

LABETTE HEALTH FINANCIAL ASSISTANCE POLICY (FAP)

PREAMBLE

Labette Health is committed to providing access to emergency and medically necessary affordable health care services for all of the residents of Labette County and its contiguous counties. Uninsured and underinsured individuals living within this service area are eligible to apply for financial assistance under the provisions described herein.

DEFINITION OF TERMS USED HEREIN

“AMOUNTS GENERALLY BILLED (AGB)” is determined as follows: Multiply gross charges for medically necessary care provided to a FAP-eligible individual by the “AGB percentage.” The AGB percentage is calculated annually as follows: Sum of all claims paid in full (including payments from beneficiaries and insureds) by Medicare fee-for-service and private payers during the prior fiscal year divided by the sum of gross charges for those claims. The AGB percentage for the current fiscal year will be determined no later than 45 days following the close of the prior year’s fiscal period.

“APPLICATION PERIOD” means the period during which Labette Health must accept and process FAP applications. This period shall be from the date of service until 240 days after Labette Health provides the patient with the first billing statement for the care provided. The application period will also serve as the **completion deadline** for receipt of all applications

“EXTRAORDINARY COLLECTION EFFORTS” means the actions that Labette Health will take in the event of non-payment of amounts generally billed not paid following the expiration of time allowed under the notification period. These may include referral to an external collection agency, the reporting of adverse information about the individual to consumer credit reporting agencies or credit bureaus, garnishment of an individual’s wages, and/or commencement of a legal civil action against an individual.

“FINANCIAL ASSISTANCE” means the amount a FAP-eligible patient’s AGB charges will be reduced once he/she is determined to be eligible under the provisions of this policy.

“NOTIFICATION PERIOD” means the period of time during which Labette Health will make every reasonable effort to inform the patient of the availability of financial assistance under this policy. This period shall be from the date of service until 120 days after Labette Health provides the patient with the first billing statement for the care provided.

“PATIENT(S)” shall mean the person for whom Labette Health provides services and/or the person who is legally responsible for payment for such services.

ELIGIBILITY

Financial assistance for all uninsured and under-insured individuals under this policy is based upon the following criteria:

1. The patient's annual household income compared to the most current published "Annual Update of the HHS Poverty Guidelines" that are in effect.
 - a. Labette Health's Amount Generally Billed charges for hospital inpatient and outpatient services shall be reduced by the following percentages in relation to the poverty guidelines. (Appendix A)

HHS Poverty Guidelines	Percentage Adjustment
At or below 150%	100%
Between 151% and 175%	75%
Between 176% and 200%	50%
Between 201% and 250%	25%
Over 251%	0%

- b. Labette Health's Amount Generally Billed charges for employed and/or contracted Physicians Group service shall be reduced by the following percentages in relation to the poverty guidelines. (Appendix A)

HHS Poverty Guidelines	Percentage Adjustment
At or below 150%	100%
Between 151% and 175%	75%
Between 176% and 200%	50%
Between 201% and 250%	25%
Over 251%	0%

2. Hospital only; All patients seeking financial assistance under this policy shall be required to apply for Medicaid in the jurisdiction in which they reside and provide proof of said jurisdiction's Medicaid application determination. A patient shall be exempt from the requirements described in this section if the patient provides an IRS Form 4029 (for religious Exemption from Social Security and Medicare Taxes and Waiver of Benefits) marked approved by the IRS.
3. All patients seeking assistance under this policy shall be required to complete to the fullest extent possible Labette Health's "Application for Financial Assistance" (Appendix B). Individuals needing assistance for completing the Application for Financial Assistance should contact Labette Health's Financial Counselor at 620-820-5252 or by e-mail to financialcounselor@labettehealth.com or in person at 1902 S. U.S. Highway 59, Parsons, KS 67357.
4. Completed applications for financial assistance must be returned during the application period in any of the following ways:
 - a. In person or by mail to Labette Health, ATTN: Financial Counselor, 1902 S. U.S. Highway 59, Parsons, KS 67357;

- b. By FAX to ATTN: Financial Counselor at (620) 820-5485;
 - c. By e-mail to: financialcounselor@labettehealth.com.
- 5. Patients approved for financial assistance under this policy shall be deemed eligible for six (6) months following the date of approval.
 - 6. Patients must reside within the service area described in the “Preamble” of this policy to be eligible for financial assistance under this policy.

