Children’s Behavioral Health Center
Charity Care and Financial Assistance Policy

Purpose:

Devereux Advanced Behavioral Health (Devereux) is a national nonprofit partner for individuals, families, schools and communities, serving many of the most vulnerable members of our society in the areas of autism, intellectual and developmental disabilities, specialty mental health, and child welfare.

Devereux operates a network of clinical, therapeutic, educational and employment programs that positively impact the lives of tens of and family consultation, traditional and therapeutic foster care, and outpatient/other specialized services. We are guided by our mission: To change lives by unlocking and nurturing human potential for people living with emotional, behavioral or cognitive differences.

In furtherance of this critical mission, Devereux provides acute inpatient psychiatric care to children and adolescents through Devereux Pennsylvania’s Children’s thousands of children, adults – and their families – every year. Our extensive array of services include: acute care, treatment in residential settings, community-based living, special education day schools, foster care, autism assessments, employment and transition services, group homes, school Behavioral Health Center (CHBC).

To individuals help get the care they need, CHBC provides financial assistance for medically necessary and emergency care, to individuals who meet the eligibility requirements. If CBHC determines that an individual is eligible, they may discount or waive an individual’s financial obligation for care. This policy covers all of the Providers who render care at CBHC.

DEFINITIONS

(a) Family. A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family.

(b) Unrelated individual. An unrelated individual is a person 15 years old or over who is not living with any relatives.

(c) Household. A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units, but only one household.
(d) **Family unit.** Either an unrelated individual or a family (as defined above) constitutes a family unit. A family unit of size one is an unrelated individual, while a family unit of two or three is the same as a family of two or three.

(e) **Income.** Income includes total annual cash receipts before taxes from all sources, with the exceptions noted below. Incomes includes money wages and salaries before any deductions; net receipts from non-farm self-employment; net receipts from farm self-employment; regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, Emergency Assistance money payments, and non-Federally-funded General Assistance or General Relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships, and assistantships; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

Income does not include the following types of money received: capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car; and tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments or compensation for injury. Also excluded are non-cash benefits; food, or housing received in lieu of wages; the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied non-farm or farm housing; and such Federal non-cash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance.

**WHO IS ELIGIBLE?**

**Financially Indigent**

A financially indigent patient is a person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility criteria set forth in this policy.

To be eligible for charity care as a financially indigent patient, a person's income shall be at or below 200 percent of the federal poverty guidelines and is unable to pay the bill. The hospital may consider other financial assets and liabilities of the person when determining ability to pay. At any time prior to collection of the patient’s account, the hospital may, upon review of the patient’s current financial condition, re-assess the patient’s status and make a new determination. However, once a patient is deemed to be financially indigent, no further determinations will be made.

The hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a
financially indigent patient. The poverty income guidelines are published in the Federal Register in February of each year and for purposes of this policy will become effective the first day of the month following the month of publication.

**Medically Indigent**

A medically indigent patient is a person who’s medical or hospital bills after payment by third-party payers exceed a specified percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill.

To be eligible for charity care as a medically indigent patient, the amount owed by the patient on the hospital bill after payment by third-party payers must exceed 5 percent of the patient's annual gross income and the patient must be unable to pay the remaining bill as determined by the hospital. The hospital may consider other financial assets and liabilities of the person when determining ability to pay. At any time prior to collection of the patient’s account, the hospital may, upon review of the patient’s current financial condition, re-assess the patient’s status and make a new determination. However, once a patient is deemed to be medically indigent, no further determinations will be made.

A determination of a patient's ability to pay the remainder of the bill will be based on whether the patient can be reasonably expected to pay the account in full over a two-year period.

If a determination is made that a patient has the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient’s ability to pay at a later date. Once a patient is deemed to be medically indigent, no further determinations will be made.

**HOW DO YOU APPLY?**

**Application Process**

Please contact the Admissions Office at 484-595-6723 to receive the Application for Charity Care and Financial Assistance.

**Identification of Charity Cases**

The hospital will post notice of its charity care program and how a patient may apply for charity care in various places including Admissions, Administration and the Business Office. These documents and notices will all include a contact phone number for further information. CBHC will also publish and widely publicize a summary of this financial assistance policy on the facility website. Such notices and summary information will be provided in the primary languages spoken by the population serviced by CBHC. Referral for charity care and financial assistance may be made by any member of the CBHC staff or medical staff, including psychiatrists and nurses. A request for charity care and financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
The Business Office will attempt to identify all cases that will qualify as charity at the time of admission. Patients identified as possible charity cases will be asked to provide the hospital with the required information and to complete a charity care approval form. Information required includes:

1. Most recent copy of IRS 1040 form.
2. Copies of most recent pay stubs/income stubs.
3. Copies of all monthly bills including but not limited to car, home, insurance, food, medical, utility and credit card bills.
4. Listing of all available assets including savings, investments, etc.

The Business Office will refer those patients who may qualify for financial assistance from a governmental program to the appropriate program, such as Medicaid. Patients who are eligible for Medicare, Medicaid, or any governmental or other healthcare, mental health or behavioral healthcare coverage may not qualify as indigent for purposes of this policy.

A determination will be made concerning the patient's eligibility for charity as information concerning the patient's financial resources is available. No collection efforts will be pursued on a charity account after such determination is made.

Failure to Provide Appropriate Information

Failure to provide information necessary to complete a financial assessment may result in a negative determination, but the account shall be reconsidered upon receipt of the required information. CBHC personnel shall provide the patient with the CBHC Charity Care and Financial Assistance Application (Attachment C). A determination of eligibility for charity may be made without a completed assessment form if the patient or information is not reasonably available and eligibility is warranted under the circumstances.

