

## Financial Assistance Policy

Memorial Medical Center	
Policy Title:	Financial Assistance Policy
Effective Date:	10/1/2016
Revision Date:	02/26/2019

Memorial Medical Center (MMC) is committed to providing emergency and medically necessary health care services to patients without regard to their ability to pay. MMC recognizes that, due to economic and personal financial hardship, financial assistance may be necessary to allow the patients we serve to get the care they need. No patient will be denied financial assistance on the basis of race, creed, nationality, origin, citizenship, or immigration status. Financial assistance will be provided to the patient and his or her guarantor (typically, the patient's parent or legal guardian) who, after investigation of circumstances surrounding ability to pay, is determined to be unable to pay all or a portion of billed charges. This includes patients who are insured, but determined to be unable to pay all or a portion of their co-payments, co-insurance, and deductibles.

Financial assistance will take the form of discounted or free care

Community based physicians not employed by the MMC (Appendix A) may bill separately for services and will not be included in this policy. Refer to Appendix B for a list of providers included in this policy.

Financial assistance will be given only after applicable insurance coverage and government assistance programs have first been explored (and applied, to the extent available). Noncompliance with insurance policy guidelines (*i.e.*, appeals, referrals, and non-authorized services) or failure to pursue available government assistance programs may prevent participation in the Financial Assistance Program, as determined by MMC in its discretion.

Notwithstanding any other provision of this policy, MMC will provide, without discrimination, care for Emergency Medical Conditions (within the meaning of Section 1867 of the Social Security Act (42 USC 1395dd)) to all individuals seeking such care, regardless of their ability to pay or their eligibility for financial assistance under this policy.

This policy addresses only the most common situations that may arise, and it is not intended to be all-inclusive. This Policy is intended to describe MMC general financial assistance guidelines.

### Procedure

- A. **Notification of Program** -- Guarantors will be notified of the availability of the MMC Financial Assistance Program upon request; guarantors will be offered a plain language summary of this policy prior to the patient's discharge (plain language summaries will be available in the emergency department, admissions area and other appropriate areas of the hospital). MMC will provide the plain language summary at the front desk or waiting area. In addition, as provided in MMC's Policy on Billing and Collection for Self-Pay Amounts, in all billing statements (at least 3) over a period of not less than 120 days commencing on the date of the first bill issued to the guarantor for such services, MMC will inform the guarantor of the availability of financial assistance. During the same 120-day period, all written and oral communications with MMC financial representatives regarding amounts due for the care provided will include information regarding the availability of financial assistance pursuant to this policy.
- B. **Determination of Household Income** -- Financial assistance will be determined by measuring the income of the household of the designated guarantor and the household of any other adult responsible for the patient

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("Household") against the current poverty guidelines established by the US Department of Health and Human Services (US DHHS).

- C. **Scope of Income to be Considered** -- All income in the Household will be considered, including gross wages, government payments including but not limited to tax refunds and *Social Security payments*, pensions, alimony, child support, unemployment compensation, and any payments that are considered *taxable* income by the US Internal Revenue Service.
- D. **Discount Percentage** -- The measure for financial assistance will be a sliding scale based on the US DHHS Federal Poverty Guidelines (FPG), as follows (see Appendix C for FPG table):

<i>Household Income Level</i>	<i>Maximum Discount Percentage (Includes Uninsured Discount)</i>
At or below 100% FPG	100%
At or below 200% FPG	50%

- E. **Calculation of Charges and Amount Due** -- Following a determination of financial-assistance eligibility, the eligible individual will not be charged more for emergency or medically necessary care than the amounts generally billed (AGB) to individuals with insurance covering such care.

At MMC the AGB is determined through the "Look-back method" which is calculated as follows:

- For 2019, MMC is using the "look-back method" to calculate the AGB. This method based AGB on fully allowed payments amounts for hospital claims with a primary payer of either Medicare fee for service or a commercial payer during the period 1/1/18-12/31/18. MMC divides the sum of total payments allowed by those payers (including coinsurance, copayments, and deductibles) by the sum of total hospital charges for those claims to identify the "AGB percentage".
- MMC will not charge patients eligible for financial assistance more than below-noted AGB percentage for emergency or medically necessary services in 2019-2020.
  - AGB for the period 3/1/2019-2/29/2020 (unless earlier updated) will be 57 percent of total hospital charges.
- MMC will re-calculate its AGB at least annually.

