Circles of Care, Inc.
Financial Assistance Policy

I. Table of Contents

II. Purpose

This Financial Assistance Policy will define when financial assistance will be provided. The policy applies to all emergency and other medically necessary care provided by the hospital facility, including care provided by substantially related entities. Emergency care is provided without discrimination and regardless of an individual ability to pay. It is the policy of Circles of Care, Inc. to provide a Financial Assessment to any patient or person responsible for the patient's care seeking financial assistance/charity.

Circles of Care, Inc. Financial Assistance
The patient or responsible party must not be able to pay for the patient's medically necessary care. The ability to pay is determined by using the Federal Poverty Guidelines (FPG). Refer to Appendix 3 for the current FPG.

The federal government updates these guidelines annually. The ability to pay is also determined by examining assets and awaiting litigation results for pending third party liability claims.

When asked, Circles of Care, Inc. (COC) will determine if the patient or responsible party has the ability to pay. This evaluation, or screening, for financial assistance is free of charge. Financial assistance will not be given for medical care unless it is medically necessary. Financial assistance includes free and discounted care.

The rest of this Financial Assistance Policy provides more information about how a patient or person responsible for a patient may ask for financial assistance. It describes when a patient will be considered eligible to receive financial assistance. Additionally, it defines the amount of financial assistance provided when meeting the requirements of this policy.

III. Definitions

Amounts Generally Billed (AGB):
Amounts Generally Billed is used to determine the financial assistance co-pay amounts. COC will conduct a look back analysis annually which will include all past claims that have been paid in a twelve-month period. This includes Medicare, Medicaid, Commercial, managed care plans and patient payments. The AGB is calculated by dividing the sum of the payments by the total charges billed. That percentage is then multiplied by the total charges for each patient encounter to arrive at the AGB per encounter. The AGB per encounter is then used with the sliding fee scale (see Appendices 2 & 3) to create a payment amount that will always be lower than the actual AGB. For instructions or additional detailed information, refer to Appendices 2 & 3.

Federal Poverty Guidelines (FPG):
A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on marketplace health insurance, and Medicaid and CHIP coverage.

Circles of Care Financial Assistance:
Financial assistance provided to patients who meet the charity care specific guidelines. It is provided to patients after emergency or medically necessary services have been rendered.

Medicaid:
A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.

IV. Procedure

A. General Eligibility Criteria and Method for Applying for Assistance:

General Eligibility Criteria

Patient's eligibility criteria are determined by:

1. County residency and citizenship/immigration status
2. Patient's family unit size
3. Family unit gross income in relation to current Federal Poverty Guidelines.
4. Documentation that may be required for determining income (e.g., W-2, Form 1040, pay stub, SNAP card, etc)

A determination will be issued using a sliding fee scale. The patient is responsible for applicable fees/co-payments per encounter.

COC will gather information about a patient's or other responsible party's income. The result will determine their eligibility for financial assistance, the amount of the discount they will receive and the amount they will be required to pay. COC will provide financial assistance counseling upon request, without additional charge, before or after the patient receives services.

Method for Applying for Assistance

Patients must complete the application process prior to evaluation for Financial Assistance. For a copy of the application, see the website, https://www.circlesofcare.org. To get a hardcopy call 321-722-5200 ext. 5904, or 5905.

Completed applications should be mailed to: Business Office, 400 Sheridan Road, Melbourne FL 32901 or faxed to 321-953-7572.

B. Additional Information

Eligibility may be retroactively applied to the COC open balance patient account for 240 days prior to the initial COC assignment date. Eligibility beyond 240-day retroactive period must be approved by an Administrator, Vice-President or designee.

COC will provide a written statement to patients or responsible parties when they qualify for Financial Assistance.

