GREENWOOD LEFLORE HOSPITAL
FINANCIAL ASSISTANCE POLICY

Scope:

This Greenwood Leflore Hospital ("Hospital") Financial Assistance Policy ("FAP") applies to all charges for emergency and medically necessary services provided by any Hospital-owned facility, including Greenwood Leflore Hospital and all Hospital-owned and operated clinics. A complete list of facilities and practitioners for which this FAP applies is attached as **Exhibit A**. Financial assistance for physicians' professional services not listed on **Exhibit A** are not covered under this policy.

Purpose:

To establish a framework to ensure financial assistance is provided to patients who meet the Hospital's established guidelines for financial assistance as set forth below.

Eligibility Criteria:

It is the policy of Hospital to provide medically necessary emergency care to all patients who present for treatment regardless of ability to pay. Hospital may extend discounts for emergency and other medically necessary services to patients who meet the following criteria:

(1) Patients are uninsured or under-insured; and
(2) who fall below 135% of the federal poverty level as published in the Federal Register on an annual basis; and
(3) who are residents of Hospital's service area (defined as Leflore County, Mississippi, and Carroll County, Mississippi); and
(4) who require non-elective, medically necessary inpatient or outpatient care.

Patient care that is cosmetic, wellness or preventive oriented, experimental, not medically necessary, or deemed to be non-reimbursable by traditional insurance carriers and/or governmental payers shall not be considered eligible for financial assistance under this FAP. Patients who are determined to be eligible for financial assistance under this FAP may be entitled to discounted care as set forth in **Attachment 1** to this FAP.

Basis for Calculating Charges

In compliance with the requirements of Section 501(r) of the Internal Revenue Code, no FAPeligible individual will be charged more for emergency or other medically necessary care than the amount generally billed ("AGB") by Hospital. Hospital calculates the AGB by using the billing and coding process the Hospital would use if the FAP-eligible individual were a Medicare fee-for-service beneficiary and sets the AGB for the care as the total amount Medicare would allow for the care (including both the amount that would be reimbursed by Medicare and

the amount the beneficiary would be personally responsible for paying in the form of co-payments, deductibles, and co-insurance).

Applying for Financial Assistance under this Policy

An individual may apply for financial assistance under this FAP by completing the Financial Assistance Application Form attached as **Attachment 2** and submitting it, along with the following required documentation to:

Greenwood Leflore Hospital
Financial Assistance Department
1401 River Road
Greenwood, MS 38930-4030

You may also contact the Financial Assistance Department at (662) 459-4312 if you have any questions about the FAP or the Financial Assistance Application. Additional copies of the Financial Assistance Application may be obtained by request from the Financial Assistance Department or by visiting the Hospital's website at www.glh.org.

Applicant and all dependents listed on the application will be considered for financial assistance under this FAP.

Required documentation for the Financial Assistance Application includes:

a. Documented proof that a patient is at or below 135% of the current federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, last three (3) unemployment check stubs, last three (3) paycheck stubs, most recently filed federal income tax return (1040), forms from Medicaid or other State-funded medical assistance, forms from employers, and/or welfare or community agencies;

b. Documented, written proof of Medicaid coverage denial, if the patient is eligible to apply. It is the responsibility of the patient to apply for Medicaid coverage and obtain proof of denial;

c. Copy of Social Security card for everyone in household;

d. Listing of all medical bills for the Hospital and/or Hospital-owned or operated clinics; and

e. Proof of Residency. Listed below are examples of acceptable proof of residency:

- County property tax assessment statement;
- Utility bill showing current county address;
- Rent receipt(s) showing evidence of county of residence;
- County food stamp letter;

- Voter registration card; or
- Valid Mississippi driver's license.

Other Terms of Hospital Financial Assistance Policy:

1. The Hospital and its clinics do not routinely offer discounts or payment waivers to patients.

2. All requests for non-emergent self-pay admissions, outpatient and clinic appointments will be referred to the Financial Counselor/Medicaid Eligibility Office for review before appointments for services are made. Patient will be screened for all possible sources of payment prior to financial assistance approval. However, as stated below, it is the patient's responsibility to apply for Medicaid coverage and to provide documentation of coverage denial in order to be eligible for financial assistance under this FAP.