METHOD FOR CHARGING FINANCIAL ASSISTANCE ELIGIBLE PATIENTS

Labette Health will determine the “Amounts Generally Billed” (AGB) by using the Internal Revenue Service’s prescribed “look back method” by multiplying full charges for medically necessary care provided to an eligible patient by the sum of all traditional Medicare fee-for-service claims and all private payer claims paid in full (including payments from beneficiaries and insured) during the prior fiscal year divided by the sum of the gross charges for those claims. Verification of the results by using the “look back method” can be obtained by contacting Labette Health’s Chief Financial Officer at (620) 820-5251.

COLLECTION ACTIONS THAT MAY BE TAKEN IN THE EVENT OF NON-PAYMENT OF ELIGIBLE CHARGES

Labette Health will make all reasonable efforts to determine whether the patient is eligible for financial assistance under this policy by:

- 1. Providing the patient a plain language summary of the financial assistance available under this policy at the time of admission and before discharge from Labette Health;
- 2. Providing information during the notification period as to how to obtain an application for financial assistance on at least three (3) billing statements and all other written communications to the patient;
- 3. Informing patients during the notification period about the availability of financial assistance in all oral communications regarding the amount due for the care that occurred;
- 4. Providing the patient with at least one written notice that informs the patient about the extraordinary collection efforts Labette Health may take if the individual does not submit an Application for Financial Assistance (Appendix B) or pay the amount due by the date specified in the notice that is at least thirty (30) days from the date of the notice and is no earlier than the last date of the notification period; and
- 5. Once Labette Health receives an Application for Financial Assistance (Appendix B) from a patient or the notification period has expired, Labette Health will not continue to notify the patient.

Labette Health will not engage in any “Extraordinary Collection Efforts” against a patient until such time as it determines the patient’s eligibility for financial assistance under this policy during the 120-day notification period and has provided the patient with the notice

described in paragraph 4 above. Extraordinary collection efforts that Labette Health may take include:

1. Referral to an external collection agency for the purpose of collecting the amounts due;
2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
3. Garnishment of an individual's wages; and/or
4. Commencement of a legal civil action against the patient.

FINANCIAL ASSISTANCE APPLICATIONS

Incomplete Applications: In the event that Labette Health receives an incomplete Application for Financial Assistance (Appendix B) during the application period, Labette Health will:

1. Suspend any extraordinary collection efforts that may be in effect;
2. Provide the patient with a written notice that describes the additional information required to make a determination of eligibility and a plain language summary of this policy; and
3. Provide the patient with at least one written notice at least 30 days before the completion deadline that informs the patient about the extraordinary collection efforts that Labette Health may initiate or resume if the application is not completed or the agreed payments made by the completion deadline. The completion deadline shall be the later of 30 days from the date of the written notice or the last day of the application period.
4. If after the written notice as provided above, the patient fails to complete the Application for Financial Assistance (Appendix B) by the completion deadline, Labette Health may initiate or resume extraordinary collection efforts.

Complete Applications: Upon receipt of a complete Application for Financial Assistance (Appendix B) during the application period, Labette Health will suspend any extraordinary collection efforts against the patient that may be in effect and make an eligibility determination. The patient shall be notified of the determination and the following:

1. ***If eligible for financial assistance*** under the provision of this policy:
 - a. Provide the patient with a billing statement that indicates the amount the patient owes, if any. If the patient owes a balance in accordance with the Percentage Adjustment schedule described in the "Eligibility" section of this policy, Labette Health will show how they determined the "Amount Generally Billed" (AGB);
 - b. Refund any excess payments made by the individual beyond the Amount Generally Billed, if necessary; and

- c. Take all reasonably available measures to reverse any extraordinary collection efforts that occurred, for example, vacate a judgment, lift any liens, remove any adverse information reported to a credit reporting agency or credit bureau.
- 2. ***If not eligible for financial assistance*** under the provisions of this policy:
 - a. Provide the patient with a billing statement that indicates the amount due Labette Health;
 - b. Provide the patient with a Financial Arrangement Agreement (Appendix C) and instructions, and the deadline to submit the agreement to avoid Labette Health initiating any extraordinary collection efforts; and
 - c. Provide the patient with a written notice of the extraordinary collection efforts Labette Health may take in the event of non-payment of the amount(s) owing.

