



Charity Care/Financial Assistance
Chapter: Finance
Policy Number: FIN 27
Origination Date: 1/27/2025
Last Revised: 2/24/2025

Policy

Healthcare Systems of America (HSA) is committed to meeting the health care needs of members of the HSA communities who are unable to pay for medically necessary care received at HSA healthcare facilities in the State of Texas, including without limitation those who are uninsured, underinsured, ineligible for a government program, or otherwise unable to make payment.

This policy establishes a framework pursuant to which St. Joseph Medical Center will properly identify patients that may qualify for financial assistance with their medical expenses under the guidelines and requirements set forth below.

HSA provides a reasonable amount of its emergency and medically necessary services at a discounted rate or without charge to eligible patients who cannot afford to pay for care, to limit expected payment from eligible patients that are uninsured or who have high medical costs with income at or below 400% of the federal poverty level.

Medically necessary services (consistent with generally accepted standards of medicine in the community) of this facility will be available as uncompensated services to eligible patients.

Eligibility for financial assistance is determined by the inability of a patient to pay, versus bad debt as the unwillingness of the patient to pay. Charity Care does not include bad debt, contractual adjustments, or unreimbursed costs. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity care and bad debt.

All individuals presenting on hospital property requesting emergency medical services, individuals presenting to a Dedicated Emergency Department requesting medical services, and patients arriving/presenting via ambulance requesting medical services shall receive an appropriate Medical Screening Examination and Stabilization services as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395 and all Federal regulations and interpretative guidelines promulgated thereunder.

Scope

This policy applies to HSA Texas facilities.

Definitions

Federal Poverty Guidelines (FPG): A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits such as health insurance and/or financial assistance.

Family: Includes the patient, the patient's spouse or domestic partner, parent, and/or caretaker of minors and dependent under the age of 21 whether living at home or not.



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Proof of Income: Total salaries, wages, and cash receipts before taxes. If the patient/applicant reports zero income, the patient/applicant will be required to report on the application how the patient/applicant and his/her family are surviving.

Procedure

A. Eligibility Requirements

1. Uninsured patients who do not have the ability to pay as determined by the financial guidelines in this policy.
2. Patients who have Medicaid Emergency coverage (and no share of cost) and whose services are not covered for a particular episode or partial episode of care. (the patient is presumed to meet the charity care eligibility requirements);
3. Uninsured patients that were screened, stabilized, or admitted through the Emergency Department that cannot be reached will be classified as charity care.
4. There are instances when a patient may appear eligible for charity care discounts, but there is a lack of supporting documentation. Presumptive eligibility charity maybe determined on the basis of individual life circumstances that may include but are not limited to:
 - a. State-funded prescription programs;
 - b. Homeless or received care from a homeless clinic or shelter;
 - c. Participation in Women, Infants and Children Programs (WIC);
 - d. Food stamp eligibility;
 - e. Subsidized school lunch program eligibility;
 - f. Low income/subsidized housing is provided as a valid address;
 - g. Patient is deceased with no known estate; and
 - h. Patients who are currently eligible for Medicaid but were not eligible in one to three months prior to eligibility are presumed to be eligible for charity.
 - i. Undocumented patients
5. Insured patients whose coverage is inadequate to cover a catastrophic situation;
6. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large medical bills;
7. Insured and uninsured patients who demonstrate ability to pay part but not all of their liability. For example, those who have an out of pocket that exceeds 10% of their annual net family income in the prior twelve months.



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B. Eligibility Procedures

1. In addition to the eligibility requirements above, consider the following factors to determine the amount of assistance for which a patient is eligible at the time of service:
 - a. Consider the patient's individual or family income, as appropriate, using the income guidelines in this policy.
 - b. Consider individual or family net worth including all liquid and non-liquid assets owned, less liabilities and claims against assets. Monetary assets shall not include retirement or deferred-compensation plans. Furthermore, the first ten thousand (\$10,000) dollars of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50% of a patient's monetary assets over the first ten thousand (\$10,000) dollars be counted in determining eligibility.
 - c. Consider employment status along with future earnings sufficient to meet the obligation within a reasonable period of time. Consider family size, family includes the patient, the spouse or domestic partner, parent and/or caretaker of minors and dependent children less than 21 years of age, whether living at home or not.
 - d. Consider other financial obligations including living expenses and other items of a reasonable and necessary nature.
 - e. Consider the amount(s) and frequency of hospital and other healthcare/medication bill(s) in relation to all of the factors outlined above.
 - f. All other resources must be applied first, including third-party payers. If a patient does not have Medicaid but would qualify, he/she should be encouraged to cooperate with the application process.
2. Determine the appropriate amount of financial assistance in relation to the amounts due after applying all other eligible resources. A patient who can afford to pay for a portion of the services will be expected to do so. Reasonable payment guidelines as defined in this policy and by law will be incorporated. Part of an account might be paid by a third party, part by the patient; part may be adjusted to a charity write-off.
3. Request evidence of eligibility especially for large balance accounts. The patient must provide supporting documentation of income which can include:
 - a. Recent pay stubs such as paychecks, General Relief, Social Security, pension, unemployment or disability check stubs, or tax returns;
 - b. Application verification may include accessing of the patient/guarantor's credit report. The patient must sign the charity form or Consent of Admissions prior to accessing his/her credit information.



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4. Determine eligibility for financial assistance at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.
5. Financial counselors, registration clerks, care managers, Patient Accounting staff and patients can initiate process.

C. Application

See policy attachment “Financial Assistance Application”.

D. Documentation Requirements

1. All patients must complete the “Financial Assistance Application” to be considered for Financial Assistance unless they are eligible for Presumptive Financial Assistance. An unsigned application can be deemed acceptable if the patient is physically unable to sign or does not live within the vicinity of the hospital or unable to return the application by mail. In these situation’s only, the hospital representative should complete all questions on the application, sign it and document why the patient is unable to sign the application.

Attachments

Amount of Financial Assistance/Charity Care Determination

Financial Assistance Application

References

Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C. Section 1395

2024 Federal Poverty Guidelines, Federal Register Notice January 17, 2024:

<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

SJMC Policy: RI 01 Emergency Medical Treatment and Labor Act (EMTALA)



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Review and Approval

The following St. Joseph Medical Center personnel have reviewed and approved this policy:

Action Date	Contact	Approved by	Description
01/27/2025	Sr. Vice President, Corporate Revenue Cycle, American Healthcare Systems (known as Healthcare Systems of America [HSA]) Director, Patient Access Director, Business Office	St. Joseph Medical Center Policy Oversight Management Committee (POMC) [2/06/2025] St. Joseph Medical Center Senior Leadership [2/06/2025] St. Joseph Medical Center Medical Executive Committee [2/11/2025] St. Joseph Medical Center Governing Board [2/24/2025]	New HSA policy released by Corporate to Texas facilities. Formatted to SJMC policy template.

****Note: this policy requires annual review and updated for revised Federal Poverty Guidelines.***

Amount of Financial Assistance/Charity Care Determination is Based on

Methodology: HSA uses the "Sliding Scale Method" to determine the dollar amount to be considered as charity care for eligible patients.

Charity Care: Patient applications that show that family income at or below 200% of the current year Federal Poverty Guidelines (FPL) will be approved for no-cost to the patient.

Discounted Charity Care: Patient applications that show that family income between 201% and 400% FPL will be granted a charity care discount, the lessor of the Amounts General Billed (AGB) or discounts as outlined below.

HSA will utilize the Prospective Medicare methodology to determine the AGB for inpatient and outpatient accounts when determining patient liability for individuals who qualify for financial assistance. The billed amount will not exceed the AGB.

The FPL for the current year can be obtained from the following website:

<https://aspe.hhs.gov/poverty-guidelines>

Federal Poverty Level	100%	200% <=	201-250%	251 -300%	301-325%	326-400%
Persons	Gross Annual Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income
1	\$ 15,060.00	\$ 2,510.00	\$ 3,137.50	\$ 3,765.00	\$ 4,078.75	\$ 5,020.00
2	\$ 20,440.00	\$ 3,406.67	\$ 4,258.33	\$ 5,110.00	\$ 5,535.83	\$ 6,813.33
3	\$ 25,820.00	\$ 4,303.33	\$ 5,379.17	\$ 6,455.00	\$ 6,992.92	\$ 8,606.67
4	\$ 31,200.00	\$ 5,200.00	\$ 6,500.00	\$ 7,800.00	\$ 8,450.00	\$ 10,400.00
5	\$ 36,580.00	\$ 6,096.67	\$ 7,620.83	\$ 9,145.00	\$ 9,907.08	\$ 12,193.33
6	\$ 41,960.00	\$ 6,993.33	\$ 8,741.67	\$ 10,490.00	\$ 11,364.17	\$ 13,986.67
7	\$ 47,340.00	\$ 7,890.00	\$ 9,862.50	\$ 11,835.00	\$ 12,821.25	\$ 15,780.00
8	\$ 52,720.00	\$ 8,786.67	\$ 10,983.33	\$ 13,180.00	\$ 14,278.33	\$ 17,573.33
Add \$5,380 for each additional person						
Uninsured Patient Amount to Pay	0%	0%	30% AGB	45% ABG	60% of AGB	80% of AGB
Under-insured Patient Amount to Pay	0%	20% of Balance	40% of Balance	60% of Balance	80% of Balance	80% of Balance

NOTE: The AGB is the maximum amount that can be collected from patients that qualify for charity care or as otherwise allowed under this policy, regardless of the percentages shown above.



