I. **Title:** Vernon Health, Inc. Financial Assistance Policy (FAP)

II. **Purpose:**

It is the purpose of Vernon Health, Inc. to provide medically necessary healthcare services to people in the communities it serves, regardless of their ability to pay. Financial assistance is available to those who meet eligibility requirements based on Vernon Health, Inc. FAP.

MISSION:

We are committed to being the best community healthcare system in the region.

VISION:

To bring value to our community, we commit to excellence in everything we do:

- Providing the ultimate experience to our patients/customers, their families, our staff and providers.
- Responding to the advances in healthcare and the changing needs of our community.
- Exhibiting leadership and stewardship toward our community's healthcare system.

III. **Policy Statements:**

A. Insert here

IV. **Definitions:**

Term(s)	Definition
"Enrollment period"	"Enrollment period" means the allotted amount of time to apply for Financial Assistance. From the first post-discharge billing statement up to day 240.
"Extraordinary Collection Action (ECA)"	"Extraordinary Collection Action (ECA)" means commencing a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process include: 1) lien; 2) foreclosure on real property; 3) attachment or seizure of a bank account or other personal property; 4) commencement of a civil action; 5) actions that cause an individual's arrest; 6) actions that cause an individual to be subject to body attachment; 7) wage garnishment.
"501(r)"	Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
"Amount Generally Billed" or "AGB"	The amount generally billed to individuals who have insurance covering emergency or other medically necessary care.

"Community"	Services provided at all Vernon Health, Inc. Hospital and Clinics located in Vernon and Crawford Counties, Wisconsin.
"Emergency Care"	A medical condition manifesting acute symptoms such that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health, impairment of bodily functions, or serious dysfunction of any bodily organ or part.
"Medically Necessary Care"	Care determined medically necessary following a determination of clinical merit by a licensed physician in consultation with the admitting physician.
"Organization"	Vernon Health, Inc., including Vernon Health Hospital, Hirsch Clinic-Vernon Health, Bland Clinic-Vernon Health, Kickapoo Valley Medical Clinic-Vernon Health, and La Farge Medical Clinic-Vernon Health.
"Patient"	Persons who receive emergency or medically necessary care at the Organization.
"Guarantor"	The patient or person financially responsible for the bill received for services provided at Vernon Health, Inc.
"Uninsured"	Patients with no insurance coverage (no coverage from health insurance or third-party payers). An uninsured patient who qualifies for Financial Assistance will receive an Uninsured Discount.
"Income"	Gross wages; salaries; tips; business/self-employment income; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

V. **Procedure:**

To establish guidelines for the Financial Assistance Policy (FAP) to patients served by Vernon Health, Inc.

1. Financial assistance is available for Medically Necessary procedures and treatments only. Medically necessary services are defined by Medicare as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. Elective procedures and treatment are not available for Financial Assistance.
2. Uninsured Discount: Patients with no third-party coverage (no health insurance) will be issued an uninsured discount on the total charges that are Medically Necessary. Patients who receive the Uninsured Discount are eligible to apply for additional Financial Assistance.
3. Financial Assistance: Patients may apply for financial assistance and will qualify when the family income is less than or equal to 400% of the current FPL.
    a. Family income equal to or less than 200% FPL are eligible to receive a 100% discount.
    b. Family income above 200% FPL but equal to or less than 225% are eligible to receive a 60% discount.

c. Family income above 225% FPL but equal to or less than 250% are eligible to receive a 55% discount.
d. Family income above 250% FPL but equal to or less than 275% are eligible to receive a 50% discount.
e. Family income above 275% FPL but equal to or less than 400% are eligible to receive a 45% discount.
f. As set forward in Section 12 below, a patient eligible for financial assistance will not be charged more for medically necessary care than the AGB.

4. Catastrophic Care: Patients not meeting financial assistance eligibility thresholds may be eligible for assistance under circumstances when medical bills would result in severe financial hardship. Patients, or their guarantors, may be eligible for catastrophic care assistance if they incurred out-of-pocket obligations resulting from medical services provided by Vernon Health, Inc. that exceed 25% of the adjusted gross income and have income below the equivalent of 600% of the Federal Poverty Level (FPL) threshold as published by the U.S. Department of Health & Human Services (or a successor).
5. Criteria used to determine eligibility for this FAP application includes family size, federal poverty levels and income guidelines.

6. In accordance with Vernon Health, Inc.'s values, employees will provide patients and family members with the ultimate experience possible during the FAP process. All patient and financial information is confidential and will not be shared outside of Vernon Health, Inc., or the Collection Agency.

a) Vernon Health, Inc. adheres to the privacy and security of patient protected health information according to regulation.

7. FAP patients must complete an application form and supply all necessary information required to make a determination for program eligibility.
    a. The application form will be subject to verification of the individual or family's current financial status.
    b. Patients may appeal FAP decisions.
    c. Information and supporting documents required for application submission are also listed on the application form.
        i. Income Verification (NA for families at or below 200% of the most current FPG):

(1) Applicants may provide one of the following:

A. Prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed), federal tax return.
B. Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business.
C. Adequate information must be made available to determine eligibility for the program.
D. Self-declaration of Income may be used.
E. Patients who are unable to provide written verification may provide a signed statement of income.

        ii. Required income documentation (NA for families at or below 200% of the most current FPG)
            1. Copy of Federal Tax Return

2. Current Proof of Income (paystubs)
3. Proof of other income (alimony, worker's compensation, unemployment, veteran's benefits)
4. Current Bank Statements
    a. Checking Account(s)
    b. Savings Account(s)

8. The enrollment period for a patient to enroll in Vernon Health, Inc.'s FAP is 240 days, starting upon issue of the first post-discharge billing statement.
    a. Patients will be unable to qualify for FAP after 240 days of the first post-discharge billing statement.
9. Financial Assistance Policy:
    a. aFAP application and list of required documents will be provided to any patient upon request.
        i. A link to all required FAP documents will be posted on Vernon Health, Inc.'s website: http://vmh.org
        ii. Financial Assistance can be requested online at http://vmh.org, by telephone, by mail or at every registration desk at the hospital, clinics, and hospice. Requests by mail should be mailed to:

            Patient Accounts
            507 S. Main St.
            Viroqua, WI 54665

10. Financial assistance is not available on charges pending insurance processing. This includes charges the patient's insurance carrier has not been able to process due to member noncompliance and pending liability or disability determinations
11. Eligible/Ineligible Services:
    a. Eligible Services:
        i. In compliance with Emergency Medical Treatment and Labor Act (EMTALA), all emergency medical services provided in an emergency room setting and billed by Vernon Health, Inc. are eligible under this policy. Vernon Health, Inc. will provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they are financial assistance eligible.
            1. All services associated with inpatient and outpatient care that is billed directly from Vernon Health, Inc. that are Medically Necessary are eligible.
    b. Ineligible Services
        i. Physician's fees associated with inpatient and outpatient care that are not billed through Vernon Health, Inc.
        ii. Services received from Providers not employed by Vernon Health, Inc. This includes the professional fees for services provided by Gundersen Health System Providers who are approved to provide services in the Vernon Health, Inc.'s hospital setting.
        iii. Services that are not Medically Necessary or are considered Elective.
        iv. Ambulance services not billed through Vernon Health, Inc.
        v. Durable medical equipment provided to the patient that is not billed through Vernon Health, Inc.
        vi. Copay balances
        vii. Out of Network balances due
        viii. Failure to comply with insurance requirements (referral, prior authorization)
        ix. Services that insurance deems "Experimental or Research"
        x. Retail pharmacy transactions

12. Plain Language Summary (PLS)
    a. Each billing statement will include a plain language summary that describes how to acquire additional information regarding eligibility and application.
    b. A PLS will also be posted on Vernon Health, Inc.'s website: www.vmh.org
    c. A PLS will be made available in printed format in English, German and Spanish at the time of registration.
13. Financial Assistance (FAP) Application
    a. FAP application and list of required documents will be provided to any patient upon request. The application can also be mailed upon request. The application enrollment period is effective within 240 days from the first post-discharge billing statement.
    b. The FAP Application will be posted on Vernon Health, Inc.'s website: http://www.vmh.org/content/financial-assistance-program
    c. Financial assistance applications will be evaluated to determine most generous discounts available under the Vernon Health, Inc. FAP and according to the Federal poverty guidelines, reviewed annually at https://www.dhs.wisconsin.gov/medicaid/fpl.htm
    d. Financial need may be determined in accordance with procedures that involve an individual assessment of financial need and will:
        i. Include a general screening process.
        ii. Include an application process, in which the patient or patient's guarantor are required to provide personal, financial and other information and documentation.
            1. This application process may be completed with the assistance of a Vernon Health, Inc. Business Office representative, online or by mail.
    e. FAP application forms may be accepted verbally, however all requested documentation will be required prior to approval and the verbal information will be transferred to an application in writing.
    f. Vernon Health, Inc. may choose to waive such conditions or criteria for the FAP in situations where the patient/guarantor is not capable of meeting these requirements per management and CFO approval.
    g. Vernon Health, Inc. understands that an individual and/or family's income situation will change over time.
    h. Vernon Health, Inc. will re-verify eligibility for the FAP every 12 months. Patients may contact the Patient Accounts office if they acquire a new bill after 1 year of FAP eligibility and need to renew their application.
    i. Eligibility for FAP will be considered for those individuals who are insured, uninsured or underinsured and who are unable to pay for their care, based upon a determination of financial need.
    j. The granting of financial assistance will be based on an individualized determination of financial need and will not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.
    k. Specific Eligibility Criteria:
14. Individual or family income, which may take into account family size and other pertinent factors.
    a. Family: Defined by the U.S. Census Bureau, a family is a group of two or more people who reside together and are related by birth, marriage, or adoption.
        i. A dependent claimed on an income tax return can be used for determining eligibility for this policy.
        ii. Other financial obligations, such as living expenses and other items in relation to living expenses and income.
        iii. Other financial resources available to patients, such as an insurance plan through the Health Insurance Exchange, Medicaid or other public assistance programs, may

affect the determination of assistance. (NA for families at or below 200% of the most current FPG)

1. FAP applicants are encouraged to apply to public programs and private health insurance coverage. Applicants choosing not to apply for these programs may be denied financial assistance. (NA for families at or below 200% of the most current FPG):
2. Applicants likely to qualify for Wisconsin Medicaid are encouraged to apply for coverage and receive a determination in order to qualify for FAP. Determinations from Wisconsin Medicaid received within six (6) months of the FAP application date will be accepted. (NA for families at or below 200% of the most current FPG):

iv. Patients receiving home health care services must meet the definition of home bound and the home must be the best place for service to be provided.

15. Amounts Generally Billed (AGB):
    a. Following a determination of eligibility under this FAP, a patient eligible for financial assistance will not be charged more for medically necessary care than the AGB.
16. Vernon Health, Inc. determines AGB based on all claims paid in full to Vernon Health, Inc. by Medicare, Medicare Advantage, Medicaid, Medicaid HMO and private health insurers (including payments by Medicare beneficiaries or insured individuals themselves), over a 12-month period, divided by the associated gross charges for those claims using the Look-Back Method
17. The AGB is the expected payment from the patient or guarantor who is eligible for Financial Assistance
    a. Only those approved for financial assistance may not be charged more than the AGB for emergency or other medically necessary care.
18. Communication of FAP:
    a. The FAP available from Vernon Health, Inc. shall be communicated by various means, which may include notices on patient billing statement, brochures located at emergency departments, urgent care, admitting and registration departments, patient financial services or other business associates involved in patient billing process. The FAP policy and complete application shall also be published on Vernon Health, Inc. website at www.vmh.org
    b. FAP application and list of required documents will be provided to any patient upon request.
    c. Patients can request an application by telephone by calling the Patient Accounts Department at (608) 637-2101.
    d. Patients can request an application by mail by sending a request to:

Vernon Health Patient Accounts

507 S. Main St.

Viroqua, WI 54665

19. Expectations and Payment:
    a. It is an expectation that the patient/guarantor will cooperate and supply all necessary information required to make a determination for financial assistance eligibility. This includes application to any program for which they may be eligible prior to their request for the Vernon Health, Inc. Financial Assistance Program.

b. Failure to do so may result in application being denied. (NA for families at or below 200% of the most current FPG)
c. In the event patient or responsible party is unable to apply for the FAP, Vernon Health, Inc. may use presumptive eligibility to make a determination of the patient's eligibility.
    i. Presumptive decisions may be based on:
        1. An applicant's prior Vernon Health, Inc. FAP application
        2. Discharged bankruptcies
        3. Deceased patient with no property in probate
        4. Current eligibility under Medicaid (NA for families at or below 200% of the most current FPG)
d. Once approved for FAP, the patient is responsible to make appropriate payments to pay off the balance owed within 12 months.
e. The lowest payment arrangement that can be made per month on any account is $30.00.
f. Temporary payment arrangements can be obtained thru a Patient Financial Counselor if the patient cannot afford the minimum of $30 per month or paid off within 24 months.
g. The uninsured discount given to patients without health insurance coverage will be applied in addition to the financial assistance percentage given.
h. No other discounts will be granted if a patient has financial assistance.