AUTHORIZATION

The Board of Directors for Labette Health has approved Patient Charges and Payment Accommodations/Financial Aid policy

APPENDIX A

GUIDELINES FOR LABETTE HEALTH FINANCIAL ASSISTANCE

The poverty guidelines that are used are subject to HHS Poverty Guidelines, and are also helpful in determining a hospital and/or Physicians Group charitable service income limits. Poverty Guidelines are published in late January. The YEARLY guidelines for 2025 are:

FEDERAL POVERTY LEVEL ADJUSTED

	100% Write Off Nominal Fee (\$0)	100 % Write Off	100% Write Off	75% Write Off	50% Write Off	25% Write Off
Family Size	Income 100%	Income 125%	Income 150%	Income 175%	Income 200%	Income 250%
1	\$15,650.00	\$19,562.50	\$23,475.00	\$27,387.50	\$31,300.00	\$39,129.00
2	\$21,150.00	\$26,437.50	\$31,725.00	\$37,012.50	\$42,300.00	\$52,875.00
3	\$26,650.00	\$33,312.50	\$39,975.00	\$46,637.50	\$53,300.00	\$66,625.00
4	\$32,150.00	\$40,187.50	\$48,225.00	\$56,262.50	\$64,300.00	\$80,375.00
5	\$37,650.00	\$47,062.50	\$56,475.00	\$65,887.50	\$75,300.00	\$94,125.00
6	\$43,150.00	\$53,937.50	\$64,725.00	\$75,512.50	\$86,300.00	\$107,875.00
7	\$48,650.00	\$60,812.50	\$72,975.00	\$85,137.50	\$97,300.00	\$121,625.00
8	\$54,150.00	\$67,687.50	\$81,225.00	\$94,762.50	\$108,300.00	\$138,375.00
For Each Additional Person Add	\$5,500.00	\$6,875.00	\$8,250.00	\$9,625.00	\$11,000.00	\$13,746.00



Application for Financial Assistance Hospital (Appendix A)

Name	Occupation		
Phone	Family Size		
Street	City	State	Zip
Social Security #			

Please list all household members' names and date of birth

Please list ALL income for ALL household members for the last 3 months

(Wages/Self-Employment, Public Assistance, Social Security/Disability, Pension, Unemployment, Workers Compensation, Child Support, Rental income, Grants/Scholarships, Non-Cash Benefits, or any other)

\$	\$	\$
\$	\$	\$
\$	\$	\$

Please list ALL your creditors and your monthly payments

Rent/Mortgage \$	Church\$	Food/Groceries\$
Electric \$	Gas \$	Water \$
Education \$	Life Insurance \$	Auto Insurance \$
Health Insurance \$	Home Insurance \$	Repairs \$
Transportation Gas \$	Clothing\$	Other\$
Other\$		
Credit Card	Balance\$	Payment \$
Credit Card	Balance\$	Payment \$
Credit Card	Balance\$	Payment \$

I (we) authorize the hospital to make whatever inquiries it deems necessary in evaluation of my credit worthiness, to contact consumer reporting agencies and other persons and to secure consumer reports and other information about me. I (we) authorize and direct any consumer reporting agency or other persons to furnish to the hospital such information about me (us) that it has or obtains.

