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Financial Assistance Program (FAP)

PURPOSE STATEMENT

Oaklawn Hospital will treat all patients with respect, dignity, and compassion regardless of their ability to pay. Oaklawn's expectation for payment is based on the patient's ability to meet payment obligations.

POLICY

Oaklawn is pleased to offer patients financial assistance in the form of discounts up to 100% of the amount owed. Eligibility is based on income and family size as well as other criteria set forth in this policy. This policy describes the eligibility and application process to determine discounts patients may qualify for. This policy gives consideration to and complies with IRS regulations pertaining to charitable hospitals as defined under section 130266-11. This policy also complies with the process for determining discounts under Public Act 107 of the Healthy Michigan law, section 105d, which indicates that hospitals cannot charge uninsured individuals at 300% of poverty level or below more than 115% of the Medicare reimbursement rate. Throughout this procedure this law will be referred to as the *Uninsured Mandated Cap*. It is the hospital's responsibility to communicate its financial assistance policies to patients and it is the patient's responsibility to provide information necessary to determine eligibility in a timely and complete fashion.

This policy applies to the insured, underinsured, and the uninsured. All patient balances including coinsurance, deductible or other non-covered services may be considered for discounts as explained in the procedure below.

Providers Covered/Not Covered by FAP Policy

This policy covers services provided by Oaklawn Hospital and those locations listed in Appendix A for Oaklawn Medical Group.

PROCEDURE

Communication of FAP/Obtaining an Application

The hospital communicates its FAP to patients in the following ways:

- *About Your Hospital Bill* brochure which is available in all waiting rooms and includes a plain language summary of the hospital's assistance program.
- Signs in all registration areas and the Emergency Department alerting patients to our FAP and how to apply.
- Messages on all statements alerting patients to our FAP and how to apply.
- Information on the hospital website concerning our FAP and how to apply.
- Patient Accounts Service Center (PASC) staff discuss FAP and payment options with patients if they call to discuss their bill. For patients with charges of $2,500 or more, an attempt to contact the patient is initiated by PASC staff prior to placement with a collection agency.
- Patient facing Oaklawn staff members provide applications and plain language summary to patients who ask or who express financial hardship and when applicable, arrange for PASC staff to talk with a patient during their visit.
- Information regarding FAP is available at the Fountain Clinic.
- Hospital Case Manager/Discharge Planner provide plain language summary (*About Your Hospital Bill* brochure) to patients as part of the intake or discharge process.

An application for assistance and a copy of this policy can be obtained as follows:

- By calling the Patient Accounts Service Center at 269.789.7000 or 269.789.7181 during normal business hours to request a mailing of these documents.
- Downloading or viewing a copy of the policy and application on the hospital website (www.oaklawnhospital.org).
- In person at the Patient Accounts Service Center office located on the first floor of the hospital (200 North Madison, Marshall, Michigan 49068).
- In any department that registers patients including the Emergency Department.

Assistance with completing the application can be obtained by calling the Patient Accounts Service Center at 269.789.7000 or 269.789.7181 and, if necessary, can be done in person by appointment.

Eligibility Determination and Time frame to Apply for Assistance

Eligibility for FAP is primarily based on annualized household income and family size. The determination of eligibility is based on the patient's financial situation at or near the time service is rendered. (This is consistent with HFMA Principals and Practices Board Statement No.15).

Patients on a fixed income need to apply once a year. All other patients must apply every six months or more frequently if their income changes significantly. The hospital will accept FAP applications up to 240 days from the date of the first billing statement. However, accounts may be referred to collections after 120 days from the date of the first billing statement and if it has been more than 30 days since an application was requested by and sent to the patient. It is in the patient's best interest to apply for financial assistance as early as possible.

If an account has been placed with a collection agency and the patient requests financial assistance, collection efforts will cease for at least 30 days to allow the patient time to complete the application. If it

is determined that the patient is eligible for financial assistance, the applicable discount will be applied to the account and if deemed appropriate the agency will reverse any credit reporting that may have occurred. If there is a balance remaining after the discount is applied, the agency may resume collections if that balance is not paid within 30 days or acceptable payment arrangements are not made with the agency. Accounts that are 240 days past the date of the first billing statement are no longer eligible for assistance.

