

JUPITER MEDICAL CENTER

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Policy Statement

Jupiter Health, Inc., / Jupiter Medical Center (“JMC”) is a not-for-profit entity committed to meeting the health care needs of community residents. JMC provides for the medical needs of unfunded or under-funded patients by rendering quality, emergent, and other medically necessary care, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, age, or ability to pay. JMC will not engage in Extraordinary Collection Actions (ECAs) before making reasonable efforts to determine whether an individual is eligible for financial assistance under this policy.

Purpose

The principal beneficiaries of the Financial Assistance Policy are intended to be uninsured and underinsured patients who do not qualify for federal, state, or local government assistance, and who are unable to pay for emergency or other medically necessary care.

Scope

Patient Financial Services.

Definitions

- AGB – percentage calculated using all claims allowed by both private pay insurers (including Medicare Advantage), and Medicare (Traditional) – using the Look-Back Method. The AGB percentage will be recalculated no less frequently than annually in accordance with IRC Section 501(r)(5). See Appendix A.
- FAP – JMC’s Financial Assistance Policy.
- Annual Family Income - The wages and salaries and non-wage income including alimony and child support; social security, unemployment, and workers compensation benefits; and pension, interest, or rental income of the Family.
- FPG –Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services and currently in effect at the time eligibility is determined. See Appendix B.
- Medically Necessary Care – those services reasonable and necessary to diagnose and provide preventive, palliative, curative, or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care generally accepted at the time services are provided.
- Emergency Care – the care or treatment for an Emergency Medical Condition as defined by EMTALA
 - EMTALA – the Emergency Medical Treatment and Active Labor Act (42 U.S.C. 1395dd).
- HCRA – Health Care Responsibility Act.
- JMC – Jupiter Medical Center Inc.
- HCDPBC – Health Care District of Palm Beach County.
- FAMILY – Everyone in the domicile who has a dependent relationship as defined by the Internal Revenue Service.

Policy

I. Overview

- A. JMC's FAP has been established to ensure a fair and equitable system for determining financial need. General guidelines are established, allowing for evaluation of financial circumstances. A patient may be determined eligible for financial assistance (either free or discounted care) when the annual individual or family income does not exceed 400% of FPG as published annually in the Federal Register. Income and assets will be considered in assessing JMC financial assistance but may not be the sole determining factor. Among other elements to be considered are temporary factors such as short-term employment layoff, unemployment, or other demonstrated hardship. An evaluation of available assets will be necessary to determine eligibility for JMC financial assistance. If assets exist to pay the debt, financial assistance may be denied. Size of bill in relation to income and assets may be a qualifying factor in determining financial assistance provided.
- B. Eligible services under this policy are services provided by JMC for emergency or other medically necessary care, per hospital guidelines.
- C. Attached to this policy is a reference to a list of all providers, in addition to JMC itself, delivering emergency or other medically necessary care in the hospital that specifies which providers are covered by this FAP and which are not. See Appendix C. Appendix C will be reviewed and updated no less frequently than quarterly and will clearly identify providers covered and not covered by this policy.

II. COMMITMENT TO PROVIDE EMERGENCY MEDICAL CARE

JMC provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. JMC will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions, or by permitting debt collection activities to interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all JMC patients in a non-discriminatory manner, pursuant to JMC's EMTALA policy.

III. Eligibility Criteria for Financial Assistance

- A. To qualify for financial assistance at JMC, the patient must not be eligible for Medicaid, HCDPBC Coordinated Care, HCRA, Victims' Compensation, or any other government funding programs, per episode of care. Proof of ineligibility for applicable programs must be provided as part of the application's supporting documentation.
- B. All applicants must participate in hospital evaluation of eligibility when applicable for Medicaid, Health Insurance Exchange plans and other programs that might be available to them prior to becoming eligible for financial assistance at JMC.
- C. To determine the write off applicable to the patient's bill, his/her total annual household income will be compared to the most current FPG:

<u>Income Level</u>	<u>Adjustment, Allowance, or Discount* Amount</u>
Less the 200% of FPG	100% Discount
200% to 400% of FPG	80% Discount
Greater than 400% of FPG	Patient to pay balance

* Discount from gross charges.

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- D. Total annual household income less than or equal to 200% of the FPG guidelines will entitle the patient to a 100% discount.
- E. Total annual household income over 200% but not greater than 400% of the FPG will entitle the patient to an 80% discount.
- F. Regardless of the applicable write off determined above, the patient's responsibility will not exceed 25% of his/her total annual household income.
- G. Total household income is the sum of the gross annual income of all persons in the family.
- H. Assets are defined as funds on deposit in savings, checking, money market accounts, or investment accounts; cash surrender value of life insurance policies; equity ownership in a homestead property of \$150,000 or greater; and equity in any non-homestead property.
- I. All patients seeking income-based financial assistance at any time in the scheduling or billing process may complete the Financial Assistance Application and will be asked to provide information on Annual Family Income. The Financial Assistance Application may be found in our Emergency department and Admissions area. A Financial Counselor would also be available to assist with application process, or to discuss payment plan options.
- J. Patients who would otherwise qualify for financial assistance under this FAP, but who, within the discretion of JMC, have sufficient assets available to pay for care, or sufficient insurance coverage or other third-party payments available to cover the care, will be reviewed by JMC on a case-by-case basis and may be deemed ineligible for JMC financial assistance.

