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Owner	Tahlia Nelson: Revenue Cycle Director
Area	Business Office

101.18 Financial Assistance Program

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PURPOSE

Crawford County Memorial Hospital is dedicated to improving the lives of the patients and their families through the delivery of compassionate and effective healthcare.

Crawford County Memorial Hospital, as a public county hospital, is dedicated to providing to qualified patients an avenue to apply for and receive free or discounted care based upon demonstrated financial need.

ELIGIBILITY CRITERIA

Definitions

The following definitions apply to Financially Indigent eligibility criteria:

"Uninsured": A patient who (i) has no health insurance or coverage under governmental health care programs, and (ii) is not eligible for any other third party payment such as worker's compensation or claims against others involving accidents.

"Underinsured": A patient who (i) has limited health insurance coverage that does not provide coverage for hospital services or other medically necessary services provided by the Hospital, or (ii) has exceeded the maximum liability under his/her insurance coverage.

"Household Income": The total income of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy.

"Net Worth": Net asset value (assets – liabilities (excluding Hospital liabilities) of all members living in the patient's household over the twelve (12) months prior to application for assistance under this policy but does not include a patients primary residence, qualified retirement accounts, nor one vehicle.

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"Financially Indigent": A patient having a Household Income less than or equal to 200% of the Federal Poverty Level and having a Net Worth less than or equal to such level that is set by this Program.

Eligibility

To qualify as Financially Indigent, the patient must be Uninsured or Underinsured and have a Household Income of equal to or less than 225% of Federal Poverty Level; provided, however, that patients who satisfy the minimum Household Income criteria but have a Net Worth in excess of $8,000 do not qualify as Financially Indigent.

Furthermore, patients who may be eligible for Medicaid or other government assistant (e.g. Hawk-i) and fail to apply for such governmental assistance are not considered eligible for financial assistance under this policy.

Patients must be a resident of Crawford County Iowa to qualify for the CCMH financial assistance program.

Patient Responsibilities

The patient has a number of responsibilities to meet in order to qualify for Financial Assistance including:

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1. Obtaining insurance coverage if affordable coverage is available to them.
2. Applying for any government sponsored insurance programs that they may qualify for.
3. Submitting all requested documentation concerning income, assets and residency that is needed to verify their qualifications for any financial assistance in a timely manner.
4. Keeping income, asset, demographic and insurance information updated to CCMH.
5. Paying all balances in accordance within the agreed time frames.
6. Paying a $20 copayment at time of service for each clinic visit or outpatient services visit.
7. If a patient does not pay or is not making payments on an account with a charity care discount, he/she may be denied future assistance.

Categories of Care Eligible for Financial Assistance

Provided that the patient qualifies as Financially Indigent the following classes of care are eligible for financial assistance under the policy:

Emergency Medical Care

1. ER/Emergency Medical Services.
2. Emergency Ambulance Services provided by CCMH.

Medically Necessary Care

1. Doctor ordered routine nursing care and those ancillary services.
2. Out-Patient IV / Chemotherapy Services.

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3. Physical, Occupational, Pulmonary, and Speech Services.
4. Cardiac Rehab Phase II Services.
5. MRI, CT, Ultrasound, etc. Services.
6. CCMH Physician Clinic Services.
7. Observation, Acute, or Skilled Services.

Categories of Care Not Eligible for Financial Assistance

Generally, any class of care which is not listed as eligible for assistance is not eligible for financial assistance, which includes, but is not limited to:

1. Physician fees including radiologists, pathologists, or any independent contractor not employed by CCMH.
2. Cosmetic or not medically necessary surgical services including elective services.
3. Phase III cardiac rehab services.
4. Sleep studies
5. Fertility testing

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Covered Providers:

Care provided by Crawford County Memorial Hospital and CCMH employed physicians and practitioners is covered by this policy. Care provided by independent community physicians and other independent service providers is not subject to this policy. Patients should contact these other providers to determine whether care is eligible for financial assistance.

Patients may obtain a current list of providers who are and are not subject to this policy at no charge by visiting a Financial Counselor or by calling 712-265-2500 or visiting the facility website at www.ccmhia.com.

Payment Requirements and Payment Plans

Discounts approved under this policy will be applied when a patient is deemed qualified. Payment plans will be offered in accordance with existing guidelines under CCMH's Payment, Credit & Collections Policy.

LIMITATION ON CHARGES & CALCULATION OF AMOUNT OWED

Patients who are deemed to be eligible for financial assistance will not be charged more than Amounts Generally Billed by the Crawford County Memorial Hospital. Discounts granted to eligible patients under this policy will be taken from gross charges.

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Calculation of Amounts Generally Billed

The "Amount Generally Billed" or "AGB" is the amount the Hospital generally bills to insured patients. The Crawford County Memorial Hospital utilizes the look-back method to establish its AGB and AGB Percentage. The AGB is CCMH's gross charges multiplied by the AGB Percentage. Patients may obtain CCMH's most current AGB Percentage and a description of the calculation in writing, free of charge, by visiting a Financial Counselor or by calling 712-265-2500. CCMH calculates its AGB Percentage on an annual basis. For purposes of this policy each new AGB Percentage will be implemented within 120 days of the 12 months period used by CCMH to calculate the AGB Percentage.