A patient or responsible party may request financial assistance for any incurred debt up to 240 days following the first post-discharge billing statement. This includes account balances after insurance payment. The criteria below are used when COC considers the request. The patient or responsible party may qualify for 100% discount if the following applies:

1. The patient or responsible party has a total household income of less than or equal to 200% of the FPG (Per the most current published Federal Poverty Guidelines); or
2. The patient or responsible party has a catastrophic balance due which exceeds 25% of their annual household income. (Ref. Appendix #3)
3. Eligible patients will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care.

C. List of Providers and Non-Providers:

This Financial Assistance Policy only applies to services provided by COC at its facilities and services provided by COC employed physicians. Please see Appendix 4 - List of Providers Covered by the Financial Assistance Policy.

D. Amount Generally Billed-Limitation of Charges

Financial Assistance Plan eligible patients will not be charged more than amounts generally billed (AGB) for emergency or other medically necessary care.

Amounts Generally Billed

Circles of Care (COC) provides financial assistance and charity care to patients meeting the eligibility criteria outlined above. After the patient's account(s) is reduced by the financial assistance adjustment, the patient/guarantor is responsible for the remainder of their outstanding liability which shall be no more than the amounts generally billed.

Circles of Care determines AGB by utilizing the "look-back" method. The AGB percentage is calculated by using claims allowed by Medicare and all other insurers for hospital services with a discharge date from the previous fiscal year (July – June). For these claims, the sum of all allowable reimbursement amounts is divided by the associated gross charges. The AGB percentage is applicable as of July 1st of each year.

The AGB percentage will be applied in the case of emergency or medically necessary care for individuals who are eligible for financial. The percentage will be applied to gross charges for such care to determine the maximum amount an individual is personally responsible for paying with respect to such care. The additional discount from the Federal Poverty Guidelines will be applied to charges already discounted by the AGB discount.

The AGB percentage is applicable as of July 1st of each year. Please refer to Appendix 2 for the current percentage of AGB.

1. **Patient Resources:**
   The following resources are provided to assist the patient in understanding the documentation necessary for the financial assessment and requirements of other potential funding sources:

a. The patient's financial assessment letter will summarize the required documents. In special situations, additional documents may be required.
b. The brochure "Financial Assistance for Medical Care" is available in all registration and intake services areas for the patient's review. The brochure is also available online at: https://www.circlesofcare.org.
c. Applicable copays have been established by financial classification, as indicated in Circles of Care Fee Schedule. The fee schedule is also available online at: https://www.circlesofcare.org.
d. All patient forms used in Financial Assessment are available online at https://www.circlesofcare.org.

2. Re-evaluations

a. If the patient's income, insurance, or family size significantly changes within the annual rating period, for a continuous four-week period or more, it is the patient's responsibility to notify the Circles of Care Financial Assessment Department by scheduling a re-evaluation appointment.
b. Patients may request a re-evaluation due to any status change(s) below:
   i. Family gross income
   ii. Change in the number of dependents
   iii. Residency status
c. The new classification will be applied to future encounters only. Therefore, bills incurred after the initial benefit was determined, but prior to the new benefit, shall be discounted based on the patient's initial classification.
d. All information and the individuals involved in the assessment process will neither be reported nor referred to USCIS or any law enforcement or customs agency.

3. Appeals

Patients have the right to appeal their assessment within sixty (60) calendar days of receiving their financial assessment rate. The Appeals Form is available at https://www.circlesofcare.org.

4. Renewals

Patients may apply for renewal of a financial assessment status by calling Patient Accounts at 321-722-5200 x5903. Documents provided for renewals must be current. A new application and applicable forms must be completed and signed upon benefit renewal.

5. Presumptive FAP Eligibility:

COC may use an abbreviated financial assistance approval process for patients or responsible parties on accounts that meet the following criteria:

a. Patients, who are eligible for FPL-qualified programs such as Medicaid, and other government-sponsored low-income assistance programs, are deemed to be indigent. Therefore, such patients are eligible for charity care when payment for services is not made by the programs. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off.

