Policy /Procedure Document	
Category/Source:	
Origination Date:	7/1/2004
Policy Number:	
Last Review Date:	4/15/2025
Last Revised Date:	4/15/2025
Next Review Due:	4/01/2026
Policy Owner:	Executive Director of Revenue Cycle
Required Approvals:	
	Chief Financial Officer
	Board of Directors

TITLE:	**Financial Assistance Policy**
SCOPE:	Beacon Health System patients receiving Emergency and/or Medically Necessary Care
PURPOSE:	• Ensure transparency, consistency and fairness towards uninsured (self- pay) patients and set guidelines for providing a financial adjustment to any uninsured or underinsured patient who obtains Medically Necessary or Emergency Services from any Beacon Health System facility. This policy ensures that Beacon Health System is compliant with the Patient Protection and Affordable Care Act and Internal Revenue Code section 501(r). This requires tax-exempt hospitals to limit amounts charged to uninsured patients for emergency and other medically necessary care to no more than those amounts generally charged to insured patients. • Screen uninsured patients for: their ability to pay, possible eligibility for health coverage programs or third-party coverage, and all available resources in order to identify charity cases in a timely manner. Health coverage programs could include, but are not limited to, Medicaid, Medicare Savings Programs, subsidized insurance plans purchased through the "Marketplace" or Affordable Care Act (ACA) Exchange, or other state, federal and local programs. To qualify for financial assistance, an individual must apply and comply with the application for any other possible payer source. • Provide program application assistance procedures, the method for applying for Beacon Health System financial assistance, the policy for the basis of calculating eligibility for free or discounted care and the actions the hospital may take in the event of non-payment.
POLICY/PROCEDURE:	

Regardless of an individual's ability to pay or qualify under this Financial Assistance Policy, Beacon Health System will provide, without discrimination, care for any emergency medical condition(s) as designated under the U.S. federal governments Emergency Medical Treatment and Labor Act (EMTALA) of 1986.

No person shall be discouraged from seeking emergency care.

No person shall be excluded from consideration for financial assistance based on age, color, creed, ethnic background, gender, national origin, physical disability, race or religion.

Uninsured (self-pay) Discounts:

Hospital Services: Patients who are uninsured (self-pay) will receive a 35% discount off their gross charges. This discount applies to all hospital services and is exclusive to any other discounts.

Ambulatory Services: Patients who are uninsured (self-pay) will receive a 20% discount off their gross charges. This discount applies to all services rendered Beacon Medical Group and Beacon Health, LLC, and is exclusive to any other discounts.

This Financial Assistance Policy applies to services provided and billed by Beacon Health System. It does not apply to physicians who are not employed by Beacon Health System and may provide services to patients of the hospital. Please see Attachment 2 for a list of provider groups who are not covered by this Financial Assistance Policy.

To manage its resources responsibly and to allow Beacon Health System to provide the appropriate level of assistance to the greatest number of persons in need, the following guidelines for the provision of financial assistance have been established.

Definitions:

- Amount Generally Billed (AGB) – Beacon Health System will apply the "look-back method" for determining AGB. In particular, Beacon Health System will determine the AGB for emergency or other medically necessary care by multiplying the Gross Charges for such care by the AGB Percentage.
- AGB Percentage – Beacon Health System will calculate the AGB percentage at least annually by dividing (1) the sum of payments on all claims allowed during the 12-month period from in the prior calendar year by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by (2) the sum of the associated gross charges for those claims.
- Cosmetic Services – those services and procedures that enhance the patient's well-being, are generally not covered by any insurance, and are categorically excluded from any financial or economic assistance.
- Emergency Services – an emergency accident, meaning a sudden external event resulting in bodily injury, or an emergency illness, meaning the sudden onset of acute symptoms of such severity that the absence of immediate medical attention may result in serious medical consequences or as defined in Section 1867 of the Social Security Act
- Elective Services – Healthcare services and procedures that are needed to support the health and well- being of the patient whether they are deemed medically necessary. Such services are eligible for consideration under this policy. A physician order containing the reason for the test or procedure may be required.
- Gross Charge – An established price, listed on the hospital's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any contractual allowances, discounts or deductions.
- Household Unit – one or more persons who reside together and are related by birth, marriage, or adoption Patients over the age of 18, such as adult children living with their parents, siblings or friends are not considered part of the household unit unless such persons are legally obligated for the debts of the patient.
- Income – Income includes salary and wages, interest income, dividend income, social security, workers compensation, disability payments, unemployment compensation, business income, income from pensions and annuities, farm income, rentals and royalties, inheritance, strike benefits, and alimony payments. Income is also defined as payments from the state for legal guardianship or custody.
- Medically Necessary – for the purpose of this policy is defined as a service that is necessary to treat a condition that in the absence of medical attention could reasonably be expected to result in jeopardizing the health or condition of the individual.
- Plain Language Summary – A statement written in clear, concise, and easy to understand language notifying individuals that Beacon Health System offers financial assistance.
- Self-Pay or Uninsured – A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of workers compensation, automobile insurance or other insurance as determined and documented by the hospital.

