GRAHAM COUNTY HOSPITAL
POLICY AND PROCEDURE

SUBJECT: **Discounting and Waiving Charges**

POLICY: GCH shall provide a discount from billed charges for non-elective treatment furnished to qualified patients whose household financial resources and/or income are at or below a certain percentage of the then-current Federal Poverty Level published annually by the U.S. Department of Health and Human Resources ("FPL"). GCH may also reduce or waive the amount of billed charges based on "good will," public relations, or risk management concerns, or if, after having made reasonable efforts, GCH has been unable to collect monies owed from the patient.

PURPOSE: The purpose of this policy is to provide assistance to low-income individuals to whom GCH provides non-elective treatment and to identify those other limited circumstances in which GCH shall reduce or waive the amount of billed charges. GCH shall not offer discounts for the purpose of generating business payable under a Federal health care program or to influence such beneficiary's selection of a particular provider, practitioner, or supplier.

PROCEDURE:

1. GCH shall not advertise its discount policy to potential patients. Any patient/responsible party who requests a financial accommodation or who indicates he/she is unable to pay the entire amount of his/her account balance shall be referred to the Patient Accounts Department. Professional staff members and employees other than those employees working in the Patient Accounts Department should not make specific representations to patients/responsible parties concerning GCH's discount policy.

2. As appropriate, the Patient Accounts Department shall assist a patient/responsible party identify potential sources of financial assistance including Medicaid, SCHIP (State Children's Health Insurance Program), and other state and local programs.

3. The Patient Accounts Department shall provide information concerning GCH's discounts for low-income individuals to a patient/responsible party upon request. Any individual who wishes to take advantage of such discounts shall (1) complete the financial assistance application for the Medicaid program and obtain the Medicaid Denial Letter, (discounts are not available to individuals who are eligible for the Medicaid Program), (2) complete the required form; and (3) provide sufficient documentation to verify his/her family income, e.g., financial statement, income tax returns, bank statements, paycheck stub. If an individual claims medical indigence (i.e., total medical bills exceed 25 percent of household income), he/she must provide documentation of outstanding medical

bills. The Patient Accounts Department shall determine the appropriate documentation necessary for verification purposes on a case-by case basis. Failure on the part of the individual to provide necessary information shall render him/her ineligible for any discount.

4. Using the information provided by the individual as well as information obtained from a credit reporting agency (if available), the Patient Accounts Department shall determine the percentage discount available on the balance owing by the individual (i.e., self-pay, coinsurance, deductible) based on the Federal Poverty Guidelines.

Graham County Hospital
and
Graham County Hospital Clinic
Sliding Fee Scale
Based on 2025 Federal Register

	Annual Income									
Family Unit Size	Less Than	20% PAY From	125% To	40% PAY From	150% To	60% PAY From	175% To	80% PAY From	200% To	Greater Than 200%
1	15,650	15,651	19,563	19,564	23,475	23,476	27,388	27,389	31,300	31,301
2	21,150	21,151	26,438	26,439	31,725	31,726	37,013	37,014	42,300	42,301
3	26,650	26,651	33,313	33,314	39,975	39,976	46,638	46,639	53,300	53,301
4	32,150	32,151	40,188	40,189	48,225	48,226	56,263	56,264	64,300	64,301
5	37,650	37,651	47,063	47,064	56,475	56,476	65,888	65,889	75,300	75,301
6	43,150	43,151	53,938	53,939	64,725	64,726	75,513	75,514	86,300	86,301
7	48,650	48,651	60,813	60,814	72,975	72,976	85,138	85,139	97,300	97,301
8	54,150	54,151	67,688	67,689	81,225	81,226	94,763	94,764	108,300	108,301
Write Off	90% W/O	80% W/O		60% W/O		40% W/O		20% W/O		None

5. Additional amounts incurred for non-elective services by an individual who has qualified for a discount during a one-year period following such qualification shall be subject to the same discount. If the individual incurs such expenses after the one-year period, he/she shall be required to submit updated information for purposes of qualifying for any discount.

6. If a patient's total outstanding medical bills (from all providers) at any time exceeds 25 percent of the patient's household annual income, GCH shall discount the amount owing by that patient to GCH at that time by 60 percent, unless the discount outlined in section 4 would be greater than 60 percent.