3. The Patient Accounts Department or clinic administration, as the case may be, determines whether the patient is a beneficiary of a private third-party payer plan or government insurance plan. If appropriate, the Patient Accounts Department or clinic administration determines whether the Hospital's agreement with the payer prohibits a financial hardship waiver or discount. As a general rule, the Hospital does not grant a financial hardship discount or waiver request to patients covered by a private or government insurance plan.

4. If the patient is determined to have no insurance coverage or is under-insured, they will be referred to the Financial Assistance Department located in the Hospital prior to the appointment being made.

5. The Financial Assistance Department will visit all Hospital inpatients not seen prior to admission and reviewed under the same criteria. Outpatients and clinic patients that cannot be seen in person will be contacted by phone or mail.

6. Determination of eligibility for financial assistance shall be applied regardless of the source of referral and without discrimination as to race, color, creed, national origin, age, handicap status, or marital status.

7. The Patient Accounts Department or clinic administration, as the case may be, will attempt to verify income. If income information is not available, the Director of Patient Accounts (or the Director's appointee) will make a decision based on patient selfdeclaration, taking into consideration the patient's health, debts, medical bills, proof of residency and future ability to pay.

8. Dual eligible patients (where Medicaid pays the Medicare premium only) meet the financial assistance guidelines set by the Hospital and will receive a charity discount at the time of Medicaid denial.

9. Medicaid patients who have exhausted their Medicaid benefits are automatically eligible for financial assistance for any medically necessary services.

10. Financial assistance determination will be made within seven (7) working days from the time all necessary/requested documentation is received from the patient.

11. A copy of the patient's Financial Assistance Application will be kept on file at the business office of the Hospital/clinics.

12. The Hospital reserves the right to grant financial assistance in extraordinary circumstances to patients of the Hospital or Hospital clinics who do not otherwise meet the financial assistance guidelines set forth in this FAP. In addition, the Hospital reserves the right to limit, reduce or eliminate the availability of financial assistance to any patient based on the Hospital's financial condition and/or the Hospital's financial ability to provide such financial assistance. For example, if the Hospital and/or clinic location is projected to operate at a loss for any given month, then the Hospital may, in its discretion, suspend the provision of discounted or charity care for such period of time that the Hospital and/or clinic location experiences a loss. Notwithstanding the foregoing, no FAP-eligible individual will be charged more than Hospital's AGB.

Billing and Collections

Actions that may be taken in the event of non-payment are described in the Hospital's Billing and Collections Policy. A free copy of this policy may be obtained on the Hospital's website or by contacting the Hospital's business office.

Review/History

1. Review: This policy will be reviewed every three (3) years or as changes warrant.
2. History: Formulated 04/18; Revised 05/18

Exhibit A

List of Facilities and Practitioners

This FAP applies to Greenwood Leflore Hospital and all clinics owned and operated by Greenwood Leflore Hospital. This FAP also applies to the professional fees for the following groups of practitioners employed by Hospital:

ER Physicians and Mid-Levels
Hospitalist Physicians and Mid-Levels
Pediatricians and Mid-Levels
General Surgeons
ENT Physicians
Podiatrist
Gastroenterologist and Mid-Levels
Primary Care Physicians and Mid-Levels
Psychiatrist
Cardiologist
Pulmonologist
Neurologist
Neurosurgeons
OB/GYN Physicians and Mid-Levels
Urologists
Orthopaedist and Assistants
Pain Management Physician and Mid-Levels
Pathologist*

This FAP does not apply to any fees for professional services provided by practitioners not employed by Hospital, including, but not limited to:

Anesthesiologists and CRNAs
Radiologists
Radiation Oncologists
Pathologist*
Physicians in private practice not employed by Hospital

*Both employed and non-employed pathologists may provide services to Hospital patients

Attachment 1

GREENWOOD LEFLORE HOSPITAL
GREENWOOD, MS
FINANCIAL ASSISTANCE CO-PAY REQUIREMENTS

Co-payments are due at the time of the service. If there are multiple patient appointments on the same day, the patient is expected to pay the co-payments for each appointment/encounter.