- Underinsured patient – A patient and/or responsible party with third party coverage for healthcare service who may have an extraordinary amount due that they cannot pay due to household unit income.

Financial Assistance Program Availability

Beacon Health System will widely publicize assistance availability using the following methods:

- The Financial Assistance Policy and Plain Language Summary will be made available at each of the main patient access and registration points at each hospital facility and medical practice. Posted materials will include instructions on how to obtain a printed version of the plain language summary and the Financial Assistance application free of charge.
- The Financial Assistance Policy summary and application will be available online at www.beaconhealthsystem.org/assist
- Information on how to apply for financial assistance will be included on the patient's statements.

Printed copies of the Financial Assistance Policy and Application may also be obtained by:

- Calling Customer Service at (574) 647-7167
- Presenting to the Cashier's office located at:
    - Memorial Hospital of South Bend
      615 N. Michigan St., South Bend, IN 46601

      Elkhart General Hospital
      600 East Boulevard, Elkhart, IN 46514

      Community Hospital of Bremen
      1020 High Rd, Bremen, IN 46506

      Three Rivers Health
      715 S Health Pkwy, Three Rivers, MI 49093

- Request by mail in writing to:
  Beacon Central Office
  Attn: Patient Accounts
  3245 Health Drive
  Granger, IN 46530

Patients with balances after insurance (e.g. deductibles, co-pays, and co-insurance amounts) may be eligible for Financial Assistance if the eligibility requirements are met whether the health plan is contracted or non-contracted.

Patients who have exhausted policy limits are eligible for Financial Assistance if the eligibility requirements are met. (The remaining account balances after the policy limits are exhausted are considered uninsured and are eligible for the Financial Assistance, or self-pay discount if not eligible for Financial Assistance.) Medicare patients are eligible for Financial Assistance if the eligibility requirements are met.

Patient must cooperate in supplying all third-party insurance information and third-party liability information. The patient must exhaust insurance/third-party liability coverage prior to patient receiving financial assistance.

The patient must cooperate with pursuing enrollment in all affordable health coverage programs that are accessible to them prior to consideration of financial assistance approval. Assistance with the assessment and enrollment is provided as a service of the hospital free of charge to the patient by certified Navigators and Certified Application Counselors certified in Indiana and Michigan.

If the account is assigned toa collection agency, the patient may still apply for Financial Assistance.

Application for Assistance

The patient's eligibility for Financial Assistance will be determined through an application process. Beacon Health System's Financial Assistance Application form is the valid application form for the application process. Beacon Health System's Financial Assistance Policy and application will be made available to all patients.

- A signature is required on the application (the patient, guarantor or legal representative). It is the responsibility of the patient/guarantor to complete an assistance application.
- The application requires the patient to provide their name, current address and valid contact information and the names and ages of persons in their household.
- The application requires the patient to list all income amounts, their sources, expenses and assets. Documentation of all information provided on the application is required to complete the assistance application. Beacon Health System, or its designee, may use national databases from credit bureaus to verify or validate the information that is provided. A written statement from the individual(s) who are supporting the applicant may also be requested if current income or lack thereof is not sufficient to meet their daily living expenses.
- Patient Financial Counselors are available to help anyone applying for assistance and are available during business hours at the hospital facilities Verification of requested income and a complete list of all countable household members may be required.
- A Financial Assistance application may be used for covered services that are provided up to six months after the date the Financial Assistance application was approved.
- The patient may appeal the decision of denied financial assistance by writing:

  Executive Director of Revenue Cycle
  3245 Health Dr.
  Granger, IN 46530

Charges

Beacon Health System will not bill patients approved for financial assistance under this policy for emergency or other medically necessary care more than the amounts generally billed to individuals who have insurance (i.e., Beacon Health System will not charge patients approved for Financial Assistance under this Policy for emergency or other medically necessary care more than the Gross Charges for such care multiplied by the AGB Percentage. Refer to AGB percentage in Attachment 1.

