Principles for Non-Profit Hospital Financial Assistance Applications

While non-profit hospitals are legally obligated to provide financial assistance to eligible patients, the process can often be seen as burdensome and complicated. Hospital facilities may have different financial assistance policies and application requirements. Additionally, not all hospitals assist individuals one-on-one throughout the application process. Many patients turn to community-based organizations to understand the eligibility requirements and application process. Although non-profit hospitals are required to "widely publicize" their financial assistance policies, many community-based organizations have taken the lead in educating community members on their rights.

Unfortunately, many eligible patients do not realize that they may qualify for financial assistance. Uninsured patients and underinsured[1] patients with insurance but high levels of out-of-pocket costs should be offered the opportunity to be screened for health coverage eligibility and financial assistance options. It is also critical that hospitals establish a simple, streamlined application process that reduces administrative burdens on patients.

Methodology

These principles were co-designed with our medical debt partners from more than a dozen organizations across nine states. Community Catalyst's co-design process actively collaborates with advocates from our partner organizations, integrating feedback to ensure the final product meets the needs of the communities they serve. This process leverages the expertise and lived experience of community-based advocates. Co-designing ensures that the people who are affected by a design decision have a say in the development of solutions, leading to outcomes that are more beneficial, efficient and user-friendly.

Principle 1: Simplify documentation requirements

- Prohibit requiring of citizenship documentation.

[1] Underinsured refers to patients with health coverage benefits that don't adequately cover their medical expenses and/or requires high out-of-pocket costs from the patient.

    - Financial assistance should be offered to all eligible patients regardless of immigration status. Many from immigrant families fear that revealing a person's immigration status may result in negative consequences for themselves or their family members[2].
- Prohibit requiring of documentation about assets or other sources of funds not tied to someone's income.
    - Certain assets such as retirement funds, 401(k) plans, savings accounts and primary homes, should not be considered in determining financial eligibility for assistance. Patients should not be expected to liquidate assets to pay for medically necessary care.[3]
- Allow various alternatives to provide household income information, such as allowing patients at their election to document income with one of the following: (1) copies of two most recent pay stubs, (2) bank statements, (3) a letter from their employer, (4) self-attestation of financial situation, (5) if applicable, marketplace determinations of income.
- Allow patients with fluctuating income, such as seasonal workers, to provide information about their yearly income if it is significantly lower than what is reflected in recent paystubs.
    - A copy of their 1040 tax return should be accepted for both seasonal workers and anyone who is self-employed.
- Prohibit requiring that documents be notarized.
- Review patients for all pending or outstanding charges and consolidate to a singular application.
    - No patient should have to submit multiple applications for different bills from the same facility.
- Allow for presumptive eligibility for patients receiving SNAP, TANF, WIC, etc. to streamline the application process.

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[2] Many states require residency within the state for a certain period of time, which differs from immigration status. Patients should be allowed at their election to prove residency through alternative methods such as but not limited to, temporary drivers licenses or state issued identification, utility bills addressed to the individual, or official letters sent to the individual's home address.

[3] Patients should be allowed to self-attest their household income. Hospitals must avoid requiring certain documentation such as multiple pay stubs to document income. Many low-income individuals often hold temporary employment where consistent pay stubs are not possible to provide.

    - Be mindful of the phrasing as you do not want people to infer that public benefit is required for eligibility.
- Develop an automatic redetermination process so that patients do not have to apply each year.