Specifically included as eligible are charges related to the following:

Exhausted benefits

b. The patient is deceased and no estate has been filed with the court of the patient's county of residence, after one year from the date of death.
c. Patients that have been approved for Victims of Crime program coverage.

6. **EMCP (Emergency Medical Care Policy):**
   Circles of Care's policy is to provide emergency care and stabilization to all patients regardless of their ability to pay. If upon examination, it is determined that emergency care is not medically necessary, then we will refer to appropriate non-emergent resources.

7. **Collection Efforts**
   Circles of Care does not use extraordinary collection efforts. COC does not report to credit bureaus or use any outside collection agencies for its collection of bad debts. COC maintains a separate Billing and Collection Policy that is available upon request. Please contact our Business Office at (321) 722-5200 to make a request. It can also be obtained on our website at https://www.circlesofcare.org. Asistencia en idioma español está disponible en 321-722-5200.

V. Appendices

Appendix 1, Plain Language Summary of Financial Assistance Policy
Appendix 2, Patient Discount Matrix
Appendix 3, Fee Discount Guidelines
Appendix 4, List of Providers covered by the Financial Assistance Policy

Reviewing Committee(s): Not Applicable
Authorization: Vice President of Business & Finance
FAP Adoption Date by Board of Directors: September 17, 2018

APPENDIX 1.

Plain Language Summary of Financial Assistance Policy (FAP)

1. As part of its mission, Circles of Care provides financial assistance for emergency and other medically necessary care to patients who lack the ability to pay for hospital services. The purpose of this policy summary is to establish a plain language guide pertaining to the evaluation and acceptance of applicants for financial assistance.

2. Determination of the ability to pay may take into account a number of financial variables, including but not limited to:

A. The earning status and potential of the patient and family
B. Other sources of income and assets, available funds
C. The family size
D. Alternate means of assistance available, such as Medicaid

3. A printed free copy, including Spanish translation, of the FAP, Plain Language Summary, and application can be obtained on our website at https://www.circlesofcare.org. Printed copies may also be obtained at 400 E. Sheridan Road, Melbourne FL, 32901 or by calling 321-722-5200 and requesting it be mailed. Spanish language assistance is available at 321-722-5200.

4. Circles of Care will charge a person for emergency or other medically necessary care who qualifies under the FAP less than the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.

5. Financial assistance discounts will be available for only emergency or other medically necessary healthcare services provided to persons who meet the financial and documentation criteria defined in the FAP policy. This definition also includes any established client receiving services in a federal government, State of Florida, Central Florida Cares Health System, or Brevard County funded program of Circles of Care, Inc.

6. Patients who are uninsured or underinsured and have a household income at or below 200% of Federal Poverty Guidelines (FPG) may receive free care (a 100% discount.). Individuals with annual household incomes between 201% and 400% FPG will be eligible for up to a 75% discount off of normal charges, based on a sliding fee scale as illustrated by Appendix 3 in the FAP. This schedule shall be updated annually to the current published Federal Poverty Guidelines. For those that qualify, the discount will be applied to our Accounts Generally Billed fee schedule.

7. For information regarding our Financial Assistance Policy, Financial Assistance Application Form, Billing and Collections, or for assistance with the application process, please contact Patient Accounts at (321) 722-5200 x5903. Asistencia en idioma español está disponible en 321-722-5200.

8. Financial assistance will be considered at any point in the billing cycle, up to 240 days from the 1st billed date, post discharge date or date of service.

Copies of our Financial Assistance Policy, Application Form, and this Summary are available in English and Spanish. Copias de nuestra póliza de Asistencia Financiera, formulario de solicitud, y este resumen están disponibles en Inglés y Español.
Return your completed application to: Circles of Care Patient Financial Services, 400 E. Sheridan Road, Melbourne, FL, 32901

APPENDIX 2

PATIENT DISCOUNT MATRIX

The AGB percentage is applicable as of July 1st of each year.