Financial Assistance Criteria

The policy set forth allows for patients to qualify for assistance by two means: financial or catastrophic. The Financial Assistance Program also allows for partial assistance or full assistance based on eligibility criteria set forth in this policy.

Financial Assistance

- A patient qualifying for financial assistance is a person who is uninsured or underinsured, receives medically necessary care and unable to pay their bill.
- To be eligible for assistance under the financial assistance guidelines, a person's income shall be at or below a percentage of the Federal Poverty Level (FPL) as determined by Federal Poverty Guidelines. (See Attachment 1 for a table of approval percentages based on % of FPL). Household size and income determines the % of FPL. Beacon Health System, or its designee, may consider other financial assets and liabilities of the person when determining eligibility.
- Beacon Health System will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for financial assistance. The poverty income guidelines are published annually in the *Federal Register* and for the purposes of this policy will become effective the first day of the month following the month of publication.
- To qualify under the Financial Assistance portion of this policy, a completed, signed Financial Assistance application must be submitted and proof of income, letter of support, proof of financial assets and

other required documents must accompany the application.

Catastrophic Assistance Criteria

- A patient qualifying for catastrophic assistance is a person whose hospital bills exceed a specified percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill.
- To be eligible for catastrophic assistance the amount owed by the patient must exceed one hundred fifty (150) percent of the patient's annual gross income and the patient must be unable to pay the remaining bill. Beacon Health System may consider other financial assets and liabilities of the person when determining ability to pay.
- If a patient has cash assets, those assets may be considered as well relative to the amount billed.
- If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should their financial circumstances change.
- After eligibility is determined under this provision, assistance will be provided to discount the bill by 75% of the current balance.

Factors to be considered for Financial Assistance

Household Size and Income

The following factors may be considered in determining the eligibility of the patient for assistance by all income earning residents in the countable household unit unless they are not dependents based on IRS guidelines for determining whether a household member can be considered a dependent.

- Last 3 pay stubs or a letter from employer(s) providing verification of gross income if currently employed. This documentation should not be more than 30 days old from date of issue and include year-to-date information.
- Last 3 bank statements (including explanations of regular deposits not explained by pay stubs)
- Social Security award or entitlement letter or other proof of gross monthly award.
- Retirement income.
- Investment income.
- Statement from person(s) who are providing direct support when there is no income reported.
- Number of dependents as defined by the IRS
    - Child under the age of 19 by the end of the year.
    - Child under the age of 24 and full-time student (must provide proof),
    - Child lived in the household more than half of the year.
    - Child was not self-support more than half of the year.
- Most recent tax return (including all supporting schedules), if available.
- List of expenses
- Other financial resources that produce income.
- If Self-Employed, Gross Income less Cost of Goods sold (information typically available on Schedule S) .

Financial Capacity

- Individuals with the financial capacity to purchase health insurance coverage through the Health Insurance Marketplace may be required to purchase and will be provided access to meet with an Indiana Certified Navigator as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.
- Individuals who have been found to be ineligible for Medicaid or other affordable health care coverage must provide proof of denial.
- Food Stamps or Supplemental Nutrition Assistance Program (SNAP) will not be counted as income.

Reasons for not being eligible for Financial Assistance

- Household income exceeds the maximum of the FPL; however, the patient may qualify under the catastrophic provision of this policy.

- If a patient is eligible for Medicaid, the Health Insurance Marketplace, (Healthcare.gov) or other state or federal programs and the patient fails to cooperate in the application, re-application, or appeal process, or the patient does not pay the required monthly premium, thereby making the patient ineligible for the State program.
- If the patient is eligible and enrolled in a Healthcare Marketplace plan and does not pay the required monthly premium, thereby causing the health plan to discontinue coverage.
- Services are not medically necessary or excluded from the program.
- Excluded services include, but are not limited to:
    - Cosmetic surgery
    - Infertility treatments, fertility services, sterilization, reversal of sterilization;
    - Services denied by your insurance due to non-compliance with your insurance coverage requirements;
    - Services reimbursed directly to you by your insurance company;
    - Services reimbursed by another third party
    - Services required for employment, schools, or athletics

Presumptive Eligibility

A patient in any of the following circumstances will be automatically deemed eligible for financial or economic assistance (presumptively eligible). No assistance application is necessary if patient is deemed presumptively eligible for assistance. Documentation validating these circumstances may be required.

- Patient and/or responsible party reside at Salvation Army, Center for the Homeless, Hope Rescue Mission, or any similar homeless shelter or they are homeless and are ineligible for Medicaid or other health coverage programs.
- Patient is deceased and no estate has been opened
- Patient is enrolled in a limited benefit Medicaid program (i.e. Emergency Only, Family Planning, etc) and the current service is not covered by their Medicaid plan. There must be a denial of coverage from Medicaid prior to the balance being adjusted to charity.

Failure to Provide Appropriate Information

Failure to provide information necessary to complete a financial assessment may result in a negative determination The account may also be submitted for approval if Beacon Health System has been able to verify information from a reliable third party, i.e. Social Security, Medicaid, credit reporting bureau, etc.

A determination of eligibility for financial or catastrophic assistance may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances. This will be approved at the discretion of the Executive Director of Revenue Cycle.

Patients who fail to provide required documentation or information will be provided notification.

No patient may be denied assistance due to their failure to provide information or documentation not specified in this policy or the financial assistance application.

Financial Assistance Determinations

All complete applications will receive a determination for the award of financial assistance. The patient will be provided with a written copy of the final determination.

Favorable Determinations

A favorable determination will include the following information:

- The date of approval
- Percentage of approved assistance
- Length of time that approval is applicable

Unfavorable Determination

An unfavorable determination will include a reason:

- Services are categorically excluded from consideration (i.e. non-emergent or cosmetic)
- The individual is fully covered, or receives services fully covered by a third-party insurer or government program
- The eligibility standards under FPL were not met
- The individual did not take reasonable action to obtain third-party coverage they were determined to be eligible for.
- They have received payment from a third-party for services
- The individual has not complied with requests from third-party payer

Credit and Collections Practices

Beacon Health System relies on timely payment of patient accounts receivable to allow the H to continue to provide high-quality medical care and to secure the latest in health care technology for its patients. Beacon Health System, recognizing the burden that unexpected health care expenses can place on patients and their families, will assist patients to resolve open accounts for hospital services by working with third party payers to adjudicate patient's insurance claims and by providing alternative payment plans for patients. With the exception of some Government and contracted care plans, ultimate responsibility for resolution or payment of accounts rests with the patient. Patients are expected to work with Hospital personnel to resolve accounts with their insurance companies and/or employers as appropriate. Where there is an estimated self-pay balance due, Beacon Health System will ask non-emergency patients to pay that balance prior to or at the time of admission/registration.

- Uninsured patients will be screened for other coverage through state assistance programs and/or financial assistance eligibility prior to requesting a deposit for care.
- Beacon Health System may request and collect a deposit, based on the patient's total estimated portion of a bill, from appropriate non-emergency inpatient admissions, same day surgery patients, and patients scheduled for outpatient procedures prior to or at the time of admission or registration. In the event that a request for payment is not made prior to or at the time of the patient's arrival, a Financial Counselor may calculate the estimated deposit amount and confer with the patient/guarantor for payment following the admission or registration process via a financial interview. (In some instances, this could occur while the patient is in his/her assigned room.) At the time of discharge, Emergency patients may be requested to pay any co-pay or deductible.
- Where appropriate, Beacon Health System may identify and request payment of, aged patient balances as part of the request for deposit. Payment for open prior balances will not delay emergency or medically necessary care. Aged open prior balances will be considered by the Patient Financial Counselor whenever payment arrangements or an alternative payment program is developed for a patient.
- Uninsured patients are given a 35% discount from gross charge for hospital charges. Uninsured patients are given a 20% discount from gross charges for physician services
- In addition to cash, check, and credit cards, the approved payment arrangement methods might include:
    - Payment Plan – A payment plan directly with the hospital is not to exceed twelve months.
    - HELP Financial– An extended payment plan which allows the patient an extended period not to exceed 36 months at 0% interest to pay their balance starting at $100Patients may elect to enroll in a HELP Financial Payment Plan at any point during the collection process.
    - Medicaid Program Eligibility– Patients who do not have coverage when they present to the hospital for treatment will be screened for other coverage through state assistance programs. An Eligibility Specialist will assist the patient/guarantor to complete and submit all necessary forms required by the Indiana Department of Public Aid for these types of programs.
    - Hospital Financial Assistance – Reasonable efforts will be made to determine if patients are eligible for Financial Assistance through the hospital Financial Assistance Program.
- If a patient does not qualify for financial assistance and does not pay their account according to the

options provided or fails to pay their balance after applying qualified financial assistance, then the patient's account will be processed for placement with a collection agency according to the Bad Debt Write Off policy.