Service	Co-Payment Amount
Primary Care Clinic Visit	$20 per visit
Specialty Care Clinic Visit	$30 per visit
Emergency Department Visit	$75 per visit
Hospital Admission	$100 per admission
Ambulatory Surgery	$40 per surgery
Ancillary Services that meet Medical Necessity	
Lab/X-ray	$10 per visit
CT/MRI/MRA/Special Procedures	$50 per visit
Hospital Physician IP/OP Visits	$45 per episode
Physician Procedure Fee-Emergency Surgeries and Procedures	$45 per procedure $100 per surgery
Lithotripsy	$600.00
Pet Scan	$850.00

Attachment 2

GREENWOOD LEFLORE HOSPITAL
GREENWOOD, MS
FINANCIAL ASSISTANCE APPLICATION
DATE OF REQUEST: _____

As provided for in Federal Law, I hereby request that Greenwood Leflore Hospital make written determination of my eligibility for financial assistance. I understand that the information that I submit concerning my annual income and family size is subject to verification by Greenwood Leflore Hospital. I also understand that if the information I submit is determined to be false, such a determination will result in denial of financial assistance.

Name:_____
First Middle Last

Address:_____
Number and Street City State Zip

Employer:_____ Telephone:_____

Income: List Cash Income From:

	Total for Last 3 months	Total for Last 12 months
Wages	_____	_____
Self-Employment	_____	_____
Public Assistance	_____	_____
Unemployment Assistance	_____	_____
Worker's Compensation	_____	_____
Alimony	_____	_____
Pensions	_____	_____
Child Support	_____	_____
Income from Dividends, Interest	_____	_____
Rent paid to you	_____	_____

Number of Dependents: Count those for which you provide more than one half support. If you have been confirmed as pregnant, then the unborn child should be counted.

Name	Date of Birth	Social Security Number**
1. _____	_____/_____/_____	_____-_____-_____
2. _____	_____/_____/_____	_____-_____-_____
3. _____	_____/_____/_____	_____-_____-_____
4. _____	_____/_____/_____	_____-_____-_____

Please provide date of birth and social security numbers for each person in household!

Residency: I am a resident of _____ County, Mississippi. Please provide one of the following forms of proof of residency:

1. County property tax assessment statement;
2. Utility bill showing current county address;
3. Rent receipt(s) showing evidence of county of residence;
4. County food stamp letter;
5. Voter registration card; or
6. Valid Mississippi driver's license.

Medicaid Eligibility: I have applied for and been denied Medicaid coverage. _____ Yes or _____ No. If "yes," please provide a copy of the Medicaid coverage denial. If "no," you must first apply for Medicaid coverage. Failure to provide a copy of the Medicaid coverage denial is grounds for disqualification under the Hospital's financial assistance policy.

Declaration:

I declare that the answers I have given are true and correct to the best of my knowledge.

I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with employer, bank, credit report, etc.

I understand that if I do not qualify based on the information provided, I would be expected to pay the full amount of services rendered.

I further agree that in consideration for receiving health care services as a result of an accident or injury, I will reimburse Greenwood Leflore Hospital from the proceeds of any litigation or settlement resulting from such act.

Patient/Guarantor _____ Date _____

Attachments:

Please submit ALL that apply to this application:

- Copy of a valid government issued picture ID
- Current Paystubs
- Previous year tax return
- Forms approving or denying unemployment compensation or workers compensation
- Written verification from public welfare agency or other governmental agency attesting to patient income status
    - Food Stamps
    - Housing
    - Welfare cash benefit
- Written verification that patient is disabled

- Medicaid coverage denial confirmation