Time Frame for Eligibility Determination

A determination of eligibility will be made by the Business Office within 10 working days after receipt of all forms and other information necessary to make a determination or as new facts are made available to the hospital.

Documentation of Eligibility Determination

Once an eligibility determination has been made, the results of the determination will be noted in the comments section of the admissions record, and a copy will be sent to appropriate hospital departments.
HOW IS FINANCIAL ASSISTANCE APPLIED?

Discounts Available

The discounts available are based on the percentage of a patient’s income in relation to the federal poverty guidelines as noted in Attachment A and are as follows:

- Patient’s with family income below 200% of the Federal Poverty Guidelines supported by appropriate documentation as determined by the Business Office, will be eligible for 100% Charity Care.
- Patient’s with family income in excess of 201% but not exceeding 300% of the Federal Poverty Guidelines will be eligible for an 80% discount.
- Patient’s with family income in excess of 301% but not exceeding 400% of the Federal Poverty Guidelines will be eligible for a 70% discount.

Patients eligible for Financial Assistance will not be billed more than what CBHC would receive if the patient were eligible for Medicaid. This is referred to in the IRS regulations as the “Prospective Method” of calculating amounts generally billed.

Application of Discounts

The application of discounts is based on the prudent buyer rates charged by CBHC.

The federal poverty income guidelines are included in this policy as Attachment A. The definitions of "family", "income" and "exclusions from income" are included in the poverty guidelines and will be used in all charity eligibility determinations.
ATTACHMENT A

Federal Poverty Guidelines effective January 18, 2018

<table>
<thead>
<tr>
<th>Persons in Family or Household</th>
<th>Poverty Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,140</td>
</tr>
<tr>
<td>2</td>
<td>16,460</td>
</tr>
<tr>
<td>3</td>
<td>20,780</td>
</tr>
<tr>
<td>4</td>
<td>25,100</td>
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<td>5</td>
<td>29,420</td>
</tr>
<tr>
<td>6</td>
<td>33,740</td>
</tr>
<tr>
<td>7</td>
<td>38,060</td>
</tr>
<tr>
<td>8</td>
<td>42,380</td>
</tr>
</tbody>
</table>

For families with more than 8 persons, add $4,320 for each additional person.

This Table shall be adjusted in accordance with annually released changes to the Federal Poverty Guidelines.

The poverty guidelines are a simplified version of the federal government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty.

The poverty guidelines given above should be used for both farm and non-farm families. Similarly, these guidelines should be used for both aged and non-aged units.
Attachment B
CBHC CHARITY CARE AND FINANCIAL ASSISTANCE FORM
ATTESTATION OF NO INSURANCE

LAST NAME: _________________________ FIRST NAME: _____________________ M.I. _____

ADDRESS: ___________________________________________________________________

CITY: ______________________________________ STATE: _____ ZIP: _________________

SSN# LAST FOUR DIGITS: _____________ DATES OF SERVICE: _________________

I hereby certify that I am currently do not have the ability to pay for the treatment on the dates stated above.

□ Initials:_____ 

I understand that by signing this document, I am applying for Financial Assistance.

□ Initials:_____ 

If any information I have given proves to be untrue, I understand that CBHC or Devereux, may re-evaluate my financial status and I may become liable for charges.

□ Initials:_____ 

Last Date Employed:___________ Family Unit Size:_____ Family Annual Income: ________

I certify the above information is true and complete. I understand that willful falsification of information contained in this application will result in denial of Financial Assistance.

_____________________________________
Patient Signature

_____________________________________
Printed Name

_____________________________________
Date

If you have questions, please contact the Admissions Office at 484-595-6723

DISCLAIMER

Devereux reserves the right to request such information as pay stubs, income tax returns, bank statements, social security, and/or other liquid financial information deemed appropriate to determine qualification for assistance.
Attachment C
CBHC CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

LAST NAME: ___________________________ FIRST NAME: ___________________________ M.I. ______

ADDRESS: ________________________________________________________________________

CITY: ___________________________________ STATE: _____ ZIP: ______________________

SSN# LAST FOUR DIGITS: _____________ DATES OF SERVICE: ______________________

I hereby certify that I am currently do not have the ability to pay for the treatment on the dates
stated above.

I understand that by signing this document, I am applying for Charity Care or financial assistance.
I will promptly provide the information necessary to process my application. Furthermore, I will
apply for any assistance (Medicaid, Insurance, etc.), that may be available to me for payment of
my hospital charges. I will provide information and take action reasonably necessary to obtain
such assistance and will assign or pay to the hospital, the amount recovered from the hospital
charges.

If any information I have given proves to be untrue, I understand that CBHC or Devereux may re-
evaluate my financial status and I may become liable for my charges.

LAST DATE EMPLOYED: __________________________________________________________

EMPLOYER NAME: ______________________________________________________________

EMPLOYER ADDRESS: ________________________________________________________________________

FAMILY SIZE: ________________________________________________________________________

ANNUAL INCOME: ________________________________________________________________

LAST 3 MONTHS INCOME: __________________________________________________________

PLEASE INCLUDE VERIFICATION OF INCOME INFORMATION TO INCLUDE YOUR TWO MOST
RECENT W2 FORMS AND FEDERAL INCOME TAX RETURNS OR YOUR LAST 3 MONTHS OF PAY
STUBS.

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY
KNOWLEDGE.

PATIENT SIGNATURE: ___________________________ DATE: ___________________________

Please submit this form to:
CBHC Business Office, 655 Sugartown Road, Malvern, PA 19355

If you have any questions on this form or are unable to produce the requested documentation for
verification of income, contact the Admissions Office at 484-595-6723