West Michigan Cancer Center
Radiation & Surgical Specialties

WMCC Financial Assistance Policy

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Consistent with the mission of West Michigan Cancer Center ("WMCC"), it is the policy of the center to care for sick persons who are partially or fully indigent. Staff will show respect and sensitivity to patients and families qualifying under the Financial Assistance Policy, as this service is an application of our mission and values. Decisions regarding care to be given are made independent of financial circumstances. A patient's eligibility under the Financial Assistance Policy is confidential and knowledge thereof shall be limited only to those staff members who need to know.

The Financial Assistance Policy program exists to serve our patients with equitable and appropriate financial evaluation of their charity status, following an assessment of third-party funding, patient funding or grants. The Financial Assistance Policy applies to all medically necessary care but excludes Retail Pharmacy. (*Refer to policy #670 Discount Drug – Co-Pay Assistance.)*

Patient accounts shall be reviewed and administered as appropriate according to the guidelines stipulated in this Financial Assistance Policy (FAP). While it shall be standard practice to administer patient accounts as outlined below, it is recognized that due to various circumstances particular to individual patient situations there may be times when the usual, standard procedures are not appropriate; in such instances discretion shall be used to determine the appropriate account management method under the circumstances, and documentation to support the decision made shall be placed in the patient's financial file / or indicated by an electronic note made within the patient's health record.

Eligibility

WMCC shall allow any patient seeking financial assistance to complete an application under the Financial Assistance Policy within four (4) months (120 days) of receipt of care. Any application under the Financial Assistance Policy after four (4) months from receipt of care shall be accepted at WMCC's sole discretion. Any oral or written communication from WMCC to the patient regarding the patient's bills during this time shall also reference the existence of the Financial Assistance Policy.

Patients are eligible to receive financial assistance after insurance payment(s) on balances (such as deductible, copays and coinsurance) if they meet the eligibility requirements as described in this policy.

WMCC will publicize the Financial Assistance Application form (FAAF) (Attachment A) in the communities served by WMCC through publishing the FAAF on its website, as well as prominently displaying the existence of the FAAF at various locations in its facility directing potential recipients where a physical copy of the FAAF may be found and communicating the FAAF existence and general provisions to various charitable organizations in the communities served by WMCC. Furthermore, WMCC's website and physical notices at its facility will have a phone number for WMCC staff who can provide individuals with information about the FAAF and application process.

This policy will address the following:

- Eligibility criteria in order to be considered for financial assistance
- Methods for applying for financial assistance
- Limitations on patient financial responsibility for those eligible for financial assistance
- Billing and collection practices in the case of non-payment
- Efforts to widely publicize the financial assistance policy

PROCEDURE

1. To be eligible for the WMCC financial assistance program, a patient must satisfy the following:
   a) A patient must complete in its entirety the FAAF
      - In the case of an incomplete application, the patient shall be notified detailing additional information necessary to consider the application complete. The patient shall be allowed 10 business days (if notice provided via mail, from post-marked date; if notice provided in person or electronically, from the date notice provided) to return the requested information or the application shall be considered incomplete and a denial can be issued. If the patient needs additional clarification or assistance with understanding what is expected to them, contact must be made within this timeframe in order for an extension to be considered.

   b) A patient must supply all requested income verification documents.
      - Recent copy of pay stub(s) displaying four (4) weeks of income and full year-to-date (YTD) income, or signed verification letter from employer on company letterhead showing YTD.
      - Self-Employed, prior years personal tax returns and tax return for the individual business including all schedules.
      - If unemployed, all year-to-date unemployment check stubs or a print-out from the state website showing year-to-date income, or verification of denial showing ineligibility for unemployment benefits.
      - If receiving Social Security benefits, provide a copy of the letter showing monthly benefit or three (3) months of bank statements showing direct deposit.
      - Documentation of other income (child support, pension, VA benefits, rental or educational income, worker's compensation, etc).

   c) A patient must exhaust all available insurances before applying. Including applying for Medicaid.
      - A Medicaid denial letter will be included with the application

   d) A patient must fall within the eligibility guidelines as defined in the Financial Assistance & Charity Screening Monthly Income Scale.

