

POLICY AND PROCEDURE

Policy # GA-018-055	Financial Assistance Program (FAP) Policy	Page 1 of 11
Manual: General Administrative		Section: Patient Accounting Services
Sponsor: Executive Vice President Chief Financial Officer		Origination Date: 06/2002
		Distribution: System wide
Approver: Vice President Financial Operations		
Regulation/Standards: Section 501(r)(4) of the Internal Revenue Code		
Revision Date (s)	07/03, 03/04, 02/06, 09/08, 11/08, 01/09, 12/09, 12/13, 06/16, 08/18	
Review Date (s)	03/14, 06/16, 08/18, 08/20	

I. Purpose

Broward Health provides charity care to patients who receive emergency and other medically necessary services and who satisfy the eligibility requirements for financial assistance under this policy. Patients receiving emergency and other medically necessary services who permanently reside within Broward Health's service area and meet the other requirements of this policy, may apply for financial assistance by submitting the Financial Assistance Program Application attached to this policy as Attachment A.

The primary criteria used to determine a patient's eligibility for financial assistance is based upon the family income as a percentage of the most current Federal Poverty Guidelines issued by the United States Department of Health and Human Services and made available annually through publication in the Federal Register.

Broward Health will not discriminate against a patient applying for financial assistance because of race, creed, color, national origin, sex, age or religion. Broward Health's service area within Broward County runs from the Dania Cut-Off Canal north to the Palm Beach County line.

II. Policy

This policy is implemented and will be administered in strict accordance with Section 501(r)(4) of the Internal Revenue Code of 1986, as amended, and Treas. Reg. Section 1.501(r)-4. All of the terms, conditions and requirements contained therein are hereby incorporated by reference in this policy as if fully set forth herein.

III. Commitment to Provide Emergency Medical Care

Broward Health provides, without discrimination, care for emergency medical conditions to individuals, regardless of whether they are eligible for assistance under this policy. Broward Health will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all Broward Health patients in a non-discriminatory manner, pursuant to Broward Health's EMTALA policy.

IV. Definitions

AGB – means amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage.

EMTALA – means the Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd.

Family Income- means the amount of money a person/family earns in one year from all sources prior to taxes. Income includes:

- Gross receipts from self-employment
- Payments from Social Security
- Railroad retirement payments
- Unemployment compensation
- Workers' compensation
- Strike benefits from union funds
- Veterans' benefits
- Public assistance (including General Assistance money payments)
- Training stipends
- Alimony
- Child support
- Military family allotments
- Regular support from an absent family member or someone not living in the household
- Private pensions or government employee pensions
- Regular insurance or annuity payments
- Dividends
- Interest (not interest paid on mortgage from tax return)
- Rent payments received
- Royalties
- Periodic receipts from estates or trusts
- Net gambling or lottery winnings

Financial Assistance – means hospital charges for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to 200% of the then-current Federal Poverty Guidelines for families residing in the Broward Health service area.

Flat Rate Fee Agreement Program- Broward Health will offer an approved Flat Rate Fee to patients for specific selected procedures to guarantee a maximum out-of-pocket expense. The Flat Rate Fee Schedule will contain all discounted procedures offered within the medical center and will be approved by the Chief Financial Officer (CFO)/Regional Director of Finance, or designee.

Medically Necessary – means services or supplies provided by Broward Health to identify or treat an illness or injury which, in the opinion of Broward Health are (i) consistent with the symptoms, diagnosis and treatment of the condition, disease, ailment or injuries; (ii) appropriate with regard to standards of good medical practice; (iii) not primarily for the convenience of the patient; (iv) the most appropriate supply or level of service which can safely be provided to the patient; and (v) necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. When applied to an inpatient, it further means that the patient's symptoms or condition require that the services or the supplies cannot be safely provided to the patient on an outpatient basis.

Permanent Residence – means any person not a citizen of the United States who is residing in the United States under legally recognized and lawfully recorded permanent residence.

Presumptive FAP Determinations- means a determination of eligibility to receive financial assistance based on information other than that provided by the patient in his or her application for Financial Assistance submitted under this policy.

Valid Picture ID – means a state issued driver’s license, state issued identification card, I-551 stamped passport, or valid alien registration card/green card.