- F. **Qualification Based on Size of Bill** -- Financial assistance may also be provided for guarantors who are unable to pay some or all of the patient's hospital bills because the bills are so extensive that payment threatens the Household's financial stability, even though the Household's income otherwise exceeds 200% of FPG. Such financial assistance will be determined based on an individual assessment of the Household's financial resources (income and assets) and the size of the patient's hospital bill.

- G. **Application Process** -- Applicants for the Financial Assistance Program must complete the "Financial Assistance Application" (Appendix D). Supporting documentation such as tax returns and check stubs as outlined in the Financial Assistance Application are required. Financial assistance applications are available by contacting the Patient Accounts Department at MMC via telephone at (715) 685-5500, in person (Monday through Friday, or by appointment) at the registration desk. The application is also available for download from MMC website: <http://ashlandmmc.com>. Representatives are available to assist families with the application process. Completed applications should be returned in person at the registration desk or by mail to the MMC Patient Billing Office, 1615



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Maple Lane, Ashland, WI 54806. If an incomplete application is submitted, a letter will be generated to the guarantor asking for additional information to be provided within 30 days.

- H. **Approval/Denial of Financial Assistance** - A letter either approving or denying a request for financial assistance will be sent to the applicant within 30 days of the receipt of a completed application. A completed application includes all required supporting documentation. Denials may be appealed through the Patient Financial Services Department. All appeals should be requested in writing, and include supporting documents that demonstrate the inability to pay that were not available or included at the time of initial consideration. Decisions regarding Financial Assistance are documented in the billing system.
- I. **Time Period for Submission of Applications** -- MMC will accept and consider financial assistance applications submitted at any time up until the date that is 240 days after the date of the first billing statement issued by MMC to the guarantor for the services at issue. Applications made during this timeframe will be considered even if the account has already been placed with a collection agency; if such an application is received for financial assistance, collection efforts will be terminated or modified as appropriate based on the financial assistance determination.
- J. **Duration of Eligibility Determination** -- A determination of qualification for financial assistance will apply with respect to all medically necessary services rendered, and charges incurred, during a period commencing *with the date of* the original services for which financial assistance was *sought* and continuing for 180 days after financial assistance qualification was determined. Additional services rendered and charges incurred after such date will require the completion of a new application as described in (G) above.
- K. **Effect of Non-Payment** -- Balances remaining after application of the financial assistance discount are subject to timely payment consistent with standard MMC billing and collection practices. In the event of non-payment, MMC may take any and all collection actions described in MMC's policy on Billing and Collection for Self-Pay Amounts; a free copy of that separate policy can be obtained by contacting the Patient Accounts Department, the Financial Counselor Office, or our website as described in (G) above.
- L. **Presumptive Financial Assistance Eligibility**—Patients who are unable to complete an application form may be eligible for Financial Assistance if other evidence is available which may indicate financial hardship. This information may be obtained from a patient interview, credit bureau or other available records. Consideration may be given on any individual basis. Examples of patient circumstances that would indicate financial hardship and presumptively qualify for financial assistance are as follows:
1. Deceased with no estate-based on the conclusion that the decedent has no assets, and therefore no ability to pay.
  2. Accounts uncollectable due to discharge of account by bankruptcy.
  3. Patients who are homeless at the time of registration or admission.
  4. If it has been determined that a patient has been approved for Medical Assistance, all accounts currently delinquent with the hospital will be written off for Financial Assistance.
  5. Any account returned by the collection agency that has been determined to be uncollectable may be considered for Financial Assistance.
  6. Qualified individuals under another organization's similar Financial Assistance application process.
  7. Patients listed for collections will be scored through a credit bureau. This score will cause a "soft hit" on your credit file and will not affect your credit score. All accounts that score below 499 and have no payments applied to the account will qualify for Financial Assistance.
  8. Patients with Medicaid coverage from other states that the hospital is not contracted with. Medicaid coverage will be verified and then billed first; presumptive eligibility will occur at the time of denial.



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- M. **Publication of Financial Assistance Policy** -- This policy, the Financial Assistance Application, and a plain-language summary will be made available for download from MMC website: <http://ashlandmmc.com> . Paper copies will be made available upon request and without charge at the registration desk. Signs notifying hospital visitors about the policy will be posted. The hospital will develop a plan to inform and notify residents of the community served about the policy in a manner reasonably calculated to reach those most likely to require financial assistance.
- N. **Uninsured Discount** – Uninsured patients = excluding those receiving cosmetic procedures will be given an uninsured discount of 5%. The discount is comparable to the discount provided to most insurance companies.



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**Financial Assistance Policy  
Appendix A: Non Covered Providers**

Ashland Audiology  
2101 Beaser Avenue, Suite 3  
Ashland, WI 54806  
715-682-9311

Ashland Pathology Services  
3410 Stanley Street  
Stevens Point, WI 54481  
715-344-1234

Bay Dental  
819 Lake Shore Drive West  
Ashland, WI 54806  
715-682-6675

Bad River Dental  
53585 Nokomis Road  
Odanah, WI 54806  
715-682-7887

Essentia Health - Ashland Clinic  
1625 Maple Lane, Suite 1  
Ashland, WI 54806  
715-685-7500

Essentia Health - Duluth Clinic  
400 E Third Street  
Duluth, MN 55805  
218-786-3520

Essentia Health Radiology Imaging  
420 E 1<sup>st</sup> Street Suite 1  
Duluth, MN 55805  
218-786-8364

Essentia Health-Lakewalk Clinic  
1502 London Road, Suite 102  
Duluth, MN 55812  
218-576-0100

Essentia Health-St. Mary's Sleep Study Center  
502 E 2<sup>nd</sup> Street  
Duluth, MN 55805

Main Street Clinic  
1001 Main Street  
Ashland, WI 54806  
715-682-5601

North Lakes Community Clinic  
300 Main St  
Ashland, WI 54806  
715-682-5207

North Lakes Community Clinic  
7665 US Highway 2  
Iron River, WI 54847  
715-372-5001

North Lakes Community Clinic  
101 Thompson Rd  
Washburn, WI 54891  
715-373-2233

Northern Waters Ophthalmology  
2111 Beaser Avenue  
Ashland, WI 54806  
715-682-0363

St. Luke's Chequamegon Clinic Ashland  
415 Ellis Avenue  
Ashland, WI 54806  
715-685-6600

St. Luke's-Duluth Clinic  
915 East 1 st Street  
Duluth, MN 55805

Superior Anesthesia Associates  
301 Ellis Avenue, Suite 3  
Ashland, WI 54806  
715-682-2206

218-786-4692

**PROVIDERS COVERED BY FINANCIAL ASSISTANCE POLICY**

**Appendix B: Covered Providers**

**Contact Memorial Medical Center  
715-685-5500**

<b>PROVIDER</b>	<b>PRIVILEGES</b>
Anderson ,Mary Ann, MD	Emergency Care
Asaithambi, Ganesh, MD	Emergency Care Telemedicine
Bachelder, Vance, MD	Internal Medicine
Bailey, Patrick, CRNA	Anesthesia
Bockhold, Stephen, MD	Emergency Care
Boyle, John, MD	Radiation Oncology
Brady, Kevin, MD	Emergency Care
Brede, Shawn, CRNA	Anesthesia
Brown, James, MD	Emergency Care
Brucher, David, PA-C	Urgent Care
Cahill, JoAnn M	Speech Pathologist
Cobarruvias, Cesar, DO	Emergency Care
Corry, Jesse J, MD	Emergency Care Telemedicine
Dornfeld, Kenneth, MD	Radiation Oncology
Gardner, Daniel, PHD	Psychology
Halbe, Susan, FNP	Urgent Care
Hanson, Sandra, MD	Emergency Care Telemedicine
Hart, Cynthia, MD	Emergency Care
Haycraft-Williams, Kimberly, MD	Emergency Care
Hess, Kevin, MD	Psychiatry
Honstad, Alex M.	CRNA



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Kebbekus, Peter, MD, PHD	Medical Oncology
Kohegyi, Rebecca , CRNA	Anesthesia
Krenzke, Karen, MD	Emergency Care
Lalich, Mihalio, MD	Medical Oncology
Lean, James, MD	Psychiatry
Malmberg, Melissa, MS	Urgent Care
McClelland, Kevin, MD	Gastroenterology
McNaney, David, MD, MBB	Radiation Oncology
Mikesell, Scott, MD	Internal Medicine
Miller, Nicholas MD	Anesthesia
Mundy, John, PHD-CRNA	Anesthesia
Murphy, Michael , FNP	Urgent Care
Patel, Sheetal, MD	Emergency Care Telemedicine
Peters, Candy, MD	Emergency Care
Sawyer, Jessica, MD	Emergency Care
Schroeter, Lea Ann, MD	Emergency Care
Schroeter, Neal, MD	Emergency Care
Shultz, Jonathan, MD	Emergency Care
Shweikeh, Mohammed, MD	Emergency Care
Singh, Mandeep, MD	Psychiatry
Stromsness, Joseph , NP	Urgent Care
Torgerson, Barbara, PA-C	Urgent Care
Tumas, Vydanas, MD	Emergency Care
Tuominen, Terrence, MD	Ear, Nose, Throat
Unni, Chandra, MD	Psychiatry
Van Vonderen, Mary, NP	Urgent Care
Wheeler, Lisa , MD	Psychiatry