Financial Assistance Application (Hospital Name)

Patient Account Number: _____ Date of Application _____

PATIENT INFORMATION

Name _____
Address _____
City _____
State/Zip _____
Best Contact # _____
SS# _____
Employer _____
Employer Address _____
Employer City _____
Employer State/Zip _____
Work Phone _____
Length of Employment _____
Supervisors Name _____

PARENT/GUARANTOR/SPOUSE **Complete if patient is under age of 18 or has designated legal guardian**

Name _____
Address _____
City _____
State/Zip _____
Best Contact # _____
SS# _____
Employer _____
Employer Address _____
Employer City _____
Employer State/Zip _____
Work Phone _____
Length of Employment _____
Supervisors Name _____

A. Income: Please provide the income for each of the following persons in your household.

Patient/Guarantor:

Wages \$ _____ Hr/ Wk/ Month/Year

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers' Comp: \$ _____

SSI: \$ _____

Other: \$ _____

Spouse/Second Parent:

Wages \$ _____ Hr/ Wk/ Month/Year

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers' Comp: \$ _____

SSI: \$ _____

Other: \$ _____

Total Yearly Family Income \$ _____

B. Living Arrangements: Please provide number of persons in the household. _____

Rent _____ Own _____ Other (explain) _____

Landlord/Mortgage Holder: _____

Phone Number _____ Monthly payment \$ _____

C. Income Verification: Please provide the following documentation to verify your income:

IRS Form W-2

Written Employer Verification

Paycheck Remittance (Last 4)

Proof of Participation in or Denial from Governmental Assistance programs

Tax Return (Prior Year)

Bank Statements (Prior 3 months)

Social Security, Workers' Comp or Unemployment Compensation Determination Letter

If you are unable to provide one of the sources of income documentation listed above, please explain why this information is not available:

D. Other Resources: Please provide the total amount of other resources available to you.

Checking: _____

Vehicle 1: Yr _____ Make _____ Model _____

Savings: _____

Vehicle 2: Yr _____ Make _____ Model _____

Cash on hand: \$ _____

Vehicle 3: Yr _____ Make _____ Model _____

E. Expenses: Please provide the following types of documentation to prove your expenses:

Copy of mortgage payment or rental agreement

Copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones)

All other medical bills

F. Attestation:

I understand the hospital may verify the financial information contained in this Financial Assistance Application in connection with The Hospital's evaluation of this Application, and by my signature hereby authorize my employer to certify the information provided in this Application. I also authorize The Hospital to request reports from credit reporting agencies and the Social Security Administration. I am aware that falsification of information on this Application may result in denial of financial assistance.

Signature of Patient or Responsible Party

Date

Hospital Employee Signature

Date



**Financial Assistance Determination Worksheet
(Office Use Only)**

Patient Name:

Accounts Number(s):

Total Yearly Income:

Total Combined Charges:

Number in Household:

Select the type of documentation or income verification provided for review from list below:

- ☐ IRS Form W-2, Wage and Earnings Statement
- ☐ Paycheck Remittance
- ☐ Tax Return
- ☐ Social Security, Work Comp or Unempl Comp Letter
- ☐ Government Program
- ☐ Written verification by employer
- ☐ Bank Statements
- ☐ Written Attestation (Patient signed "Financial Assistance Application" verifying total yearly income)
- ☐ Verbal Attestation (Patient verbally verified total yearly income)
- ☐ Patient Deceased
- ☐ Other, Please specify:

Is total yearly income within the Federal Poverty Guidelines (FPG)? Reference "Schedule A"

Select appropriate answer/determination in response to the question above:

- ☐ **YES, Approved for 100% financial assistance as Financially Indigent**
- ☐ **YES, Approved for 100% financial assistance as Presumptive**
- ☐ **YES, Approved for 100% financial assistance as Undocumented**
- ☐ **YES, Approved for 100% financial assistance as Special Circumstance**
- ☐ **NO, Does not qualify for assistance**

Approval/ Authorization of Financial Assistance Write-off:

Review of the "Financial Assistance Application" and the provided supporting documentation has been completed on my behalf. I can attest that the financial assistance determination was based on the provided information and meets FIN 27 Charity Care Financial Assistance policy requirements.

BOM:

Date:

CEO:

Date:

CFO:

Date:

DATE:

Patient Name:

Address:

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and are pleased to inform you that you have been approved for **100%** financial assistance, for the below mentioned accounts:

Account #	Date of Service	Amount Approved

Should you have any questions or concerns regarding your financial application, please do not hesitate to contact me.

Sincerely,

Your Name

Vendor Management, CBO
2375 N Glenville Drive, Building B
Richardson, TX 75082
Phone: **Your Phone Number**



DATE:

Patient Name:

Address:

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and unfortunately at this time, assistance has been denied. The reason for denial is: **Insert specific brief explanation.**

You have the right to appeal this decision. Should you choose to appeal this decision, you must complete the attached Appeal/Dispute Form and address the written appeal within 30 calendar days from the date of this determination letter to:

Insert Name of Designated Person

If you have any questions or concerns regarding this notification or your financial application, please do not hesitate to contact me.

Sincerely,

Your Name

Vendor Management, CBO
2375 N Glenville Drive, Building B
Richardson, TX 75082
Phone: **Your Phone Number**