Amount of Financial Assistance/Discount

Patients who qualify for financial assistance as Financially Indigent are eligible for financial assistance based upon the following sliding fee scale for 2025:

Family Size	1	2	3	4	5	6	7	8	Add'l
Income	15,650	21,150	26,650	32,150	37,650	43,150	48,650	54,150	5,500

Poverty Guideline	% Written Off
0 – 125%	100%
126 – 160%	75%
161 – 190%	50%
190 – 224%	25%
225 – OVER	0%

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Such scale will be updated on an annual basis by referencing the U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs as reported by the U.S. Department of Health and Human Services.

If financial assistance provided to the patient results in a charge greater than AGB, the patient shall be provided additional financial assistance such that the patient is not personally responsible for more than AGB. In determining whether an eligible patient has been charged more than AGB, the Hospital considers only those amounts that are the personal obligation of the patient. Amounts received from third party payors are not considered charged or collected from the patient.

Medical Settlement:

In the event that there is a liability claim paid or a medical settlement made to the patient for medical/ surgical bills that the patient applied to have treated as Financial Assistance, the Hospital reserves the right to void the application for Financial Assistance, approved or not, seek restitution from the patient, and pursue whatever legal recourse is necessary to secure payment.

APPLICATION PROCESS & DETERMINATION

Patients who believe they may qualify for financial assistance under this policy are required to submit an

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application on the Hospital's financial assistance application form during the Application Period.

For purposes of this policy, the "Application Period" begins on the date care is provided to the patient and ends on the later of (i) the 120th day after the date the first post-discharge (whether inpatient or outpatient) billing statement is provided to the patient OR (ii) not less than 30 days after the date the Hospital provides the patient the requisite final notice to commence extraordinary collection actions ("ECAs").

Patients may obtain a copy of this policy, a plain language summary of this policy, and a financial assistance application free of charge (i) by mail by calling 712-265-2500 (ii) by download from the facility website at www.ccmhia.com , or (iii) in person at (a) the emergency room, (b) admission areas, or (c) patient financial services at the main hospital entrance.

Emergency Medical Care

Emergency medical treatment will be provided without regard to ability to pay and regardless whether the patient qualifies for financial assistance under this financial assistance policy. CCMH will not take any action that may interfere with the provision of emergency medical treatment, for example, by demanding payment prior to receiving treatment for emergency medical treatment conditions or permitting debt collection activities that interfere with the provision of emergency medical care in the emergency department. Emergency medical treatment will be provided in accordance with CCMH policies governing and implementing the Emergency Medical Treatment and Active Labor Act.

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No Application Submitted

If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and
2. Provides at least thirty (30) days' notice to the patient that:
    - Notifies the patient of the availability of financial assistance;
    - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and
    - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;
3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and
4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

Incomplete Applications

If a patient submits an incomplete financial assistance application during the Application Period,

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"reasonable efforts" will have been satisfied if the Hospital:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information of the Hospital department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 30 days to provide the required information; and
2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, the Hospital must suspend ECAs and make a determination on the application.

Completed Applications

If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if the Hospital does the following:

1. Suspends all ECAs taken against the individual, if any;
2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and
3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

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If the Hospital has requested that the patient apply for Medicaid, the Hospital will suspend any ECAs it has taken against the patient until the patient's Medicaid application has been processed or the patient's financial assistance application is denied due to the failure to timely apply for Medicaid coverage. The requirement for a Medicaid denial letter may be waived for patients who will not qualify for Medicaid due to not having a social security number.

If a patient is eligible for financial assistance other than free care, the Hospital will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the ABG for the care provided;
2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to the Hospital (unless such amount is less than $5); and
3. Take reasonable measures to reverse any ECAs taken against the patient.

COLLECTION ACTIONS

For further information on the actions the Hospital may take in the event of non-payment, please see the Hospital's Payment, Credit & Collections Policy (CCMH Policy #101.16). Patients may obtain the Payment, Credit & Collections Policy free of charge (i) by contacting patient financial services at

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712-265-2500, (ii) by request in person at patient financial services, the emergency room front desk or the admissions desk.

ADDITIONAL INFORMATION

Confidentiality and Record Keeping

All information obtained from patients, guarantors and family members shall be treated as confidential. CCMH will retain a central repository by each patient/guarantor containing financial assistance applications. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

Due Process

If the applicant is not satisfied with the decision rendered, he/she may request a meeting with the Patient Financial Services Director to ascertain the rationale used in making the decision.

If the applicant is not satisfied with the explanation given by the Patient Financial Services Director, he/she may request a meeting with the CFO or CEO of the Hospital.

Notification to the Public

Notifications of Financial Assistance opportunities will be posted in the Admitting areas, Emergency Room and other Outpatient areas of the Hospital. It will also be included in the information packets given to patients who are admitted to the medical/surgical area.

Annual Review

The income guidelines and criteria for approval will be reviewed on an annual basis to assure that the Financial Assistance Program of Crawford County Memorial Hospital is current in meeting the needs of the medically indigent.

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Attachments

- 101.18 Financial Assistance Provider List Exhibit C.pdf
- Exhibit B: Financial Assistance Application
- To Apply for Financial Assistance

Approval Signatures

Step Description	Approver	Date

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Quality & Compliance Approval	Marcy Fink	04/2025
Policy Owner	Tahlia Nelson: Revenue Cycle Director	04/2025

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