Springfield Hospital

Where People Come First

FINANCIAL ASSISTANCE POLICY

I. OVERVIEW:

Springfield Hospital (SH) is a non-profit healthcare corporation serving portions of Windsor, Windham and Bennington Counties, Vermont and portions of Sullivan and Cheshire Counties, New Hampshire. Springfield Hospital (with campuses in Springfield and Bellows Falls, VT) provides acute care services, including mental health, and also operates specialty physician practices.

SH is committed to meeting the needs of the residents of its defined service area regardless of insurance status or ability to pay. SH will provide without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the financial assistance policy.

II. SCOPE AND PURPOSE:

A. To specify the criteria for identifying individuals that are eligible to receive services rendered by SH either free of charge (i.e.: 100% discount) or at partially discounted rates.
B. Patients qualifying under the Financial Assistance Policy (FAP) will be exempt from liability for the determined discount.
C. The FAP applies Federal Poverty Guidelines, updated annually, adjusted for household size, to identify patients with a documented inability to pay for either the entirety or for a portion of the services rendered. Individuals that receive a partial discount are liable for balances not discounted and will be subject to collection efforts by SH for the balance due after discount.
D. The FAP does not apply to elective or cosmetic services or services that are not medically necessary. Patients are encouraged to inquire prior to the rendering of services as to whether or not a service qualifies for the FAP.

III. GENERAL REQUIREMENTS:

A. Financial assistance will be granted only after the submission of a signed application for financial assistance by the patient, relative, legal guardian, power of attorney, or SH Patient Financial Counselor with written authorization from the patient/guarantor/legal guardian. The application must be received by SH within thirty (30) days of the furnishing of the application.

B. In order to be eligible for financial assistance for services provided by Springfield Hospital, the patient/guarantor must be a resident of the State of Vermont, or Sullivan or Cheshire Counties in New Hampshire. Applicants who reside outside Vermont or the indicated New Hampshire counties, and who have been deemed eligible for assistance for Springfield Medical Care Systems Community Health Center services, may also be deemed eligible for Springfield Hospital assistance. See Springfield Hospital Medical Discount Schedule Attachment A.

C. Springfield Hospital does not engage in extraordinary collection activities before SH has made reasonable efforts to determine whether the individual is eligible for financial assistance under the financial assistance policy.

1. Springfield Hospital will not charge eligible patients more for emergency or other medically necessary services than the amount generally billed (AGB) to patients who have Medicare. The amount generally billed (AGB) is calculated based on the percentage of what Medicare allows for services billed in a 12 month period. The percentage calculated will be multiplied times the total charges on the claim to arrive at the AGB. See sample methodology attachment B.
2. Patient balance will hit the self -pay category on discharge if the patient is uninsured or after insurance has processed and a statement is then generated.
3. Statements will contain contact information regarding inquiries for financial assistance and budget payments.
4. Patient accounts may be sent to a collection agency for unpaid balances greater than 120 days and the patient has not applied for financial assistance.
5. Credit bureau reporting may begin for unpaid balances greater than 240 days or for incomplete financial assistance applications.

D. Applicants may qualify for financial assistance under the following circumstances.

1. Federal Poverty Guidelines: The patient's and/or guarantor's income is equal to or less than the current approved SH income poverty guidelines included in the attachments to this policy and there are no other assets available to the patient which could be used in the settlement of Springfield Hospital charges only. A principal residence generally would not be considered an available asset in this regard. Springfield Hospital allows savings of up to $10,000 for burial expense.
2. Medicare Beneficiaries: Deductibles and coinsurances due from Medicare beneficiaries can be eligible for discount under the FAP assuming the patient submits an application and qualifies.
3. Medicaid Beneficiaries: Coinsurances due from Medicaid beneficiaries qualify for FAP. A Medicaid beneficiary need not complete a FAP application in order for coinsurances to qualify.
4. Extenuating Circumstances: Accounts that fall outside of the established SH guidelines but involve extenuating circumstances can be approved by the Director, Revenue Management, Patient Financial Services in consultation with the Chief Financial Officer.

E. A patient who applies for financial assistance will receive a written notice of the determination of SH within 30 days of submission of the written application and all required supporting documentation.

F. Once SH determines the patient to be eligible for financial assistance, this determination MAY be in effect for 1 year from the date of the initial determination. If approved for financial assistance, any and all changes regarding income, insurance status, family size, etc. must be reported to SH.

G. SH shall not discriminate on the basis of race, color, national origin, ethnicity, religion, creed, sex, sexual orientation or age (for any persons beyond the age of majority) in its application of policies concerning the acquisition and verification of financial information, and eligibility for financial assistance.

H. The patient and/or guarantor must cooperate fully with SH to explore and obtain all possible alternative insurance coverage.

I. The patient and/or guarantor are encouraged to maintain coverage through New Hampshire Medicaid, Vermont Medicaid, or one of the marketplace plans available thorugh the Vermont Health Connect.