V. Eligible Services

This policy applies only to charges for emergency or other medically necessary services provided by Broward Health and certain other providers. Services covered under the Flat Rate Agreement Program do not apply to this policy. Attached to this policy as Attachment B is information on how to access a list of all providers, in addition to Broward Health itself, delivering emergency or other medically necessary care at Broward Health that specifies which providers are covered by this policy and which are not covered.

VI. Measures to Widely Publicize the Availability of Financial Assistance

Broward Health will make available copies of the FAP Policy, FAP Application and the plain language summary in English, Creole, Portuguese and Spanish. The copies will be made available on Broward Health’s website, by mail, in the emergency room, and in all registration areas of the hospital. Copies will also be provided to other healthcare providers in the community and community organizations. Also, paper copies of the plain language summary of the FAP will be provided to patients as a part of the intake/discharge process. Signage will also be posted in prominent areas of the hospital visible to the public.

VII. How to Apply for Financial Assistance

Broward Health will accept an application for financial assistance from any person provided they meet certain qualifications and have applied and complied with all application and review requirements of any available local, state or federally funded health insurance programs. Applicants must gather all information requested on the FAP checklist, FAP Income Statement and FAP Application and meet personally with a Broward Health financial counselor in order to initiate the application process for financial assistance.

If deemed eligible for other funding sources (excluding Auto/Liability sources), the applicant will be ineligible for financial assistance under this policy. Where applicable, proof of denial from other funding sources must be presented prior to the initiation of a financial assistance application. If the applicant refuses to apply for available assistance programs (examples include, but are not limited to, Health Insurance Marketplace, Medicaid, Medicare, Florida KidCare, etc.) and comply with the application process, the applicant will then be deemed ineligible for financial assistance under this policy.

A completed application for financial assistance is required for all patients of Broward Health for services where no other funding source exists. Documentation supplied must correspond with the treatment date and each applicant must have a valid picture ID.

Each application will require a signature from the applicant, or responsible party attesting to the truthfulness and accuracy of the information provided on the application. Any person found to be intentionally providing fraudulent information will have the application denied without reconsideration.

Broward Health financial assistance applicants will be required to notify an appropriate representative of Broward Health in the event that their income circumstances change during the effective period of the financial assistance approval.

Each financial assistance application will serve to determine eligibility to receive financial assistance for all uninsured household family members listed within the application.

By signing the financial assistance application, the applicant is required to apply and comply with any available local, state or federally funded health insurance programs including the Health Insurance Marketplace. Failure to do so will result in revocation of the approved financial assistance.

Application for financial assistance must be completed during the application period which begins on the date the care is provided and generally ends on the 240th day after the date that the first post discharge billing statement for the care is provided.

The completed financial assistance application will be processed within approximately 30 business days of receipt pending no unforeseen circumstances.

Once an application is approved for financial assistance, the approved application is valid for twelve (12) months from the date of service established by the Central Financial Assistance Unit (CFAU) to provide financial assistance for emergency or other medically necessary services provided to the patient. The approval period can be reviewed/amended at any time at the sole determination of Broward Health Administration.

VIII. Basis for Calculating Amounts Charged to Patients

Following a determination of eligibility under this policy, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the amounts generally billed to individuals who have insurance covering such care (AGB). Broward Health uses the Look-Back Method to determine AGB. Under this method, AGB is calculated by dividing the sum of all of its claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital during a prior 12-month period by the sum of the associated gross charges for those claims. Broward Health will begin applying the AGB percentage by the 120th day after the end of the 12-month period used in the calculation. Members of the public may obtain the current AGB percentage and an accompanying description of the calculation in writing and free of charge via the hospital contact information listed in section X of this policy.

Broward Health does not bill or expect payment of gross/total charges from individuals who qualify for financial assistance under this policy.