Principle 2: Ensure equitable access to applications and hospital support staff

- Provide interpretation and translation to limited English proficient speakers. Federal regulations require nonprofit hospitals to provide application materials available in languages spoken by the lesser of: (1) 1,000 persons in the community, or (2) 5% of the community. If a patient requests an additional language the hospital does not have readily available, the hospital should make all reasonable efforts to provide translated materials and interpretation services in their preferred language at no cost to the patient.
- Ensure that the appropriate staff are aware of the existence of financial assistance, health coverage options and other benefit programs.
    - There should be regular ongoing training provided to appropriate staff to ensure they have the ability to assist patients throughout the financial assistance application process.
    - For instance, social workers and staff involved in billing and financial assistance should be well versed in these areas. [4]
    - Hospitals should also be equipped to inform patients of their rights to externally appeal insurance claims denials.
- Make financial assistance staff available to patients via phone or email to provide status updates on applications and assist patients with the process.
    - Hospital staff should verbally notify patients about financial assistance in all calls about billing and collection matters in the patient's preferred language.
    - In any attempt to collect debt from a patient, including initial billing statements, the hospital system should include language and information around the system's financial assistance policy in each language commonly spoken in the community.
- Provide the application and financial assistance policy in plain language and written at an 8th grade reading level. It is vital for patients of all education levels to be able to read and understand these documents.

[4] Any staffing that does intake including receptionists or nurses who take copays and insurance information should be included in this group.

    - Information about income limits should be provided in dollar amounts, not FPL%.
    - Applications should also set clear expectations of what type of response to expect and provide a timeframe.
- Proactively contact self-pay patients about financial assistance, proactively screen patients and offer help applying for financial assistance and other benefits.
- Assist patients when requested, free of charge, in completing the application and explain the documents the patient must provide.
- Make paper and electronic copies of the financial assistance application widely available, including:
    - In hospital waiting areas;
    - During the intake and discharge process;
    - Attached to billing statement notifications; and
    - On the hospital's main web page and all web pages where patients can pay bills

Principle 3: Incorporate reasonable timelines

- Accept financial assistance applications at any time during the collection process.
- Do not move forward any collection actions on a hospital bill while a financial assistance application is in process – even those actions that do not rise to the level of extraordinary collection actions (ECAs).
    - Under IRS regulations, a nonprofit hospital must suspend any pending ECAs while a financial assistance application is pending.
    - Patients have up to 240 days to apply for financial assistance from the date of the first billing statement. Hospitals should make reasonable efforts to refrain from initiating ECAs until after the full 240-day application period.
- Allow patients an appeal process if the initial application for assistance is denied or the patient is receiving less than they believe they should be receiving. The hospital should halt collecting payment or collection actions while the appeal process is active.
- Allow patients a minimum of 60 days to submit all additional information needed to complete the application if it is submitted without all necessary components. Hospitals should clearly provide instructions on any additional information or documentation needed from the patient.
- Provide early notification of denials that includes a detailed rationale for the denial, and inform the patient about the appeals process.

    - If the application is simply incomplete, not denied on merit circumstances, that should be clearly stated in plain language for the patient with clear instructions on how to complete their application.
- Include language and information around the system's financial assistance policy translated in each language commonly spoken in the community in any attempt to collect debt from a patient, including initial billing statements.

Principle 4: Implement a regular review process

- Consult the community in the development of the hospital's policy and adapt to stated needs of the community.[5]
- Conduct review on a regular basis (defined as at least as often as the Community Health Needs Assessment) of all financial assistance policies, applications, and rates of charity care. Hospitals should ensure the application materials are consistent and updated to align with current financial assistance policies.
    - Hospitals should provide public reporting to disclose the following: (1) number of applications/approvals for financial assistance, (2) number of denials/appeals for financial assistance with associated reasoning, and (3) demographics of patients applying for/receiving/being denied financial assistance.
- Provide a clear way for patients and community stakeholder groups to submit feedback around the accessibility of the financial assistance application and process. This feedback should be carefully reviewed and used to regularly improve the application process.
- Regularly assess the language needs of the community to ensure financial assistance materials are translated into appropriate languages. Hospitals should secure access to interpretation services and translated materials when needed at no cost to the patient.

[5] "The community" included should include community-based organizations, trusted community partners, members of the community living in the catchment area of the hospital, patients of the hospital, and any other person or organization that has members living around or going to that facility.