IV. CRITERIA FOR NOTIFICATION AND ASSISTANCE OF THE AVAILABILITY OF FINANCIAL ASSISTANCE

A. NOTIFICATION:

1. Patients will be made aware of the availability of the Financial Assistance Policy through the posting of signs in all registration areas throughout SH and in the Patient Financial Services offices located at 192 Park Street, Springfield, VT 05156.
2. SH shall make available copies of the Financial Assistance Policy application at any and all registration areas where patients access SH services.
3. On an Inpatient admission that occurs outside the hours of operation of the registration department, the admitting office will be responsible for delivering the application to the patient the following day or as soon as possible.
4. SH will attempt to inform the public of its Financial Assistance Policy through the SH website (www. springfieldhospital.org) and/or use of public announcements, paid advertising, etc.

B. ASSISTANCE:

SH will assist all patients with the completion of an application for Financial Assistance and whenever possible with applications for other programs such as Medicaid, Medicare Part D, Vermont Health Connect, etc. A patient may obtain confidential and compassionate assistance at:

1. The SH Patient Business Services offices located at 192 Park Street, Springfield, VT or by calling (802) 885-7081, ext. 7785.
2. Valley Health Connections – Through an arrangement with SH, assistance with applications is available through Valley Health Connections located at 268 River Street, Springfield, VT or by calling (802) 885-1616.

Applicants must call in advance and must submit all requested documentation and the application completed to the best of their ability in advance.

V. DOCUMENTATION AND AUDIT:

1. Each financial assistance application shall be accompanied by patient documentation of all efforts made by SH to determine eligibility.
2. Financial Assistance application documentation shall be kept on file for a period of 5 years. After 5 years all paperwork may be permanently destroyed.

VI. DECISION OF ELIGIBILITY FOR FINANCIAL ASSISTANCE:

Patient Financial Services will make the initial determination of eligibility for financial assistance using the above policy. This information will be recorded in writing in the appropriate section of the application forms.

Patient Financial Counselors will submit any applications for extreme hardship that fall outside the guidelines. Accounts that fall outside of the established SH guidelines but involve extenuating circumstances can be approved by the Director, Revenue Management, Patient Financial Services, in consultation with the Chief Financial Officer. An attestation may need to be provided by the applicant.

VII. PROVIDERS PARTICIPATING IN SH FINANCIAL ASSISTANCE POLICY

SH physicians and other providers participate in the SH Financial Assistance Policy. Please see our physician directory at www.springfieldhospital.org where each providers' biography page indicates whether the provider is a participant in the SH Financial Assistance Policy. The Provider financial assistance participation will be reviewed and updated quarterly.

Attachment A - SPRINGFIELD HOSPITAL MEDICAL DISCOUNT SCHEDULE

Family #	60040 100% FPG Patient Pays Zero		60041 120% of FPG Patient Pays Zero		60042 140% FPG Patient Pays Zero		60043 160% FPG Patient Pays Zero		60044 180% FPG Patient Pays Zero		60045 200% FPG Patient Pays Zero	
	From	To	From	To	From	To	From	To	From	To	From	To
1	0	$13,590	$13,591	$ 16,308.00	$ 16,309.00	$ 19,026.00	$ 19,027.00	$ 21,744.00	$ 21,745.00	$ 24,462.00	$ 24,463.00	$ 27,180.00
2	0	$18,310	$18,311	$ 21,972.00	$ 21,973.00	$ 25,634.00	$ 25,635.00	$ 29,296.00	$ 29,297.00	$ 32,958.00	$ 32,959.00	$ 36,620.00
3	0	$23,030	$23,031	$ 27,636.00	$ 27,637.00	$ 32,242.00	$ 32,243.00	$ 36,848.00	$ 36,849.00	$ 41,454.00	$ 41,455.00	$ 46,060.00
4	0	$27,750	$27,751	$ 33,300.00	$ 33,301.00	$ 38,850.00	$ 38,851.00	$ 44,400.00	$ 44,401.00	$ 49,950.00	$ 49,951.00	$ 55,500.00
5	0	$32,470	$32,471	$ 38,964.00	$ 38,965.00	$ 45,458.00	$ 45,459.00	$ 51,952.00	$ 51,953.00	$ 58,446.00	$ 58,447.00	$ 64,940.00
6	0	$37,190	$37,191	$ 44,628.00	$ 44,629.00	$ 52,066.00	$ 52,067.00	$ 59,504.00	$ 59,505.00	$ 66,942.00	$ 66,943.00	$ 74,380.00
7	0	$41,910	$41,911	$ 50,292.00	$ 50,293.00	$ 58,674.00	$ 58,675.00	$ 67,056.00	$ 67,057.00	$ 75,438.00	$ 75,439.00	$ 83,820.00
8	0	$46,630	$46,631	$ 55,956.00	$ 55,957.00	$ 65,282.00	$ 65,283.00	$ 74,608.00	$ 74,609.00	$ 83,934.00	$ 83,935.00	$ 93,260.00