The Affordable Care Act makes insurance available to all individuals; therefore, the only discount available to the uninsured is the uninsured mandated cap and if applicable the Oaklawn 50/50 (explained below). In Michigan most low income patients are eligible for Healthy Michigan (Medicaid) through the Marketplace.

Notwithstanding the foregoing, the following restriction applies: financial assistance is generally secondary to all other financial resources available to the patient, including group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g., auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services. All such financial resources must be exhausted.

Method of Applying for Financial Assistance

The following information is required in order to be considered for a FAP discount:

1. Application for Assistance (form A-56) (Attachment I)
2. Copy of last two payroll check stubs showing year to date earnings. If check stubs do not show YTD earnings or does not have sufficient information to estimate annual income, additional documentation may be requested.
3. Support for all other income including but not limited to:
    a. Unemployment benefits.
    b. Pension, disability, social security, or retirement income.
    c. Child support or alimony.
    d. Rental income.
    e. Dividends from stocks or bonds.
    f. Housing or rental allowances.
    g. Income for caring for foster children.
    h. Any other income received.
4. Latest federal income tax return if any of the following apply:
    a. Patient/guarantor is self-employed. For patient's self-employed with self-employed income exceeding $5,000, the tax return must be prepared or reviewed by a reputable tax firm.
    b. Clergy (because of housing allowance)
    c. A tax return can be requested on any application if it would be helpful in making a

determination or it is needed to confirm information.

5. If there is no income received, a letter of support from the individual(s) assisting the patient to meet their basic needs is required.
6. Copy of last two most recent bank statements.
    a. For patients who show balances in checking and/or savings of $5,000 to $10,000, the patient and/or household assistance eligibility will be reduced. (i.e., patient's eligible for 100% will be reduced to 75%). With a minimum eligibility of 50% assistance
    b. For patients who show balances in checking and/or savings of $10,001 to $29,999, the patient and/or household will only be eligible for the minimum assistance of 50%.
7. Copies of any medical insurance cards or other proof of insurance coverage available to the patient including group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, third party liability situations or any other instance in which another person or entity may have a legal responsibility to pay for the cost of your medical services.
8. If the patient in uninsured, the patient and their family must apply for Medicaid and have a response before their application will be reviewed for eligibility. If Medicaid is denied, a copy of the denial letter must be included with the application and must be dated within the last 12 months.
9. Copy of Michigan driver's license of Michigan state identification card

Oaklawn Hospital reserves the right to ask for additional documentation before making a final determination on a patient's eligibility for financial assistance. This may include, but is not limited to:

1. Additional bank statements
2. Prior Year Tax Return
3. Proof of residency
4. Disclosure of claims and/or income from personal injury and/or accident-related claims

The completed Application for Assistance and supporting documentation can be submitted in one of the following ways:

- Emailed to PASCFAX@oaklawnhospital.com
- Mailed to Oaklawn Hospital, Attn: Patient Accounts Service Center, 200 N. Madison, Marshall, Michigan 49068
- Dropped off at the Patient Accounts Service Center office located on the first floor of the hospital.

Exclusions

The following are exceptions and exclusions, and these persons and/or services will not be eligible for financial assistance.

1. Persons incarcerated.
2. Services provided related to felony activity.
3. Persons who should have legally filed an income tax return but did not.
4. Illegal aliens.
5. Persons living outside of Oaklawn Hospital's service area and do not regularly utilize Oaklawn Hospital (these patients should be seeking financial assistance from their local community hospital). (Eligible for mandated cap and will be considered on a case-by-case basis.)
6. Frequent visits to the Emergency Department when these visits are non-emergent or non-urgent in nature (to discourage inappropriate use of the Emergency Department). (Eligible for mandated cap and will be considered on a case-by-case basis.)
7. Injuries resulting from driving under the influence of drugs or alcohol.
8. Failure of insurance to pay because pre-certification rules, COB questionnaires or other requirements were not followed by the patient.
9. Injuries related to a motor vehicle accident without auto insurance, if the person should have legally had auto insurance coverage.
10. Cosmetic Surgery, and any encounters not related to an emergency, or medically necessary service.
11. The patient and/or household shows evidence of $30,000 or more in checking and/or savings.
    1. With the exception of the following protected assets:
        a. IRA, 401K, cash value retirement plans/pensions
        b. College savings plans
        c. Primary personal residence
12. Persons who do not cooperate in providing the requested information required to make a decision for eligibility.