Sample Hospital Financial Assistance Application

Last Updated: Insert Date

Name: _____

Address: _____

_____

Phone: _____

Race/Ethnicity (optional): _____

Family size / number in household dependents: _____

Date: _____

Do you have insurance (please circle): YES NO

If so, please list: _____

	Monthly	Annual	Documented	Self-Declared
1. Gross Employment Wages			☐	☐
2. Social Security Income (SSI)			☐	☐
3. Unemployment Income			☐	☐
4. Social Security Disability Income (SSDI)			☐	☐
5. Short-Term Disability (STD)			☐	☐
6. Workers' compensation			☐	☐
7. Additional income sources a. Self-employment b. Tips/bonuses/commissions c. Pension payments d. Payments from retirement accounts e. Lottery winnings disbursements f. Payments from trust funds.			☐	☐
Total (lines 1-7)				

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signed: _____ Date: _____

If you have questions or need help completing this application, call [PERSON OR DEPARTMENT] at [DIRECT NUMBER]. You **do not** have to make any payment to the hospital until the hospital sends you a letter with its decision on your application. Applications must be received within 240 days from the date of receiving the first post-discharge bill.

If you have received a bill or bills from the hospital, check here: _____
Please submit completed form to: [insert mailing/email address/website portal/fax number]

To provide feedback to our facility regarding our financial assistance application, please submit comments to __Insert Staff Member____ via email to ___Insert email address_____ or mailing to __Insert Mailing Address_____.

For Office Use Only

Received via: Email ____ In-Person ____ Fax _____

Date Received: _____

Facility Name: _____ Staff Member: _____

Know your rights to non-profit hospital financial assistance

Federal Regulations [IRC §501(r)(4-6)] require non-profit hospital facilities to make "reasonable efforts" to determine financial assistance eligibility before engaging in Extraordinary Collections Activities (ECAs).

ECAs are actions taken by a hospital facility against an individual related to collecting payment for a bill. For example, this may include placing a lien on your property, garnishing your employment checks, causing your arrest or suing you for nonpayment.

- Hospitals **must first notify** you in writing of their financial assistance policy before initiating any ECAs to obtain payment for your care. Hospitals also **must notify** you at least 30 days before initiating ECAs to obtain payment for the care.
- ECAs must not be initiated for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care.

Hospitals are required to follow a **120-day "notification period"** and a **240-day "application period**," both beginning on the date the first "post-discharge" billing statement is provided.

- Hospitals **must inform you about their financial assistance policy within 120 days** after you receive your first bill upon release from hospital care. You will have 240 days from receiving your first bill to apply for financial assistance.
    - If you submit an incomplete application during the 240-day application period, the hospital facility must notify you about how to complete your application and give you a reasonable opportunity to do so.
    - If you submit a completed application during the 240-day application period, the hospital facility must determine if you are eligible for financial assistance.
- A hospital facility may continue to accept and process financial assistance applications from patients **at any time**.

The 2024* federal poverty level (FPL) income numbers below are used to calculate eligibility for hospital financial assistance and state indigent care programs.

	2024 Federal Poverty Level for the 48 Contiguous States (Annual Income)						
Household/Family Size	**100%**	**133%**	**138%**	**150%**	**200%**	**300%**	**400%**
1	$15,060	$20,030	$20,783	$22,590	$30,120	$45,180	$60,240
2	$20,440	$27,185	$28,207	$30,660	$40,880	$61,320	$81,760

3	$25,820	$34,341	$35,632	$38,730	$51,640	$77,460	$103,280
4	$31,200	$41,496	$43,056	$46,800	$62,400	$93,600	$124,800
5	$36,580	$48,651	$50,480	$54,870	$73,160	$109,740	$146,320
6	$41,960	$55,807	$57,905	$62,940	$83,920	$125,880	$167,840
7	$47,340	$62,962	$65,329	$71,010	$94,680	$142,020	$189,360
8	$52,720	$70,118	$72,754	$79,080	$105,440	$158,160	$210,880
Add $5,380 for each person in household over 8 persons							

*Note: FPL chart above is effective as of January 12, 2024. FPL is subject to change on an annual basis.

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