Family #	60046 220% of FPG Patient Pays 10%		60047 240% FPG Patient Pays 20%		60048 260% FPG Patient Pays 30%		60049 280% FPG Patient Pays 40%		60050 300% FPG Patient Pays 50%		>300% FPG Patient Pays 100%	
	From	To	From	To	From	To	From	To	From	To	From	To
1	$ 27,181.00	$ 29,898.00	$ 29,899.00	$ 32,616.00	$ 32,617.00	$ 35,334.00	$ 35,335.00	$ 38,052.00	$ 38,053.00	$ 40,770.00	$ 40,771.00	+
2	$ 36,621.00	$ 40,282.00	$ 40,283.00	$ 43,944.00	$ 43,945.00	$ 47,606.00	$ 47,607.00	$ 51,268.00	$ 51,269.00	$ 54,930.00	$ 54,931.00	+
3	$ 46,061.00	$ 50,666.00	$ 50,667.00	$ 55,272.00	$ 55,273.00	$ 59,878.00	$ 59,879.00	$ 64,484.00	$ 64,485.00	$ 69,090.00	$ 69,091.00	+
4	$ 55,501.00	$ 61,050.00	$ 61,051.00	$ 66,600.00	$ 66,601.00	$ 72,150.00	$ 72,151.00	$ 77,700.00	$ 77,701.00	$ 83,250.00	$ 83,251.00	+
5	$ 64,941.00	$ 71,434.00	$ 71,435.00	$ 77,928.00	$ 77,929.00	$ 84,422.00	$ 84,423.00	$ 90,916.00	$ 90,917.00	$ 97,410.00	$ 97,411.00	+
6	$ 74,381.00	$ 81,818.00	$ 81,819.00	$ 89,256.00	$ 89,257.00	$ 96,694.00	$ 96,695.00	$ 104,132.00	$ 104,133.00	$ 111,570.00	$ 111,571.00	+
7	$ 83,821.00	$ 92,202.00	$ 92,203.00	$ 100,584.00	$ 100,585.00	$ 108,966.00	$ 108,967.00	$ 117,348.00	$ 117,349.00	$ 125,730.00	$ 125,731.00	+
8	$ 93,261.00	$ 102,586.00	$ 102,587.00	$ 111,912.00	$ 111,913.00	$ 121,238.00	$ 121,239.00	$ 130,564.00	$ 130,565.00	$ 139,890.00	$ 139,891.00	+

For families with more than 8 persons, add $4,720 for each additional person

1/27/22

Attachment B - Sample Methodology

Program ID: REDESIGN
Paid Dates: 8/1/2007 To 10/13/2021
Report Run Date: 10/12/2021
Provider FYE: 9/30/2021
Provider Number: 471306 Springfield Hospital

Provider Summary Report
Consolidated Summary of All Report Types

Page: 1
Report #: OD44203
Report Type: 1000

SERVICES APPLIED FOR THE PERIODS: 10/01/2020 - 09/30/2021

REPORT TYPE		CHARGES GROSS	GROSS REIMBURSEMENT	DEDUCTIBLES	COINSURANCE	MSP	SEQUESTRATION	REBILLING ADJUSTMENT	ESRD RDCTN/ NTWK PYMTS	MSP OTHER	OTHER ADJUSTMENTS	NET REIMBURSEMENT
INPATIENT REPORTS	110	$ 7,143,920.21	$ 4,096,723.88	$ 490,948.00	$ 6,231.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,599,544.88
TOTAL		$ 7,143,920.21	$ 4,096,723.88	$ 490,948.00	$ 6,231.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,599,544.88
PSYCH INPATIENT	11U	$ 773,556.01	$ 472,591.90	$ 44,520.00	$ 32,706.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 395,365.90
		$ 773,556.01	$ 472,591.90	$ 44,520.00	$ 32,706.00	$ -	$ -	$ -	$ -	$ -	$ -	$ 395,365.90
OUTPATIENT REPORTS												
(excluding MSP-LCC)												
	140	$ 7,600.00	$ 2,072.42	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,072.42
	145	$ 974,337.61	$ 156,627.79	$ -	$ -	$ 17.62	$ -	$ -	$ -	$ -	$ -	$ 156,610.17
	850	$ 24,272,195.58	$ 8,726,615.40	$ 165,456.03	$ 4,069,237.96	$ 1,069.81	$ -	$ -	$ -	$ -	$ -	$ 4,490,851.60
	852	$ 17,146.69	$ 6,172.56	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,172.56
	855	$ 1,934,005.88	$ 594,388.76	$ 28,834.57	$ 83,649.65	$ 11.81	$ -	$ -	$ -	$ -	$ -	$ 481,892.73
TOTAL		$ 27,205,285.76	$ 9,485,876.93	$ 194,290.60	$ 4,152,887.61	$ 1,099.24	$ -	$ -	$ -	$ -	$ -	$ 5,137,599.48
SERVICE PERIOD TOTAL		$ 35,122,761.98	$ 14,055,192.71	$ 729,758.60	$ 4,191,824.61	$ 1,099.24	$ -	$ -	$ -	$ -	$ -	$ 9,132,510.26

AMOUNT GENERALLY BILLED:

GROSS CHARGES $ 35,122,761.98
GROSS REIMBURSEMENT $ 14,055,192.71

AMOUNT GENERALLY BILLED % 40.02%