- Patients will be issued a Final Notice 30 days prior to placing accounts with a collection agency and pursuing any extraordinary collection actions. Extraordinary collection actions will not be taken until after Beacon Health System has made reasonable efforts to determine if a patient will qualify for financial assistance. Extraordinary collection actions may include suit and/orwage garnishment,

Failure of Patient to pay Remainder of Account after Financial Assistance

Failure of a patient/guarantor to pay the remainder of their account after deducting the assistance portion may cause the account to be placed with a collection agency. Patients will be issued a Final Notice 30 days prior to placing accounts with a collection agency. The remainder of the account will be subject to any collection action including legal recourse such as suit and/or wage garnishment if it remains unpaid.

Processing and Approvals

Once a patient's financial assistance application has been processed, a request will be sent for approval. Approvals are required based on the below amounts:

Up to $250	Patient Financial Counselor
Up to $10,000	Patient Accounts Manager
Up to $25,000	Patient Accounting Director
Up to $50,000	Executive Director of Revenue Cycle
Up to $100,000	VP of Finance
Unlimited (required over $100,000)	Chief Financial Officer

Financial Assistance will apply retroactively to all open accounts with dates of service that are within the applicable statute of limitations.

	Document Revision History:		
Review Date:	**Revised Date:**	**Reviewed/Revised By:**	**Summary of Changes:**
11/22/2015	11/22/2015	Julie Phillips	Updated to new policy format. Expanded definitions for approval criteria. Changed approval level for Coordinator to align policies with both hospitals in the system. Added definition for Catastrophic Assistance. Added list of non-covered providers. Updated language surrounding calculation of AGB. Added limit for lookback timeframe for account approvals.
11/30/2017	1/7/2018	Julie Phillips	Added billing and collections practices into Financial Assistance Policy. Updated approval levels to add level for Executive Director. Updated Office address for Billing Office
05/01/2023	10/01/2023	Molly Hanson	Made updates to include non contracted health plan considerations. Also, added information regarding Medicare Bad Debt exclusions.
4/15/2025	4/15/2025	Molly Hanson	Aligned language to create single, system-wide policy. Added approval level for VP of Finance; aligned timeline on prior balances to statute of limitations; updated CarePayment to HELP Financial; clarified language, updated non-covered providers attachment; updated AGB; updated non-covered providers list

SIGNATURES OF APPROVAL:

Date Signed	Signature		
4/22/2025	**Approved at Beacon Health System Finance Committee**		

Attachment 1

Discount Schedule

Percentage of Federal Poverty Level (FPL)	Reduction Percentage
0% to 200%	100%
201% to 300%	75%
301% to 350%	69%(AGB percentage*)

*AGB percentage updated 4/15/2025

Attachment 2

Providers Not Covered by Financial Assistance Policy

- South Bend Emergency Physicians
- Elite Emergency Physicians Inc.
- Apogee Medical Management, Inc.
- South Bend Clinic
- Elkhart Clinic
- Radiology, Inc
- ObGyn Associates of Northern Indiana
- Michiana Anesthesia Care (Southeast Anesthesia)
- Allied Physicians of Michiana
- South Bend Orthopaedics
- Orthopedic & Sports Medicine Center (OSMC)
- Michiana Hematology/Oncology
- Pediatrix, Inc
- South Bend Medical Foundation
- Nephrology Physicians, LLC
- Otorhinolaryngology Associates
- Oaklawn Psychiatric Center
- Campbell Ear, Nose and Throat
- General and Vascular Surgery
- Pediatric Cardiology of Michiana
- Midwest Eye Consultants
- Michiana Gastroenterology
- Family Medicine of South Bend
- Bendix Family Physicians
- River Park Family Medicine