Financial Assistance Eligibility Scale

Family Income as a Percentage of FPL	Discount Percentage
Up to 200%	100%
Up to 250%	90%
Up to 300%	80%
Up to 350%	70%
Up to 400%	60%
Up to 450%	50%

2021 Federal Poverty
Level (FPL) Guidelines Reference

Family Size	Yearly Income
1	$12,880
2	$17,420
3	$21,960
4	$26,500
5	$31,040
6	$35,580
7	$40,120
8	$44,660

e) Until all application information is completed and received and a patient has been deemed to be eligible for Financial Assistance, an account will be considered as a self-pay account and the patient will be responsible for the full balance of the account.
f) WMCC financial assistance determination will be valid for medically necessary services for six (6) months from the date of the signed application. Adjustments on prior service dates will be considered if determined to be medically necessary and account is not already placed with an agency.
g) Catastrophic circumstances may be considered by request if both of the following situations are met: 1.) The patient applies and already qualifies for financial assistance with the current FPL discount scale with less than a 100% discount and 2.) A single admission results in at least $15,000 in patient responsibility. If both conditions are met, the account would be reviewed for a 100% adjustment.

Determination of qualifying for financial assistance is subject to change if it is discovered that information was withheld or circumstances change at any time within the eligibility period. If information provided as part of the eligibility determination is later determined to be inaccurate, WMCC shall have the right to hold the patient accountable to provide payment for services received. Failure to comply the requested information or return necessary documentation can result in ineligibility for financial assistance.

Exclusions

The following scenarios or services will be excluded from consideration for financial assistance eligibility:

a) Patients who have another available coverage option, such as Medicaid and do not take the necessary steps to secure coverage.
b) Patient with insurance who failed to follow the insurance company's rules for pre-certification, coordination of benefits (COB).
c) The patient and or family shows evidence of at least $100,000 in checking and/or savings.
d) Retail Pharmacy
e) Charges as a result of collection agency referral such as court costs, filing fees, interest, and/or attorney fees.

Limitations on Patient Financial Responsibly
In accordance with Section 501 (r) (5) of the Code, in no case shall an FAP-eligible individual be responsible for more than amounts generally billed (AGB) for emergency and other medically necessary care. The AGB for the purposes of this policy was determined using the look-back method. The AGB for WMCC shall be re-calculated on at least an annual basis and any updates shall be reflected in the policy.

Additionally, in accordance with Michigan Law (Public Act 107), for uninsured patients with family income up to 250% of the federal poverty level, the maximum payment required is 115% of the Medicare rate for such services.

Billing and Collections
In the event of non-payment after proper notification of the availability of financial assistance, actions may be taken to collect on balances owed. Reasonable efforts shall be made to determine eligibility and provide notification of available financial assistance in accordance with 501(r) regulations prior to collection agency placement or extraordinary collection action (ECA) initiation. ECAs may include reporting to credit agencies, and judicial or legal actions such as liens or garnishments. At least three (3) statements, delivered by mail or electronically will be issued to the responsible party if there is an outstanding balance before consideration for collection agency referral.

Prior to initiation of any ECA's at least one (1) statement will include notice of collection agency referral and potential ECAs. Such statement will be provided at least 30 days before the initiation of any ECA, and the WMCC Plain Language Summary will accompany this notification. It is expected that the patient's address and phone number provided to WMCC is valid; if notice is provided to the address on file, reasonable efforts to provide notification in accordance with Section 501(r) (5) of the Code will have been met. Credit reporting may take place as soon as 90 days from collection agency list date (at least 210 days from first billing statement for services received), and additional judicial or legal actions as soon as 120 days from collection agency list date.

WMCC staff and management are responsible for ensuring reasonable efforts have been met on applicable accounts prior to any ECA initiation. WMCC and their external collection agencies shall be authorized to report unpaid accounts to credit agencies, and to file litigation, garnishment, obtain judgment liens and execute upon such judgment liens using lawful means of collection. WMCC and authorized external collection agencies may also take other actions, including, but not limited to, telephone calls, emails, texts, mailing notices, and skip tracing to obtain payment for medical services provided.

Patients not eligible for financial assistance will have an option of prompt pay discounts.

a) Self-pay patients
    a. Applicable to entire account balance with a 30% reduction; paid within the 30 days of first statement.
b) Blue Cross patients without Office Visit Coverage
    a. Per Blue Cross Provider Consultant once a claim is processed and an office visit evaluation and management code (E&M code) is denied for non-coverage, the charge is considered self-pay status. WMCC may offer a prompt pay discount of 30% without violation of the signed participation agreement between the practice and Blue Cross. This situation is applicable to Blue Cross plans without office visit coverage only.
c) Other Insurances with Limited Coverage

   a. Patients with limited insurance coverage may also be granted the prompt pay discount of 30%. Limited insurances are policies that do not cover Chemo, Radiation, Surgery or office visits. Explanation of benefits (EOB) denial must be included with request showing non-covered services.

d) Settlement requests
   a. Patients must submit in writing their request for settlement to the Billing Manager. The WMCC Financial Director, Executive Director and Billing Manager will review. A discount not greater than 20% will be considered.

Presumptive Eligibility

Presumptive methods may be used in some instances to determine financial assistance eligibility. Methods may include previously submitted application data, external publicly available data sources that provide information on patient's ability to pay (such as credit scoring), or other program enrollment resources if patient lacks documentation that supports eligibility. For example, eligibility may be determined presumptively for homeless patients, those who already receive assistance in a state or federally-funded program, those residing at an address that indicates subsidized housing, or for deceased patients with no known estate. In the case that presumptive eligibility is used and results in less than 100% discount, patients shall be made aware of more generous discounts that are available.

Attachment A

200 North Park Street
Kalamazoo, MI 49007-3731
Phone: 269.382.2500 / Fax: 269.84.8628
www.wmcc.org

West Michigan Cancer Center
& INSTITUTE FOR BLOOD DISORDERS
A Borgess Bronson Collaboration

FINANCE DEPARTMENT

FINANCIAL ASSISTANCE APPLICATION FORM

Date: ___________________________________

Dear Applicant,

Thank you for your interest in the West Michigan Cancer Center and Institute for Blood Disorders financial assistance program. Enclosed is the applications for Financial Assistance. The following information is a checklist of verification items needed from you. If you are married, be sure to also include verifications for your spouse.

You (and your spouse, if applicable) will also need to include:

- Recent copy of pay stub(s) displaying four (4) weeks of income and full year-to-date (YTD) income or signed verification letter from employer on company letterhead showing this information.
- If self-employed, prior year's personal tax return(s) and tax return for the individual's business included all schedules.
- If unemployed, all year-to-date unemployment check stubs or a print-out from the state website showing year-to-date income, or verification of denial showing ineligibility for unemployment benefits.
- If receiving Social Security benefits, provide a copy of the letter showing the monthly benefit or three (3) months of bank statements showing direct deposit.
- Documentation of other income (child support, pension, VA benefits, rental or educational income, worker's compensation, etc).
- Medical Denial Letter from Department of Human Services.

The West Michigan Cancer Center and Institute for Blood Disorders reserves the right to request additional documentation from you before making a final financial assistance evaluation. This could include, but is not limited to a Medicaid Denial Letter, bank statements, proof of assets, driver's license or State ID and disclosure of claims and/or income from personal injury and/or accident related claims.

For details or assistance, please contact the Patient Financial Counseling Department at 269-382-2500 Monday – Friday, 8:00am to 5:00 pm.

Thank you,

WMCC Billing

FINANCIAL ASSISTANCE APPLICATION FORM

To be considered for financial assistance, please complete all pages of the enclosed application and include requested proof of income documents that apply to you and your spouse (if applicable), listed in the income section. All lines must be completed. If after you submit the application the West Michigan Cancer Center and Institute for Blood Disorders determines more information is needed, you will receive a letter with the details describing what is needed. The program covers emergent and medically necessary services provided by the West Michigan Cancer Center and Institute for Blood Disorders. The program will not cover medical bills you may have with other providers; please contact them directly to see what financial assistance programs they may have to offer.

Section One: Patient Information
Please complete all of the below information regarding demographics and insurance information. All lines must be completed.