IX. Eligibility Criteria**1. RESIDENCY**

- a. This policy addresses natural born, naturalized citizens or permanent residents of the United States, as defined by the United States Citizenship and Immigration Services, who have permanently resided within the service area of Broward Health for at least 30 days prior to the date of receiving emergency or other medically necessary care.
- b. Broward Health requires that all non-Broward County residents and citizens of other countries requesting non-emergency treatment must present evidence of appropriate funding prior to non-emergency inpatient hospitalization or outpatient services. Patients who are non-Broward County residents or citizens of other countries may be referred from other medical institutions to the specialized facilities and resources available at Broward Health provided that funding and reciprocal transfer or placement agreements are guaranteed.
- c. Broward Health will provide inpatient and outpatient emergency care without regard to residency and funding status to individuals who present themselves at any of the Broward Health facilities and are evaluated by physicians to require emergency care.

2. INCOME

- a. A qualified/approved applicant for financial assistance whose family income is at or below 200% of the Federal Poverty Guidelines for Broward County will receive full financial assistance with a co-pay responsibility. Applicants whose income is above 200% will not be eligible for financial assistance. See Attachment C for copay amounts.
- b. The determination for financial assistance will be based upon the family's income for the twelve months prior to the date on which the applicant receives emergency or other medically necessary care.
- c. An applicant who has had a change in circumstance that has kept the applicant from being able to work may apply/re-apply for financial assistance once a diagnosis is provided to support the inability of the applicant to work due to his/her illness. If the applicant must have life sustaining treatment, a reconsideration of the applicant's current account status will be reviewed to determine if the applicant is eligible to receive financial assistance for such life sustaining treatment.

3. LEVELS OF AUTHORITY FOR APPROVALS

- a. All completed applications, including all required supporting documentation, which fall within the poverty level income guidelines will be reviewed and approved by a CFAU representative once verified.
- b. A Presumptive FAP Determination may be made on the basis of the following:
 1. All Medicaid and Medicaid HMO inpatients/outpatients, since already qualified as indigent by Medicaid, will have an indigent allowance applied to any outstanding medical center balances after all benefits have been exhausted.

- 2. Patients who are registered with Broward Health Homeless Clinic as W72 (homeless grant) approved, the only requirement for FAP approval will be for the patient to submit a signed FAP income statement.
- c. Any incomplete or questionable applications or appeals, where eligibility cannot be fully verified based on the documentation provided, must be reviewed by the Administrative Director of Medical Center Business Operations or designee for a determination of the applicant's eligibility for financial assistance.
- d. The VP Financial Operations must approve any exceptions based on residency and or exemption from other funding sources. Any exceptions made must be clearly documented as part of the application.

X. Actions Taken in the Event of Nonpayment

Information regarding the collection actions that Broward Health may take in the event of nonpayment of charges for medical care are described in a separate Billing and Collection Policy. Patients and other members of the public may obtain a free copy of this separate policy from Broward Health via the hospital contact information listed herein.

XI. Hospital Contact Information

Broward Health Website: www.browardhealth.org

Broward Health Facility Contact Information:

Broward Health Medical Center
(954)355-5442
1600 S Andrews Ave
Fort Lauderdale, FL 33316

Broward Health North
(954) 786-6589
201 E Sample Rd
Deerfield Beach, FL 33064

Broward Health Imperial Point
(954) 776-8708
6401 N Federal Highway
Fort Lauderdale, FL 33308

Broward Health Coral Springs
(954) 344-3006
3000 Coral Hills Drive
Coral Springs, FL 33065

For a listing of additional Broward Health facilities, including outpatient facilities, urgent care centers, and clinics, visit <http://www.browardhealth.org/Locations>.

XII. Regulations/Standards

Section 501(r)(4) of the Internal Revenue Code

XIII. References

F.S. 409.911(1)(c)

Internal Revenue Code §§ 501(r)(4) (financial assistance policies); 501(r)(5) (limitation on charges); and 501(r)(6) (billing and collection requirements) (and Treasury Regulations issued thereunder)

XIV. Administration and Interpretation

The interpretation and administration of this policy is the responsibility of the Executive Vice President Chief Financial Officer

ATTACHMENT A – Includes the Financial Assistance Program Checklist, Financial Assistance Program Income Statement, and the Financial Assistance Program Application.

ATTACHMENT B – PROVIDER LIST- A list of providers delivering emergency and other medically necessary care covered by the FAP Policy is available on Broward Health's website (www.browardhealth.org).

