

 <b>ST. JOSEPH</b> Regional Medical Center	DIVISION:  BUSINESS SERVICES
SUBJECT:  <b>FINANCIAL ASSISTANCE POLICY</b>	APPROVED:    
ISSUED:05/20/96    REVIEWED:08/01/06    REVISED:12/29/10    REVISED 03/17/2014    REVISED 9/08/2017,12/27/2017,08/28/2018, 02/20/19, 2/11/21, 6/01/21, 2/4/2022, 1/21/2025	

## I. PURPOSE:

The purpose of the financial assistance program is to identify patients, who lack the financial resources to pay all, or part of, their bills. An appropriate adjustment will be made to a patient's bill based on the policy guidelines of St. Joseph Regional Medical Center based on the philosophy of the Roman Catholic Diocese of Boise to provide health care to patients without regard to their economic status.

Charity is understood to mean the forgiveness of a partial or full hospital bill based on the financial position of the patient or guarantor. Each individual case must be considered on its own merit.

## II. ELIGIBILITY CRITERIA:

Charity care is always secondary to all other financial resources available to the patient. This includes:

1. Group or individual medical plans.
2. Workman's Compensation plans.
3. Medicaid/County Welfare programs.
4. Other State, Federal or Military programs.
5. Third party liability situations (i.e., auto accidents or personal injuries).
6. Religious Cost Share programs.
7. Any other person or entities who may have a legal responsibility to pay for the medical service, or who offer a program that would pay for a portion or all of the service.

This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.

Determination of eligibility of a patient for charity care shall be applied regardless of the source of referral and without discrimination as to religion, race, color, national origin, or handicap status.

An application for financial assistance will consider the individual's circumstances such as extraordinary discretionary expenses, catastrophic medical expenses, the existence and availability of family assets, the responsible party's future income capacity and the individual's ability to make payments over a 3 year period or less.

## **100% CHARITY: Uninsured & Insured Patients**

In light of the individual's circumstances and to the extent that hospital charges are not covered by a third party resource, 100% charity care will be provided for that portion of the bill that is the patient's responsibility for patients with gross family income at or below 175% of the Federal Poverty Guidelines as adjusted for family size.

Patients who are currently approved for a Medicaid indigent program are eligible for 100% charity write off of medical bills. Medicaid patients that exceed their annual emergency room visits will be eligible for charity. Managed care Medicaid patients with services that were not approved by the primary care physician will not be eligible for charity. Cost share balances for Idaho Medicaid and spend down balances for Washington Medicaid patients will be the patient's responsibility.

Deceased patients with no estate in probate are eligible for 100% charity write off.

## **SLIDING SCALE: Uninsured & Insured Patients**

Partial charity care will be provided to patients with gross income between 176% and 250% of the Federal Poverty Guidelines as adjusted for family size. The bill owed for patients meeting these criteria will be reduced according to the following sliding scale. The financial obligation which remains after the application of this sliding fee schedule will be payable in monthly installments over a period of time not to exceed 36 months. If the patient cannot afford monthly payments, the account can be evaluated for additional financial assistance.

<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

2025

St. Joseph Regional Medical Center

Sliding Scale per Family Size and Annual Income

Household Size	FPL	0% to 175%	176% to 200%	201% to 225%	226% to 250%
1	\$15,650	\$27,388	\$31,300	\$35,213	\$39,125
2	\$21,150	\$37,013	\$42,300	\$47,588	\$52,875
3	\$26,650	\$46,638	\$53,300	\$59,963	\$66,625
4	\$32,150	\$56,263	\$64,300	\$72,338	\$80,375
5	\$37,650	\$65,888	\$75,300	\$84,713	\$94,125
6	\$43,150	\$75,513	\$86,300	\$97,088	\$107,875
7	\$48,650	\$85,138	\$97,300	\$109,463	\$121,625
8	\$54,150	\$94,763	\$108,300	\$121,838	\$135,375
% PT Pays	0%	0%	10%	20%	30%
% Charity	100%	100%	90%	80%	70%

For Family Units with more than 8 members add \$5,500 for each additional

### **III. FINANCIAL ASSISTANCE: Uninsured & Insured Patients**

Full or partial charity care may also be provided to patients with gross family income above 250 percent of the Federal Poverty Guidelines when circumstances indicate that there is no possibility of debt restructuring to allow for monthly payments and that full or partial payment may cause severe financial hardship.

Certain circumstances may warrant charity consideration and will be referred to the Director of Business Services for review. Under special circumstances judgment may be used to determine charity eligibility where the patient has access to significant cash or liquid asset balances.

### **IV. ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE:**

#### **MEANS TEST:**

The means test described does not apply to Patients treated and discharged from the Emergency Department. Those patients' financial eligibility will be solely determined based on family size and household income per Section II above. For purposes of applying for financial assistance, patient who are treated and discharged from the Emergency Department can ignore the Assets and Liabilities section of the Financial Assistance Application.

The patient or guarantor who is applying for financial assistance must complete a financial statement. Documentation to verify family income will be required. For determination purposes, family members will be defined as persons occupying the same household who are identified as dependents for tax purposes. The financial statement will be used to identify financial resources that could reasonably pay the medical bill in a four-year period.

For eligibility determination, eligible liquid assets include cash, savings accounts, medical savings accounts (MSAs HRAs), stocks and bonds. Retirement accounts with less than \$50,000 are not eligible assets. The first \$75,000 of a patient's/guarantor's residency is not an eligible asset. Automobiles needed to transport all working parties to and from work are not eligible assets. Recreational vehicles and vacation homes are eligible assets.

Eligible income includes all income listed as "Monthly Income" on the Financial Assistance Application. The income shall be annualized when appropriate. The annualizing process will take into consideration seasonal employment and temporary increases and/or decreases of income.

Expenses listed on the financial statement will be reviewed for reasonableness. The financial statement lists expenses into two categories, living expenses and liabilities expenses. Total income will be compared against the living expenses alone and then the combined living and liability expenses.

As a guide for determining living expenses, Medicaid's allowable amounts for household food will be used. Non necessary items and voluntary over use of credit cards will be considered in the determination of available resources for payment of medical bills. If the applicant has made life-style choices that prevent the individual from paying their medical expenses, the account will be not be eligible for charity, except in conjunction with an equitable payment plan through consumer credit counseling services.

#### **Required Documentation:**

Attach copies of the documents listed below for both the patient/guarantor and spouse (please submit only copies; no original documents):

- Most recent tax return, including W-2 forms and supporting schedules
- Last 2 pay stubs or a letter from an employer verifying income (include employer's phone number and address)
- Bank statements for the past 2 months
- Written verification of any other income received (e.g. child support, social security, alimony)

OR

- **If you have no income, a letter or a comment below from you stating your source for paying living expenses**

#### **V. APPEAL PROCESS:**

Patients that do not qualify for financial assistance will be sent a "Financial Assistance Denial" letter. If the patient wishes to appeal the decision, the patient must do so in writing within 30 days of the notification. The appeal request will be forwarded to administration for review. If denied a second time the patient will be notified and payment arrangements will be established.

#### **V. Applying for Financial Assistance:**

A patient may apply for assistance by completing a Financial Assistance Program application (FAP). The FAP application and FAP Application instructions are available by contacting Patient Financial Counseling at 208-799-5327 or St. Joseph Medical Group billing office at 208-750-7464. The forms are available online at [Billing & Financial Assistance | St. Joseph Regional Medical Center \(sjrmc.org\)](http://sjrmc.org)

#### **VII. CONFIDENTIALITY:**

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.