29,593	$33,820	$50,730
3	$21,330	$26,663	$31,995	$37,328	$42,660	$63,990
4	$25,750	$32,188	$38,625	$45,063	$51,500	$77,250
5	$30,170	$37,713	$45,255	$52,798	$60,340	$90,510
6	$34,590	$43,238	$51,885	$60,533	$69,180	$103,770
7	$39,010	$48,763	$58,515	$68,268	$78,020	$117,030
8	$43,430	$54,288	$65,145	$76,003	$86,860	$130,290
For each additional person, add	$4,420	$5,525	$6,630	$7,735	$8,840	$13,260

*Based on Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)