The current AGB is 45%. The AGB discount will be calculated and adjusted annually. (See **AGB Calculation** below). Gross charges are discounted by 55% and then an additional discount will be applied from the Federal Poverty Level matrix (See appendix 3).

Example: Family of 4 with household income of $60,000. Gross Service Charges of $ 3840. $3840 * 45% (AGB discount of 55%) = $1728. From the Federal Poverty matrix, Appendix 3, the additional discount is 75% and is applied to $1728 = $432 total balance due for services rendered.

Patient Discount Matrix

	Family Income as % of Federal Poverty Level	**Discount for Medically Necessary Services or Emergency Care**
Uninsured Patient	<400%	55%
Underinsured Patient	<400%	55%
Balance after Insurance Payment	<400% FPL	Any patient liability after insurance payment, except non-covered charges
Charity Care	<200% FPL	100%
ALL	>400% FPL	No Discount

*Note: Charity Cases are reviewed on a case by case basis. Patient must meet Charity Care guidelines and Family Income as a percentage of FPL to qualify for Charity Care.

AGB Calculation for the fiscal year 7/1/2018 through 6/30/2019.

*Total Hospital Receipts: $6,687,000

*Total Hospital Gross Charges: $14,500,000

AGB percentage: 46% - Rounded down to 45%

Discount for Medically Necessary Services or Emergency Care: 55%

* $ Amounts from the Fiscal Year: 7/1/2017 through 6/30/2018

APPENDIX 3

Fee Discount Guidelines

2018 - Published Federal Poverty Guidelines									
		200% or Less:		**201%-250%**		**251%-300%**		**301%-400%**	
		Min. Gross Income Level	**Max. Gross Income Level**	**Min. Gross Income Level**	**Max. Gross Income Level**	**Min. Gross Income Level**	**Max. Gross Income Level**	**Min. Gross Income Level**	**Max. Gross Income Level**
Family Size	**FPG Base***	**100% Discount**		**75% Discount**		**50% Discount**		**25% Discount**	
1	$12,140	$0	$24,280	$24,281	$30,350	$30,351	$36,420	$36,421	$48,560
2	$16,460	$0	$32,920	$32,921	$41,150	$41,151	$49,380	$49,381	$65,840
3	$20,780	$0	$41,560	$41,561	$51,950	$51,951	$62,340	$62,341	$83,120
4	$25,100	$0	$50,200	$50,201	$62,750	$62,751	$75,300	$75,301	$100,400
5	$29,420	$0	$58,840	$58,841	$73,550	$73,551	$88,260	$88,261	$117,680
6	$33,740	$0	$67,480	$67,481	$84,350	$84,351	$101,220	$101,221	$134,960
7	$38,060	$0	$76,120	$76,121	$95,150	$95,151	$114,180	$114,181	$152,240
8	$42,380	$0	$84,760	$84,761	$105,950	$105,951	$127,140	$127,141	$169,520

**If there are more than eight individuals in the family, $4,320 should be added to the FPG base* per each additional individual.*
***Notwithstanding these percentage discounts, any applicant who qualifies for financial assistance under this policy will not be required to pay more than AGB for emergency or medically necessary care provided by Circles of Care.*

APPENDIX 4

Circles of Care Hospital

List of Providers Covered by the Financial Assistance Policy

July 1, 2018

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F), this list specifies which providers of emergency and medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). Elective procedures and other care that is not emergency care or otherwise medically necessary are not covered by the FAP for any providers.

PHYSICIANS COVERED BY THE FAP	PHYSICIANS NOT COVERED BY THE FAP
Circles of Care Medical Staff	Daniel Stump, MD
Caroline Griffin, ARNP	Gary Mosher, MD
Cynthia Luke, ARNP	Parwati Maddali, MD
John Magri, MD	Vineet Mehta, MD
Mari Aldeghi, ARNP	
Marilyn Moss, MD	
Sangita Sahay, MD	