7. For any remaining balance, or for individuals who do not qualify for a discount but have difficulty paying (e.g., persons with large medical bills that comprise a significant percentage of their income), the Patient Accounts Department will work with the individual to establish an appropriate payment plan based on the amount due and the individual's financial status, with terms extending up to five years. If an individual fails to make minimum monthly payments, the full amount of the balance shall be immediately due and owing unless the individual demonstrates good cause for his/her failure to make such payments in a timely manner.

8. Any individual whose bill was discounted and for whom the Patient Accounts Department arranges a payment plan shall be required to submit sufficient documentation of his/her family income on an annual basis. If such income increases or decreases to such extent the percentage discount the individual would have received would have been different, the Business Office Manager of the Patient Accounts Department shall make an appropriate adjustment to the balance owed by the individual.

9. All discounts must be approved prior to being offered to any person. If approved, the appropriate adjustment shall be made to the account and documented in the permanent notes: "Dates, Charity/Hardship Discount Taken." Appropriate documentation for all discounts extended to patients/responsible parties based on financial need (including completed applications and documentation of family income) shall be maintained for a period of five years following resolution.

10. In addition to discounts and waivers based on financial need, GCH may adjust the amount owed by a patient or responsible party for the following reasons:

    (a) If, after having made reasonable efforts, GCH has been unable to collect monies owed from the patient or responsibility party. It is not necessary that GCH file legal action against the patient prior to waiving the patient's financial obligation.

    (b) Good will, public relations, or risk management concerns, so long as there is no intention to influence patient referrals or induce any federal healthcare program beneficiary to receive services from GCH. The reasons supporting such a discount or waiver shall be properly documented in the patient's record.

11. GCH shall provide the discounts specified herein and otherwise make other financial accommodations without respect to the patient/responsible party's race, color, religion, creed, sex, national origin, age, or disability of such person, or any other classification prohibited by law.

NOTICE

GRAHAM COUNTY HOSPITAL HAS ADOPTED THE FOLLOWING POLICIES FOR CHARGES FOR HEALTH CARE SERVICES

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at a reduced charge to persons unable to pay for services after determining eligibility. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of their inability to pay for services, or because payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency which administers the State plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to persons entitled to medical assistance under the plan.

Graham County Hospital
Graham County Hospital Clinic

Financial Assistance Application Checklist

☐ **Completed application**

☐ **Proof of income (i.e. recent paystub, copy of social security deposit, child support deposit information)**

If you do not have any monthly income, please explain how you are meeting your monthly expenses.

_____

_____

_____

_____

☐ **Copy of most recent bank statement, checking and any savings accounts**

☐ **Copy of Kansas Medicaid denial letter (dated within the last 6 months)**

☐ **Copy of last year's filed federal income tax return.**

If you are not required to file, please explain so below.

_____

_____

Please submit the completed checklist, application and required documentation to

Graham County Hospital or Clinic

304 W. Prout Street/Hill City, Kansas 67642/(785) 421-2121
114 E. Walnut/Hill City, Kansas 67642/(785)421-2191

Graham County Hospital Financial Assistance Application

YOUR CONTACT INFORMATION

First Name _____ Last Name _____

Birth Date _____

Address _____

City/State _____ Zipcode _____

Phone _____ Email _____

Spouse Name _____ Birth Date _____
(if applicable)

List all other household members:

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Total # of household members _____

Employment Status

- ☐ Full/Part time
- ☐ Self Employed
- ☐ Retired
- ☐ Unemployed - seeking job
- ☐ Unemployed - unable to work
- ☐ Other:_____

If employed, please provide employers name, address and phone number:

If employed, please list average hours worked per week:

Do you have Health Insurance?

- ☐ Yes
- ☐ No

Monthly Income: (Attach copies of Proof of Income)			
Income Type:	**Responsible Party**	**Spouse**	**Other Members of the Household (18 & Older)**
Wages			
Social Security			
Pensions			
Unemployment			
Workman's Compensation			
Government Assistance			
Disability Payments			
Veteran's Payments			
Child Support			
Other Income			
Monthly Subtotal			
Total Income	**Monthly:**		

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patients household income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill.

Patient/Guarantor Signature Date

For Office Use:
Date Completed:
Status: ☐ Denied reason:_____ ☐ Approved % of Discount_____
Staff Signature: