WHITE RIVER HEALTH SYSTEM
The Care You Need. Where You Need It.

FINANCIAL ASSISTANCE POLICY

Revised: 9.11.2018
Effective: 09.17.2018

I. POLICY

A. White River Health System (*the Organization*) is a not for profit, tax-exempt entity with a mission to provide a safe, efficient delivery of quality healthcare and to improve the health of our communities through education and outreach. Consistent with this mission, the Organization recognizes its obligation to the communities it serves to provide financial assistance to those in need within those communities.

B. The Organization will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the philosophy and mission of the Organization; (ii) explains the decision processes of who may be eligible for Financial Assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to patients. In the event that applicable laws, rules or regulations are changed, supplemented or clarified through interpretative guidance, the Organization will modify this Policy and its practices accordingly. The Organization maintains the Financial Assistance policy a free copy of which can be obtained by contacting the Financial Advocate Department at 870-262-1253 or by accessing www.whiteriverhealthsystem.com. The Financial Assistance Policy sets forth the actions that may be taken in the event of non-payment of amounts determined to be patient responsibility under this Policy.

II. ELIGIBILITY AND DETERMINATION OF DISCOUNT

Eligibility: A patient will be eligible for Financial Assistance if the patient: (i) has limited or no health insurance; (ii) applies for but is deemed ineligible for government medical assistance (for example, Medicare or Medicaid); (iii) cooperates with the Organization in providing the requested information and financial documentation; and (iv) demonstrates "financial need" based on **Exhibit 1**. In addition, a patient may be eligible for Financial Assistance in the event the Organization, in its discretion, deems such eligibility appropriate under a patient's unique circumstances (including potential medical hardship). Consideration may be given to the existence of substantial medical debt, and additional documentation regarding assets and living expenses may be requested. For purposes of this Policy, the term "patient" is used with regard to the patient or the applicable payment source for the patient's care (*e.g.*, parent, guardian or other responsible party).

A. Financial Need: A patient will be deemed to have financial need based on the current annual Federal Poverty Levels ("FPG") in effect from time to time. The table below sets forth the income requirements and related financial assistance discount on the charges for Organization's services rendered. Income includes salaries and wages, legal judgments (child support, divorce proceedings, etc.), unemployment compensation, worker's compensation, dividends, interest checks and other recurrent sources of income.

PATIENT INCOME	DISCOUNT
At or Below 150% of the FPG	100% or Free Care
Between 151% and 200% of the FPG	90% Discount
Between 201% and 250% of the FPG	80% Discount
Between 251% and 300% of the FPG	70% Discount
Between 301% and 350% of the FPG	60% Discount
At or Above 351% of the FPG	0% Discount

B. Calculation of Amounts to Be Billed: In no event will care be discounted more than the cost to provide such service. The net amount to be billed to a patient qualifying for financial assistance hereunder will be determined by (i) calculating the gross charges for services rendered to the patient, and (ii) applying the appropriate discount (as determined pursuant to the above and Exhibit 1), pursuant to all other provisions contained within the policy.

C. All true self-pay patients will receive a 51% self-pay discount.

III. PROCEDURES AND OBLIGATIONS FOR DETERMINING ELIGIBIITY FOR FINANCIAL ASSISTANCE

A. All patients will be informed of the availability of financial assistance pursuant to this Policy. Patients with an anticipated or actual self-pay balance will be referred to the Organization's Financial Advocacy Department.

B. Because a patient is not eligible under this Policy until s/he has applied for and been deemed ineligible for federal and state governmental assistance programs, Patient Matters will assist patients in enrolling in federal and state governmental assistance programs, including, but not limited to the Health Care Exchange Programs. Trained financial advocates and other personnel may be contacted at 870-262-1253 or any assistance required in completing the Application for Financial Assistance or with any other materials required by the Organization under this Policy.

C. Although the Organization will attempt to make an eligibility determination during pre-registration or prior to services being rendered, this may not always be possible, either because the patient does not provide the necessary documentation, or the patient's circumstances change after services are rendered, or in other instances where a given patient's circumstances or needs are identified. **A patient may request consideration at any time, and the Organization will evaluate a patient's eligibility under this Policy as requested, up to and including consideration during the collections and judgment phase.** Patients are encouraged to contact the Organization's Financial Advocacy Department if their circumstances change or if additional need is identified. The Organization's Financial Advocates will review all information provided and relevant circumstances bearing on the need for Financial Assistance, will make a

determination of eligibility, and will notify the patient of his/her financial obligations, if any, as set forth below.

D. Administrative Procedure

1. Organization staff will immediately forward to White River Health System's financial advocates the account information for any patient who has no insurance. Financial advocates will contact the patient to schedule a financial interview as soon as is practical but ideally before medically necessary service, and prior to services being rendered.

2. To determine whether a patient is eligible for Financial Assistance, the patient will be required to complete the Patient Financial Assistance Application with Financial Advocates (**Exhibit 2**). The Application will be made readily available to patients through methods including (without limitation) posting on White River Health System's website, distribution in White River Health System's Patient Registration areas and the Patient Financial Advocacy offices, and inclusion in the informational binders provided to patients.

3. Patients must complete the Application with the financial advocate provided by the Organization and provide supporting documentation within ten (10) days of submitting Application. Failure to timely supply required information will result in denial of a patient's request for provision of Financial Assistance. Patients are obligated to cooperate and provide all information needed in a timely manner. The Organization will make reasonable efforts to offer and provide assistance to patients in connection with the completion of the Application. However, if assistance is needed in gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Organization's trained financial advocates 870-262-1253. Financial Advocates also are available to assist patients with assessing their financial situations, gathering information requested by the Organization, and assisting with similar tasks.

4. As part of the financial interview process, financial advocates will request the following documentation in order to process and validate Financial Assistance.

Required Supporting Documentation	Examples of Acceptable Documentation
Confirmation of Annual Income	Most Recent Federal Income Tax Return Last 4 pay stubs Most recent W-2 or 1099 Social Security Award Letter Full Bank Statements for recent 3 months Unemployment Statement Workers Compensation Award Letter Pension or Retirement Statement Investment Income
Verification of Social Security Number and/or Date of Birth	Driver's License State Issued Identification Card Social Security Card Birth Certificate Baptismal Certificate Military Discharge Papers School Records
Verification of Residency	Mortgage Statement Rental Agreement/Lease Tax Bill Room & Board Statement Utility Bill Written Verification from Landlord

E. Although the information above is required from patients seeking Financial Assistance, the Organization in its discretion may choose not to require some or all documentation depending upon circumstances and the patient's ability to obtain documentation. The Organization may rely on documentation received from credit Organizations or other outside entities in determining a patient's eligibility for Financial Assistance.

F. Patients have an obligation to provide information reasonably requested by the Organization so that the Organization can make a determination of a patient's eligibility for Financial Assistance. **If a patient claims he/she has no means to pay but fails to provide the information reasonably requested by the Organization, there will be no Financial Assistance extended and normal collection efforts may be pursued in the Organization's sole discretion.**

G. Eligibility and Notification Process:

1. Upon receipt of a patient's Patient Financial Application, the Financial Services Department will review the patient's application to determine that it is complete, including all required documentation. If it is not complete, the application will be returned to the patient for completion. If the Organization returns an application to a patient as incomplete, the financial advocate will attempt to contact that patient by telephone. If the advocate is able to reach the patient by telephone, they will offer the patient an in-person or telephonic interview to determine such patient's eligibility for Financial Assistance. If the Organization is unable to reach the patient by telephone, or if there is no listed telephone number available, the financial advocate will send a letter to the patient that details what is needed and that explains to the patient that it is his/her responsibility to contact the Organization's Financial Advocacy Department within ten (10) days of receiving the letter. The Organization's trained financial advocates will offer to meet with the patient to assist him/her in completing the application so that White River Health System has all of the necessary information to make a determination of the patient's eligibility for Financial Assistance.

2. The Financial Advocacy Department will complete the Financial Assistance Eligibility Determination Form attached as **Exhibit 3**, and will determine the amount the patient owes, if any. The Financial Services Department will inform the patient of his/her eligibility for Financial Assistance, and the amount of such Financial Assistance, within ten (10) business days of the determination.

3. A determination of eligibility under this Policy will be effective for one (1) year after the approval date, which includes three (3) months retroactivity, if applicable. At the end of such time period, patients continuing to require essential medical services will be expected to re- apply or update their prior applications, in order to permit the Organization to make a new determination regarding the patient's continuing eligibility for Financial Assistance.

IV. COMMUNICATION

The Organization will communicate the availability of Financial Assistance to its patients and the general public through measures that include providing or posting copies of this Policy, summaries thereof (if more conducive to patient understanding), appropriate signage and/or brochures on the Organization's website; In the Patient Registration areas; In the Patient Financial Advocacy Departments; In other waiting areas throughout the

Organization's premises (as may be reasonably workable and appropriate); In patient informational binders; and in bills and statements sent to patients.

Pertinent materials will be provided in English and Spanish, which are the languages appropriate to the communities served by the Organization. Other languages will be added as necessary in the event of changes to the Organization's patient population. All such materials will include pertinent contact telephone numbers and/or e-mail addresses to permit patients appropriate resources for completion of the Application and answers to any other questions they may have about the Organization's Financial Assistance Program.

IV. DOCUMENTATION AND RECORDKEEPING

A. The Financial Advocacy Department will maintain and scan all documentation of Financial Assistance within the Organization's Financial Assistance shared drive. The Financial Assistance file will include a cumulative total of Financial Assistance cases, together with supportive documentation. Supportive documentation will include, at a minimum, the following: (i) The number of applicants for free and reduced cost services; (ii) The number of approved applicants; (iii) The total and average charges and costs of the amount of free and reduced cost care provided; (iv) Any other information required by, or necessarily to permit complete and accurate reporting under, applicable federal and state laws.

B. The Director of Revenue Cycle will review the status of the Financial Assistance program with the Chief Executive Officer, or his/her designee, on a regular basis. The Chief Executive Officer or his/her designee will be responsible for presenting this Financial Assistance Policy to the Board of Directors at least annually. Such presentation will include a detailed statement on what the Organization's policy is on Financial Assistance, the impact of this Financial Assistance Policy on the Organization's operations and the level of need and benefits being conferred to the community under the Organization's Financial Assistance program.

C. Information about the amount of Financial Assistance extended will be provided in accordance with federal and state laws and regulations on reporting information under the Organization's Financial Assistance Policy.

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APPENDIX I

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file and there is a lack of corresponding supporting documentation. However, there is often adequate information provided by the patient or through external sources which could provide sufficient evidence to offer the patient charity care assistance. In the event there is no concrete evidence to support a patient's eligibility for charity care, White River Health System may use outside sources in determining charity care eligibility *presumptively*. Once determined, due to the inherent nature of the presumptive circumstances, the discount that will be granted is a 100% write off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances including:

(1) Homeless or received care from a homeless clinic
(2) Deceased with no spouse and no estate
(3) Approved by the court for Bankruptcy

EXHIBIT 1

FINANCIAL ASSISTANCE ELIGIBILITY GUIDELINES

Based on 2018 Federal Poverty Guidelines

Family Size	100%	138%	150%	200%	250%	300%	350%	400%
1	$12,140	$16,753	$18,210	$24,280	$30,350	$36,420	$42,490	$48,560
2	$16,460	$22,715	$24,690	$32,920	$41,150	$49,380	$57,610	$65,840
3	$20,780	$28,676	$31,170	$41,560	$51,950	$62,340	$72,730	$83,120
4	$25,100	$34,638	$37,650	$50,200	$62,750	$75,300	$87,850	$100,400
5	$29,420	$40,600	$44,130	$58,840	$73,550	$88,260	$102,970	$117,680
6	$33,740	$46,561	$50,610	$67,480	$84,350	$101,220	$118,090	$134,960
7	$38,060	$52,523	$57,090	$76,120	$95,150	$114,180	$133,210	$152,240
8	$42,380	$58,484	$63,570	$84,760	$105,950	$127,140	$148,330	$169,520

**** For *family* units with more than 8 members, add $4,320.00 for each additional member.**

Note: This Exhibit shall be updated annually to reflect the most current FPGs issued by the U.S. Department of Health and Human Services

EXHIBIT 2

Patient Financial Assistance Application

Patient Name: _____

Medical Record Number(s): _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____

State: _____ Zip code: _____

Marital Status: _____

Employer: _____

Address: _____

City: _____ Phone Number: _____ Supervisor: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Company Address: _____

City: _____ Phone Number: _____ Supervisor: _____

Please list all dependents with their date of birth who lives in your household:

_____

_____

_____

_____

_____

Is anyone handicapped living in your home: _____

Please provide a copy of your latest tax return, payroll stub or copy of Social Security award letter/check

Please answer ALL of the questions to the best of your ability.

1. What is the market value of your house/trailer? $ .00
2. List any vehicles you own with their market value.

Year	Make	Model	
			$ .00
			$ .00

3. List all of your bank account and investment balances

Bank	Account #	
		$ .00
		$ .00

4. List any other property you own (land rental property, boat, motorcycle, camper, etc.) with its market value.

	$ .00
	$ .00
TOTAL ASSETS (add 1 through 4)	$ .00

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5. What are the loan balances for the property listed above?

House/Trailer:	$ .00
Vehicle(s):	$ .00
Other:	$ .00
Other:	$ .00
Other:	$ .00

6. List all your medical bills with your balances after insurance has paid (list names & phone number or attach copy of the bill)

	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
	$ .00
TOTAL LIABILITIES (add 5 & 6)	$ .00

The information provided is correct to the best of the knowledge and belief. You are hereby authorized to contact any of the above listed employers, creditors, banks and others for the purposes of confirming my assets, debt and financial status. Any information provided on this application which is found to be materially false, or that cannot be conformed, may result in denial of this application for financial assistance.

Signature of Applicant_____Date_____

**********For White River Health System use only**********

Assets verified Yes / No Were all required copies included? Yes / No

Liabilities verified Yes / No The adjusted gross income per application is $_____.00

Income verified Yes / No {(Assets – Liabilities) *10% + Total Annual Income}

Financial Advocate _____Date _____

PFS Director/Supervisor of Patient Accounts _____Date _____

Approved Discount %_____Posted date_____

EXHIBIT 3

PATIENT/PAYMENT SOURCE FINANCIAL WORKSHEET

To be completed by the Financial Advocate based on application and required supporting documentation.

Patient: _____ Medical Record Number: _____

Household Size: _____

1A Calculation of Available Income

Monthly Salary	**_____x12 _____**	
Pension	**_____x 12 _____**	
Monthly SSI/VA	**_____x 12 _____**	
Income Total		**_____ x 12 _____ (AA)**

1B Calculation of Monthly Expenses

Rent	**_____**	
Electric	**_____**	
Gas	**_____**	
Telephone	**_____**	
Water	**_____**	
Car Payments	**_____**	
Credit Cards	**_____**	
Insurance	**_____**	
Other _____	**_____**	
Food ($100.00 x dependents)	**_____**	
Monthly Expense Total	**_____**	
Expense Total		**_____x 12_____(BB)**

1C Eligible Income for Medical Bills **_____ (CC)**
(AA – BB) (if less then 0, enter 1)

1D Medical Billing Estimate to Patient **_____ (DD)**

1E Identification of Liquid Assets

Bank Accounts	**_____**	
Bonds	**_____**	
Stocks	**_____**	
CD's	**_____**	
Mutual Funds	**_____**	
Liquid Asset Total		**_____(EE)**

1F Total Patient Due Minus Liquid Assets (DD- EE) **_____(FF)**

1G Eligible Income Minus Patient Due (CC-FF) **_____(GG)**
Note: If GG is a negative number, then patient will have no financial responsibility.

_____ I attest that the above information is correct.

_____ I attest that the Patient/Payment Source is unemployed and cannot provide employment documentation.

_____ _____

Signature of Patient/Payment Source **Date**

EXHIBIT 4

Follow-Up

White River Health System
1710 Harrison Street
Batesville, AR
72501

870-262-1253

MM/DD/YY
Medical Record#: _____

Patient Name
Patient Street and Number
Patient City, State, Zip Code

Dear Patient Name,

I am writing regarding your account #Click here to enter text. at White River Health System.

You currently have a balance of $_____ that I may be able to help REDUCE through our Financial Assistance Program.

In order to process your application for Financial Assistance, I will need to confirm your income, date of birth, and residence. Please view below for sample documents needed to do this.

- **Confirmation of Annual Income**
  - Samples: Bank Statements, 2 Months of Pay Stubs, Recent W2 or 1099, Award Letters
- **Verification of Date of Birth**
  - Samples: Driver's License, Social Security Card, Birth Certificate
- **Verification of Residency**
  - Samples: Mortgage Statement, Tax Bill, Utility Bill, Rental Agreement

In order to be considered for a discount or possible write-off of your bill, please provide this documentation within the next 10 business days.

After 30 days from initial contact by the Financial Advocates, if you have not submitted your supporting documentation, your bill will follow standard collection procedures.

If you have any questions, please call 870-262-1253.

Sincerely,
White River Health System Financial Advocates

Approval

White River Health System
1710 Harrison Street
Batesville, AR
72501

870-262-1253

MM/DD/YY
Medical Record#: _____

Patient Name
Patient Street and Number
Patient City, State, Zip Code

Dear Patient Name,

I am happy to make you aware that you have been approved for our Financial Assistance Program, which will provide you with a ___% discount applicable on the following accounts:

Account #	Old Balance:	New Balance:
Total New Balance Due:		

Your remaining balance totals $_____.

Please submit payment in full if you have not setup a payment plan. Should you need to setup a payment plan, please call 870-262-1253.

Sincerely,
White River Health System Financial Advocates

Denied - Insured

White River Health System
1710 Harrison Street
Batesville, AR
72501

870-262-1253

MM/DD/YY
Medical Record#: _____

Patient Name
Patient Street and Number
Patient City, State, Zip Code

Dear Patient Name,

I regret to inform you that you did not qualify for the Financial Assistance Program based on the information you provided below:

- Annual Income: $_____
- Household Size: _____
- Insurance: _____

If any of the above information has changed, please contact us at 870-262-1253 to review for eligibility.

Should the above information remain accurate, your **remaining balance total is $_____.**

Please submit payment in full if you have not setup a payment plan. Should you need to setup a payment plan, please call 870-262-1253.

Sincerely,
White River Health System Financial Advocates

Denied Self-Pay

White River Health System
1710 Harrison Street
Batesville, AR
72501

870-262-1253

MM/DD/YY
Medical Record#: _____

Patient Name
Patient Street and Number
Patient City, State, Zip Code

Dear Patient Name,

I regret to inform you that you did not qualify for the Financial Assistance Program based on the information you provided below:

- Annual Income: $_____
- Household Size: _____
- Insurance: _____

If any of the above information has changed, please contact us at 870-262-1253 to review for eligibility.

Should the above information remain accurate, you do qualify for a 51% discount which is reflected in your **current total balance of $_____.**

Please submit payment in full if you have not setup a payment plan. Should you need to setup a payment plan, please call 870-262-1253.

Sincerely,
White River Health System Financial Advocates

EXHIBIT 5

Required Supporting Documentation

Required Supporting Documentation	Examples of Acceptable Documentation
Confirmation of Annual Income	Most Recent Federal Income Tax Return Last 4 pay stubs Most recent W-2 or 1099 Social Security Award Letter Full Bank Statements for recent 3 months Unemployment Statement Workers Compensation Award Letter Pension or Retirement Statement Investment Income
Verification of Social Security Number and/or Date of Birth	Driver's License State Issued Identification Card Social Security Card Birth Certificate Baptismal Certificate Military Discharge Papers School Records
Verification of Residency	Mortgage Statement Rental Agreement/Lease Tax Bill Room & Board Statement Utility Bill Written Verification from Landlord