ATTACHMENT C – COPAY AMOUNTS

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Attachment A (1 of 3) - Financial Assistance Program Checklist

**BROWARD HEALTH
CENTRAL FINANCIAL ASSISTANCE UNIT - CFAU
(954) 767-5344**

You must apply for and comply with the application process for any available local, state, or federally funded health insurance programs for which you or any listed uninsured family member may qualify, e.g. Affordable Care Act (Healthcare Exchange), Medicare, Medicaid, Florida KidCare, etc. Failure to do so will result in a denial of your application.

Proof of Residency/Identification: For all adults applying (One of these)

- Florida Driver's License or State issued Identification Card (must not be expired)
- US Passport
- I-551 stamped non US Passport (all entry dates copied)
- Valid Alien Registration receipt card/green card or Form I-551, I-797 Notice of Approval
- Voters Registration Card

Proof of Address: 2 items for each adult (patient, spouse and/or legal guardian) applying

- Current proof of address dated within 30 days: utility bill (electric, phone, water, cable, gas, etc.), mortgage/lease/rent receipt, voter's registration card, mail, other.
 - o If above information is in another name, then proof of residence/ID will be required from named person along with notarized letter indicating applicant is living at that residence.
- Prior proof of address greater than 30 days utility bill (electric, phone, water, cable, gas, etc), mortgage/lease/rent receipt, voters registration card, mail, valid ID with current address issues at least 30 days prior to application date.
- Proof of school enrollment for children living in the home
**PO BOX addresses and Broward Health Bills will not be accepted as proof of address*

Proof of Children/Dependents:

- Tax Return, birth certificates or proof of legal guardianship

Proof of Income (12 months verification required for all adults/ if married spouse's income also required):

Employed:

- Current Income Tax Return (copies can be requested from IRS (800-829-1040) or www.irs.gov/pub/irs-fill/f4506)
- Current Pay Stub (with Year to Date Gross Income)

If not available:
Current W-2 and current pay stub showing gross income or
Pay stubs for previous 12 months showing year to date gross income, or

Self Employed:

- Current Income Tax Return (copies can be requested from IRS (800-829-1040) or www.irs.gov/pub/irs-fill/f4506)

If not available:
 Income verification letter (company letterhead or notarized) for the previous 12 months with gross income.
 12 months bank statements

Unemployed:

- Unemployment Stub
- Pension/Social Security award letter/1099
- Notarized letter of monetary support from supporter with length of time and monthly amount.
- Notarized letter of room and board support from supporter with length of time support is being provided.
****Supporters ID/Proof of Address is required****

All information is subject to verification. Providing false information may result in the DENIAL of any type of Financial Assistance through Broward Health.

Your signature confirms that you have received the checklist and that you will need to provide the information listed above at your appointment in order to complete the Financial Assistance Application. (If married and spouse is also applying, both must attend to complete the application process).

Patient Name: _____ Date: _____
 Patient Signature: _____ Witness: _____



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Attachment A (2 of 3)- Financial Assistance Program Income Statement

CENTRAL FINANCIAL ASSISTANCE UNIT – NBHD

Patient Number _____

**APPLICATION FOR FINANCIAL ASSISTANCE
AND
INCOME STATEMENT**

I hereby apply for financial assistance for services rendered by a North Broward Hospital District (NBHD) facility.

I certify the following: (check all that apply)

1. Family unit income received for the 12 months prior to service date, did not exceed \$«gross_inc». Can the above income amount be verified? Please check one: YES NO

2. The family unit is not currently receiving any regular monthly income, nor have we received such income in the 12 months prior to the date of service, from Social Security, Medicaid, a pension, Unemployment Compensation or any other source.

I/We hereby apply for financial support for services rendered by a North Broward Hospital District (NBHD) facility and certify that the information provided by me and contained hereon is true, accurate, and correct to the best of my knowledge. **I hereby authorize the NBHD and its assignees to order a consumer credit report and verify other credit information. I/We hereby give consent to the NBHD to verify all statements made on this application. I/We authorize Broward Health to release my/our medical and financial information to business associates of Broward Health for audit purposes**

In the event the undersigned, the patient, or any other person on the patient's behalf are entitled to receive insurance benefits or settlement proceeds because of services rendered to the patient by any facility of the NBHD, said insurance benefits or settlement proceeds are hereby assigned to the NBHD for application against said patient's hospital bill. Insurance benefits and settlement proceeds will take precedence over the adjusted financial assistance amount. It is further agreed that the NBHD or any of its facilities may issue a receipt to said insurance company for any such payment thereby releasing said insurance company from any and all obligations under the insurance policy to the extent of the payment. The undersigned and the patient, however, remain responsible for the hospital charges not covered by this assignment in the event this application for indigent care is denied.