Actions Taken in the Event of Non-Payment

The actions that are taken by the hospital in the event of non-payment of any balance due from the responsible party are described in the hospital's Collection Policy. Collection action taken could include placement with third party collection agency, a blemish on the responsible party credit report, garnishment of wages or other litigation. A copy of the Collection Policy is available to the public and can be obtained by calling the PASC (269.789.7000 or 269.789.7181), viewed on or downloaded from the hospital's web-site (www.oaklawnhospital.org), or in person at the PASC office located on the first floor of the hospital.

Expenses

Expenses are typically not considered in determining eligibility for assistance. In unusual circumstances when the patient or their family has experienced a catastrophic event, expenses may be considered and can be documented on the back of the Financial Assistance Application.

Family Size Definition

Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. The Hospital will also accept non-related household members when calculating family size.

The family size will be the same as filed on the person's latest income tax return plus any other person's whose income is considered in determining eligibility and adjusted for any applicable changes since the income tax return was filed. Parental income for adult children is considered in determining eligibility if the adult child is claimed by their parent(s) on their parent's income tax return. In the case of divorce, children who are supported by child support can be included even if they are unable to be claimed on the family's income tax return.

In the case of cohabitation without marriage both parties' income is considered when determining income and both parties' dependents are considered in the family size. (Patients can, however, be eligible for the mandated cap without providing their significant other income).

Income Definition

Income includes gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony, child support; assistance from outside the household; and other miscellaneous sources.

Presumptive Assistance

For patients that are enrolled in an out-of-state Medicaid program, presumptive assistance can be granted if the patient was unable to get the service in their home state (i.e., emergency) and the patient can provide proof of active coverage. Otherwise, these patients are only eligible for the mandated cap.

Presumptive assistance is assumed for patients that are deceased if a copy of the death certificate (preferred) or obituary is obtained.

Fountain Clinic

The hospital partners with the Fountain Clinic, a non-profit organization in Marshall that helps those who are uninsured or underinsured obtain medical services. The hospital provides a grant to the Fountain Clinic on an annual basis. Patients referred by the Fountain Clinic are assumed to be eligible for assistance.

Income Guidelines

Persons who submit a complete application and meet all other requirements explained in the policy are eligible for assistance based on federal poverty level (FPL). These guidelines are taken from the Department of Health and Human Services "Table of Poverty Guidelines" and are updated annually (see Appendix B). Patients at 200% of FPL or below will receive a full write-off of the amount owed. Patients at 201% to 250% of FPL will have the amount owed reduced by 75%. Patients at 251% to 300% of FPL will have the amount owed reduced by 50%. As explained previously, patients that choose not to

have insurance are only eligible for the mandated cap (115% of Medicare reimbursement applied to gross charges).

In order to be eligible for the maximum discount based on income (100%, 75%, or 50%), services must be medically necessary and urgent or emergent (versus elective). The hospital works with the patient's physician to determine if the services meet these criteria. When possible, determination for eligibility should be made in advance of the service being rendered however emergency medical services are always provided regardless of the patient's ability to pay and regardless of past payment history or unpaid balances.

If a patient is FAP eligible as described in this policy, all medical care received will be discounted to no less than the mandated cap. This may be applicable for services not eligible for a higher discount because service was not urgent/emergent as explained above. (Per IRS regulations all medical services for FAP eligible patients are limited to something less than gross charges.)

If the patient qualifies for partial assistance, the discount is applied regardless of the payment of the balance, which will follow the normal billing cycle. (See previous section, *Actions Taken in the Event of Non-Payment.)*

AGB

The AGB (Amounts Generally Billed) is calculated annually by the Finance Department and represents an overall average that the hospital is reimbursed by all payers, excluding Medicaid. The hospital calculates two AGB percentage rates: inpatient and outpatient. The AGB is updated annually following the hospital's fiscal year end. The current AGB is shown on Appendix B. This amount is used to ensure that patients that are FAP eligible are not charged more than the AGB per IRS regulations. The hospital uses the look back method to calculate the AGB.

Oaklawn 50/50 Plan

The Oaklawn 50/50 Plan is an assistance/discount plan that helps people pay large balances. The plan provides a discount on large balances, matching patient payments up to 50% of the bill. This discount is in addition to any discounts the patient may qualify for as described previously.