20. Determination:
    a. The final determination for FAP shall be made within a reasonable amount of time upon receipt of the completed application, required supplemental documents and determination of other program(s) eligibility.
    b. The patient or guarantor will be notified in writing of the final determination. The patient or guarantor shall also be notified if a determination is delayed pending an incomplete application or if additional information is needed.
        i. The patient or guarantor has 30 days to respond to a request for additional information/incomplete application.
            1. Failure to respond will disqualify the patient for the financial assistance program. If the patient wishes to re-attempt to qualify, the patient will need to complete a new application and provide the required documents.

21. Appeal:
    a. The patient may request an appeal in writing following final determination or denial of FAP.
    b. The Vernon Health, Inc. Patient Accounts Manager and CFO will review all appeals requests within a reasonable amount of time upon receipt.
        i. The patient or guarantor will be notified in writing of final determination.

22. Extraordinary Collection Actions (ECA) and Reasonable Efforts:
    a. Vernon Health, Inc. will make reasonable effort to determine FAP eligibility before considering extraordinary collection actions.
        i. Reasonable efforts include providing notice orally and in writing, of the FAP during the notification period ending 120 days after the date of the first billing statement post-discharge.
        ii. It is the guarantor's responsibility to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "reasonable effort" will have been made.
        iii. Patients who qualify for financial assistance will remain active for one year, unless their ability to pay improves during the 12-month period. For assistance beyond 12 months, a new application is required.
    b. In the event a FAP and/or payment are not received, Vernon Health, Inc. or other authorized parties may proceed with extraordinary collection actions with a minimum of 30 days prior

notice. This could include sending collection letters or referral of account to a collection agency. The collection agency will continue collection efforts which may also include credit bureau reporting or legal actions.

i. The approved amount thru the FAP may be sent for legal actions, not the total billed amount.
ii. Age of placement: accounts that are sent to the collection agency will be submitted 121 days after first post-discharge billing statement if there is no sufficient payment.
iii. The collection agency will be notified via email or the agency portal if a patient requests to apply for FAP if within 240 days of the first post-discharge billing statement. Any ECA that is already in process will be suspended until eligibility is determined.
    1. Any payments made to an account by the patient prior to FAP approval, will be refunded to the patient if the amount is greater than the discount received with FAP. The minimum account refund is $5.00.
iv. Any account older than 240 days will not be eligible to re-apply for income or status changes.

c. Vernon Health, Inc. authorizes the collection agency to file a Motion for Contempt if the consumer (patient) fails to complete a Financial Disclosure Statement that small claims court sends to them upon entry of judgement.
    i. The court allows fifteen (15) days to return the completed statement.

VI. **Locations and Providers that follow Financial Assistance Program under Vernon Health, Inc:**

Vernon Health Hospital
507 S. Main St.
Viroqua, WI 54665

Hirsch Clinic-Vernon Health
407 S. Main St. Ste 400
Viroqua, WI 54665

Bland Clinic-Vernon Health
100 Melby St.
Westby, WI 54667

La Farge Medical Clinic-Vernon Health
206 N. Mill St.
La Farge, WI 54639

Kickapoo Valley Medical Clinic-Vernon Health
102 Sunset Ave.
Soldiers Grove, WI 54655

VII. **References:**

www.medicare.gov
US Census Bureau: https://www.census.gov
Translation: https://apps.mla.org/map_data

VIII. **Policy Ownership and Authority:**
This is a PRA procedure owned and given authority by the Director, Revenue Cycle; it will be catalogued in the PRA Department Manual.

Description of Change(s)

Description of Change(s)	Name, Title or Committee Name	Date
Created	Ashley Lagerquist, Manager Patient Registration & Accounts	10/2026
Last Revision	Ashley Lagerquist, Director – Revenue Cycle	06/2022
Approved	Ashley Lagerquist, Director – Revenue Cycle	09/2024
Only keep the initial creation, last revision and last approval dates (Month/Year format). Previous versions must be archived in accordance with corporate retention policy; all versions and review activities must be tracked electronically in the policy management system.		