I/We further understand any changes in income, family size, insurance status or address must be disclosed to the NBHD. The NBHD reserves the right to reevaluate this application for indigent care should additional information become available including but not exclusive to changes in income, family size or address. I/We know that anyone who makes or causes to be made false statement commits a crime punishable by law, and can be fined or put in jail for fraud and/or perjury (Florida Statutes 837.012, 775.082, 817.50). I/We further agree to apply for available local, state, or federally funded health insurance programs for which I/we may qualify and understand that failure to do so will result in denial of the application.

PATIENTS NAME: _____ DATE: _____

PATIENT SIGNATURE : _____

SPOUSE SIGNATURE: _____

GUARANTOR NAME: _____
 (If other than patient) (Please Print) (Relationship to Patient)

WITNESSED BY: _____
 (NBHD Representative) (Second Witness)



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Attachment A (3 of 3)-Financial Assistance Program Application



MAPS Case Data Sheet

Patient Number: _____ Corporate ID: _____
 Coverage Start Date: _____ - Coverage End Date: _____ Plan Code: _____

Have you applied for Healthcare Insurance Exchange? Yes No

If yes, what was the outcome? Eligible Ineligible

Was the Healthcare Ineligibility Letter provided? Yes No

Have you applied for Medicaid? Yes No

If no, were you screened and deemed technically ineligible? Yes No

If yes, what was the outcome? Approved Denied If denied, reason: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ SIG MR Num.: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Spouse Name: _____ DOB: _____ SSN: _____

Guarantor Details -

Guarantor Name: _____ SSN: _____

Guarantor Address: _____

Household Member Details -

Household Member Name	Date of Birth	SSN	Relationship to Applicant

Employment Details -

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Member Name: _____ Relationship to Applicant: _____

Employer: _____ Start Date: _____ End Date: _____

Monthly Income: _____ Phone: _____

Patient Details -

Originating Employee: _____ Annual Income: _____

Family Size: _____ Date of Service: _____ Monthly Income: _____

Percent FPL: _____ Patient Name: _____ Patient Number: _____

Notes & Collected Images - -

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Attachment C- Copayment Amounts

Federal Poverty Guidelines (FPG) Calculation per family size*
Emergency Room (ER) Visits Co-payment

FAMILY SIZE	100% OR BELOW THE FPG	101% - 150% OF THE FPG		151% - 200% OF THE FPG	
	W80	W81		W88	
	MAXIMUM HOUSEHOLD INCOME	MINIMUM HOUSEHOLD INCOME	MAXIMUM HOUSEHOLD INCOME	MINIMUM HOUSEHOLD INCOME	MAXIMUM HOUSEHOLD INCOME
1	\$12,760.00	\$12,760.01	\$19,140.00	\$19,140.01	\$25,520.00
2	\$17,240.00	\$17,240.01	\$25,860.00	\$25,860.01	\$34,480.00
3	\$21,720.00	\$21,720.01	\$32,580.00	\$32,580.01	\$43,440.00
4	\$26,200.00	\$26,200.01	\$39,300.00	\$39,300.01	\$52,400.00
5	\$30,680.00	\$30,680.01	\$46,020.00	\$46,020.01	\$61,360.00
ER	\$10.00	\$25.00		\$25.00	
IN PT	PAID FOR BY TAX DOLLARS	PAID FOR BY TAX DOLLARS		PAID FOR BY TAX DOLLARS	
OUT PT	PAID FOR BY TAX DOLLARS/ APPLICABLE GRANTS	PAID FOR BY TAX DOLLARS/APPLICABLE GRANTS		PAID FOR BY TAX DOLLARS/APPLICABLE GRANTS	

**MAXIMUM
INCOME IS
\$104,800**

*For family size greater than 5 FPG will be calculated during the application process.

Last updated 08/2020