I certify that the above information is true and accurate to the best of my knowledge. Further, I will direct any assistance (Medicaid, Medicare or other insurance coverage and/or insurance settlements) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pass to the hospital the amount recovered for hospital charges. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of providing financial assistance services, and that I will be liable for charges for services provided.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

Approved _____ Date _____

Please see reverse side of application



APPENDIX B

Application for Financial Assistance Physicians Group

Parsons, Altamont, Chanute, Cherryvale, Chetopa, Erie, Independence, Oswego, St Paul, Pittsburg

Name	Occupation		
Phone	Family Size		
Street	City	State	Zip
Optional Social Security			

Please list all household members' names and date of birth

Please list ALL income for ALL household members for the last 3 months

(Wages/Self-Employment, Public Assistance, Social Security/Disability, Pension, Unemployment, Workers Compensation, Child Support, Rental income, Grants/Scholarships, or any other income)

\$
\$
\$
\$
\$
\$

I (we) authorize the hospital and/or Physicians Group to make whatever inquiries it deems necessary in evaluation of my credit worthiness, to contact consumer reporting agencies and other persons and to secure consumer reports and other information about me. I (we) authorize and direct any consumer reporting agency or other persons to furnish to the hospital and/or Physicians Group such information about me (us) that it has or obtains. I certify that the above information is true and accurate to the best of my knowledge. Further, I will direct any assistance (Medicaid, Medicare or other insurance coverage and /or insurance settlements) which may be available for payment of my hospital and/or Physicians Group charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pass to the hospital and/or Physicians Group the amount recovered for hospital and/or Physicians Group charges. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of providing financial assistance services, and that I will be liable for charges for services provided. If you are eligible for a reduction of your bill, the amount you may owe will be determined by a sliding scale based on the Federal Poverty Guidelines.

Applicant Signature _____ Date _____

Co-Applicant Signature _____ Date _____

Approved _____ Date _____

Financial concerns can interfere with recovery simply because patients don't understand why and how they are charged. Please familiarize yourself with the terms of your insurance coverage to help you understand the hospital and/or Physicians Group billing procedures and charges.

Labette Health provides care to all people regardless of their ability to pay. This application may provide assistance if you have no insurance, or have financial difficulty with an unpaid balance at Labette Health.

For questions about the financial assistance call: (620) 820-5257.

APPLICATION REQUIREMENTS

1. A fully completed and signed Application for Financial Assistance.
2. Copies of all your income for the three months prior to date of this application for all persons living in the household must accompany your completed application.
3. A copy of last year's income tax return to verify all sources of income.
4. Social Security cards can be used to verify family size.
5. Verification that all insurance proceeds have been paid to Labette Health, including settlements.

Ways to return your application: you can mail it, fax it, e-mail or return it in person.

Labette Health

Attn: Financial Counselor

1902 S. US Hwy 59

Parsons, KS 67357

Fax: (620) 820-5485

E-mail: financialcounselor@labettehealth.com

In person: the Business Office (registration area) at Labette Health

Please note only accounts from Labette Health Physicians Group for this current year will be considered for financial assistance. Also, please be aware that payments must be made on your accounts during the application process until you are notified of approval or denial.



APPENDIX C

Financial Arrangement Agreement Hospital and/ or Physicians Group

Please check one of the following:

A. INSURANCE PLAN

1. _____ I have Insurance, but do not have the policy information with me. I understand it is my responsibility to provide this information to the Hospital and/or Physicians Group within 48 hours. I assume any and all financial responsibility for this Hospital and /or Physicians Group visit.

INSURANCE COMPANY _____ POLICY # _____

B. CASH PLAN

I do not have insurance. Please check one of the following

1. _____ I will pay my account in full when leaving the hospital and/or Physicians Group.
2. _____ I would like to pay _____ now and make payment arrangements for the balance
3. _____ I would like to make payment arrangements.
4. _____ I would like assistance with the Application for Financial Assistance.
5. _____ Payroll Deduct (Labette Health employees only)
6. _____ I would like to combine this account with another account that is already set to terms. I understand I will need to increase my monthly payment amount to qualify.

Please Date, Print and Sign below:

Date _____ / _____ / _____

Name of Patient (PRINT)

Account Number

Signature of Patient or person assuming financial responsibility