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White, Herbert, MD	Psychiatry
White, John, MD	Emergency Care
White, Travis, MD	Emergency Care
Wiley, Kristiane, NP	Nurse Practitioner
Wood, David, DPM	Podiatry



**Appendix C: Federal Poverty Guidelines FFY 2019**

Unit Size	100% Discount (100% of FPL)	50% Discount (200% of FPL)
<b>1</b>	\$12,490	\$24,980
<b>2</b>	\$16,910	\$33,820
<b>3</b>	\$21,330	\$42,660
<b>4</b>	\$25,750	\$51,500
<b>5</b>	\$30,170	\$60,340
<b>6</b>	\$34,590	\$69,180
<b>7</b>	\$39,010	\$78,020
<b>8</b>	\$43,430	\$86,860
<b>9</b>	\$47,850	\$95,700
<b>10</b>	\$52,270	\$104,540



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### Appendix D: Financial Assistance Request Form

<b>I. Patient Information</b>					
PATIENT'S NAME LAST		FIRST		MI	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY		STATE	ZIP
DATE OF BIRTH	TELEPHONE - HOME		TELEPHONE - WORK		TELEPHONE - CELL
<b>II. Guarantor Information</b>					
NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL			RELATIONSHIP		Please check this box if you are applying to pre-qualify <input type="checkbox"/>
STREET ADDRESS		CITY		STATE	ZIP
DATE OF BIRTH	TELEPHONE - HOME		TELEPHONE - WORK		TELEPHONE - CELL
<b>III. Household Information – Please indicate ALL people living in your household, including applicant (use additional paper, if necessary)</b>					
HOUSEHOLD MEMBERS FIRST AND LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	EMPLOYER NAME	YEAR TO DATE INCOME	INSURED? IF YES, LIST INSURANCE (I.e. Blue Cross, Medica, etc.)
1.					Yes <input type="checkbox"/> No <input type="checkbox"/>
2.					Yes <input type="checkbox"/> No <input type="checkbox"/>
3.					Yes <input type="checkbox"/> No <input type="checkbox"/>
4.					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>IV. EMPLOYER</b>				SALARY WEEKLY \$	
<b>V. SPOUSE'S EMPLOYER</b>				SALARY WEEKLY \$	
<b>VI. OTHER INCOME</b>				AMOUNT \$	
<b>VII. Expenses and Assets</b>					
Rent/mortgage payment \$		Checking account balance \$		Health Insurance Premium \$	
Mortgage loan balance \$		Savings account balance \$		Other Assets \$	
Real market value of home \$		Stocks, bonds, CDs, etc. \$		Monthly Food Costs \$	
Real estate other than primary \$		Recreational vehicles \$		Child Support received/paid \$	
<i>Please feel free to attach additional information regarding your current situation.</i>					
<b>VIII. Required Documentation – Information that must be sent with this application</b>					
<b>Please check off that you have included the following:</b>				Income verification showing earnings or pay stubs for all year-to-date. THIS IS ANY OTHER INCOME NOT REPORTED ON YOUR BANK STATEMENT AS DIRECT DEPOSIT. <input type="checkbox"/>	
<input type="checkbox"/> Copy of previous year's tax returns <input type="checkbox"/> FIRST PAGE ONLY		<input type="checkbox"/> Copy of latest bank statements <input type="checkbox"/> SHOW ALL DIRECT DEPOSIT INCOME			
We may require additional documentation in order to assist you. If so, we will contact you at the telephone numbers you have listed. If you have questions regarding this form, please call 715-685-5500.					
* Please note: If your parent or someone else provides your basic living support, you must include their tax and income information.					
<b>IX. Authorization</b>					
I hereby certify the information contacted in the above financial questionnaire is correct and complete to the best of my knowledge. I authorize Memorial Medical Center to verify any or all information given.					
RESPONSIBLE PERSON'S SIGNATURE _____				DATE _____	