To qualify for the 50/50 program, patients must meet the account balance and income criteria described in Appendix B.

For every dollar the patient pays, the hospital provides a matching discount up to 50% of the bill.

Balances apply to single accounts only with the exception of mom and newborns. These can be combined for the purpose of 50/50. Exceptions for catastrophic or episodes of care that result in multiple account balances may be considered on a case-by-case basis if approved by the Director of the Patient Accounts Service Center. Balances can be self-pay, copay/deductible, or even balance after a partial assistance discount.

Patient must enroll in the program and provide proof of income. Enrollment is done as part of the Application for Assistance process, however, if patients do not want to be considered for other discounts, they only need to provide proof of income and family size.

Once the patient enrolls, any payments they make within 60 days of program approval will be matched up to 50% of the bill. Any payments the patient made prior to the enrollment date are also matched. Payments after the expiration date are not matched. Only self-pay payments are matched. Insurance payments are not matched.

The 60-day time frame can be extended if authorized by the Director of the Patient Accounts Service Center. This may be appropriate at times to allow patients more time to secure funds if they are applying for a loan or disposing of assets. The write-off is unconditional and applies regardless of what happens with any balance remaining. Patients can still make payment arrangements for any balances remaining at the end of 60 days.

Incomplete Applications

When the financial application is incomplete or missing information, PASC staff will provide notification via phone call and/or mail advising the patient what information is needed to complete the application. Patients have 15 days to provide this information. If the information is not provided within 15 days, normal collections will proceed. It is in the patients' best interest to provide complete and accurate information when submitting an application.

Patients can reapply or submit missing information at any time during the 240-day window to apply for assistance since the first statement was sent.

Notification of Determination

Every effort is made to process all applications within 30 days of receipt. While patients remain in the statement cycle while their application is being processed, once an application is received all collection activity (referral to collection agency) will cease until a determination of eligibility has been made. Patients are notified in writing of the determination. If patients do not qualify, they are given the reason that they did not qualify and can reapply if additional information or correction is applicable. When a partial discount is taken, the patient will have at least 30 days to pay the balance or make payment arrangements prior to any collection activity being taken or resumed.

The PASC Director will review all applications and authorize assistance up to $10,000 per individual account. For assistance exceeding $10,000 but less than $25,000, the authorization of the Director of Financial Planning & Reimbursement is also required. For assistance exceeding $25,000, the authorization of the Chief Financial Officer is required.

If a patient is determined to be FAP eligible and has made payments in excess of the discount, they will be refunded the overpayment amount.

Any approval for financial assistance is subject to change if it is discovered that information was withheld. If information provided is later found to be inaccurate or fraudulent, Oaklawn has the right to reverse all applied discounts and ask the patient for payment in full for services rendered.

Emergency Medical Care Policy

The hospital does not allow actions that discourage individuals from seeking medical care and has insured that its FAP policy is in compliance with EMTALA. A copy of the hospital's EMTALA policy can be

obtained by calling the PASC at 269.789.7000 or 269.789.7181.

Help is Available

IRS regulation 501(r)-4(5)(ii) indicate that the FAP documents should be translated to other languages if the population of the community served constitutes the lesser of 1,000 individuals or 5%. Oaklawn does not meet this threshold but is happy to assist any individuals that may need help with interpretation or help of any kind completing the application.

If patients have questions regarding this policy, need help submitting a financial application, or for any other inquires related to the financial assistance program or the patient's outstanding accounts, contact PASC at 269.789.7000 or 269.789.7181.

ATTACHMENTS:

Application for Assistance, Appendix A, Appendix B

Attachments

- Application for Assistance - Hospital.pdf
- Oaklawn Hospital FAP Appendix A.pdf
- Oaklawn Hospital FAP Appendix B.pdf

Approval Signatures

Step Description	Approver	Date
	Catherine Yates: Board Chair [JA]	3/28/2025
	Andrew Poole: EXECUTIVE	3/27/2025
	Gregg Beeg: EXEC-PRES-CEO	3/25/2025
	Douglas Martin: DIR-OMG FINANCE-OMG ADMINISTRATION	3/20/2025
	Tiffany Elkins: DIRECTOR	3/20/2025