Account Number: ______________________ Date(s) of Service: ______________________

Name: ____
Last Name First Name Middle Name

Address: ______________________ City: ______________ County: ____________
Number and Street

State Of Residence: __________ Zip Code: __________ Social Security Number: ___/___/____ Date of Birth: ___/___/____

Marital Status: Single ☐ Married ☐ Divorced ☐ Home Phone: (____) ______________________

Are you a legal resident of the United States? Yes ☐ No ☐ Other Phone: (____)______________________

Name of Employer: ______________________ Patient ☐ Spouse ☐ Other ☐

Name of Employer: ______________________ Patient ☐ Spouse ☐ Other ☐

Did you have health insurance (other than Medicaid) at the time of your service? If yes, please provide your insurance information and a copy of your insurance card. Yes ☐ No ☐

Name of Insurance: ______________________Effective date of insurance: ____/_____/______

Subscriber Name: ______________ Subscriber ID: ______________Group Number: ____________

Section Two: Household
Please provide the below information for all immediate family members who live in your home.
-For these purposes family includes the patient's spouse, patient's children under 18 (natural or adoptive) who live in the home.
-if the child(ren) are over the age of 18 and claimed on your current year taxes, child(ren) can be listed. Taxes must be included to show proof.

Family Member Name(s)	Date of Birth	Relationship to Patient

Section Three: Income
Provide any below proof of income that applies for yourself, your spouse and all other family members

Income Source	Current Monthly Gross Income – Patient	Current Monthly Gross Income – Spouse/Other	Total Monthly Family Income	Proof of income (for below applicable sources)
Wages				Recent pay stub(s) showing at least 4 weeks' income and pay stub(s) showing full year to date income, or signed income verification letter from employer(s) documenting this information
Self-employment				Copy of last year's personal and business tax return including all schedules.
Child Support or Alimony				Copy of current court documentation, printed confirmation from Friend of Court, or check copies/bank statement documenting year to date income.
Social Security/Pensions				Copy of benefit award letter, or 3 months of bank statements showing monthly deposit
Dividends Interest, Rental Income				Dividend/Interest Statement, rental income statement or copy of last year's tax return showing dividend, interest or rental income
Unemployment, Worker's Comp				Year to date unemployment benefits documented with full years' pay stub(s) or a print out from the state website showing year to date income or denial letter showing ineligibility, Worker's Comp benefit letter showing year to date income
Veterans Benefits				Veterans benefits Letter
Other Income				Bank Statement or documentation showing any other income (education-based income, misc, income, etc)
Total				

If no income, please briefly describe how basic living needs are being met and who is providing the support.

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Section Four: Assets
Please list all assets that apply for yourself, your spouse and all other family members.

Asset Type	Current Balance for Patient	Current Balance for Spouse/Other
Bank Account – Savings	$	$
Bank Account - Checking	$	$
Stocks, Bonds, Funds	$	$
HAS/FSA Account	$	$
TOTAL	$	$

Section Five: Attestation
Please read the below section carefully and sign and date in the designated areas.

I understand the information I submit to the West Michigan Cancer Center and Institute for Blood Disorders will be verified. I give permission to the West Michigan Cancer Center and Institute for Blood Disorders to access my credit report if needed. I also understand that the West Michigan Cancer Center and Institute for Blood Disorders may ask for more information, for example proof of assets, bank statements, or a Medicaid denial letter if it is needed to decide eligibility. The application may be denied if I do not provide the requested documents. I will exhaust all other possible resources for payment of my services such as Medicaid, SSI or SSDI, etc. I will take any action reasonably necessary to obtain such assistance and will assign or pay to WMCC the full amount recovered.

I understand that if I am accepted as a recipient of uncompensated service, the West Michigan Cancer Center and Institute for Blood Disorders may release my name to other health care providers indicating I was a recipient of uncompensated services.

I authorize a representative of the West Michigan Cancer Center and Institute for Blood Disorders to obtain personal, financial or medical information from any source deemed necessary to determine my eligibility for uncompensated services. I authorize West Michigan Cancer Center and Institute for Blood Disorders to apply for additional funding on my behalf as it becomes available. I may revoke this at any time by contacting the financial counseling department.

I have carefully read this application and all of this information I have provided is true.

Signature of Financially Responsible Party ______ Date ______ Relationship to Patient (if not self) ______

Signature of Spouse ______ Date ______