IV. Presumptive Eligibility

- A. If JMC determines through third party verification databases that a patient has Annual Family Income at or under 200% of the FPG, that patient will be deemed eligible for financial assistance without further information or documentation at scheduling or prior to admission. No application is required for approved presumptive cases. Presumptive adjustments are documented in the patient accounting system. Patients that are awarded presumptive eligibility will receive a approval letter.
 - 1. External billing and collection agencies.
 - 2. Credit bureaus.
 - 3. Propensity-to-pay scoring model.
 - 4. FICO score information.
- B. Presumptive eligibility may be determined based on individual circumstances that may include:
 - 1. State-funded prescription programs.
 - 2. Homeless or received care from a homeless clinic or shelter.
 - 3. Participation in Women, Infants and Children Programs.
 - 4. Food Stamp eligibility.
 - 5. Subsidized school lunch program eligibility.
 - 6. Eligibility for other state or local assistance programs that are unfunded (Medicaid share of cost).
 - 7. Low income/subsidized housing as a provided valid address.
 - 8. Patients are deceased with no known estate.
 - 9. Patient discharged to a SNF;
 - 10. Patient's income is below 200% Federal Poverty Guidelines and considered self-pay
 - 11. Patients that are referred through a National Association of Free Clinics

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12. Medicaid Eligible Patients, when the following criteria applies:
 - Medicaid eligibility requirements are met after the service is provided
 - Non-covered charges occur on a Medicaid eligible encounter; and
 - The provider is not credentialed or contracted
 - Low income/subsidized housing is provided as a valid address
13. Individuals determined by JMC to be eligible for financial assistance under these presumptive eligibility provisions will receive a 100% discount on eligible services.

V. Proof of Income and Residency

- A. The Financial Counselor responsible for evaluating the patient's eligibility will gather supporting documentation for household income, expense, and residency. Acceptable documentation includes any of the following:
 1. Current driver's license.
 2. Social Security Card.
 3. Letter from employer stating income and length of employment - must be written on company letterhead.
 4. Financial institution or bank statements.
 5. W-2 or 1099 from previous calendar year.
 6. Paycheck stubs or 1099s from current year.
 7. IRS tax return from the most recent calendar year.
 8. Tax appraisal form for homestead property-most recent year.
 9. Forms approving/denying unemployment.
 10. Written verification from public/governmental agencies that can attest to the patient's income during the past 12 months.
 11. Food stamp referral.
 12. Medicaid remittance confirming Medicaid exhausted benefits.
 13. Written attestation from patient of income and address.
 14. Documentation confirming patient's debts and assets.
 15. Proof of address (utility bill, gas, electric, phone).
 16. Proof of ineligibility for government assistance programs.
- B. If verification of income is not available, the Financial Counselor will document facts supporting the need for assistance.
- C. The application must be signed by the patient, guarantor, or representative before being processed by the Financial Counselor, considering the presumptive eligibility requirements.

VI. Procedure for Applying for Financial Assistance

- A. Financial assistance eligibility is evaluated by a Financial Counselor and based on assets and gross family income.
- B. Financial assistance is available only after all other possible and or available payer resources have been exhausted, i.e., Medicaid, HCDPBC.
- C. A Financial Assistance Application will be offered to unfunded or under-funded patients who receive qualifying emergency or other medically necessary care at JMC.
- D. A determination of the applicant's eligibility is made within 30 days of the application assessment and approval.

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- E. A Financial Counselor will be available to help the patient complete the FAP application, and if patient may qualify, will ask patient to apply for government assistance (Medicaid, HCDPBC, etc.)
- F. Catastrophic expenses fall under the FAP if patient responsibility of uncompensated charges exceed 25% of the total annual family income and or assets. A review of the patient's financial position will be done to determine eligibility under this provision.
- G. Accounts may also be deemed eligible and referred for financial assistance by external collection agencies and or attorneys.
- H. Asset and credit investigation may be done on all charity adjustments.
- I. A financial assistance request for \$10,000.00 and above requires (but is not limited to) the most current Federal Tax Return and the most current financial institution and bank statements be provided. If the patient does not have one or both, the following can be used for verification of income or assets: paycheck stub, letter from employer, statement of monthly benefits for social security, or letter of support.
- J. If the patient does not provide the required information, or cooperate in the application process, the patient may not be entitled to financial assistance.
- K. JMC will not deny financial assistance under the FAP based on an applicant's failure to provide information or documentation that JMC's FAP or FAP application form does not require an individual to submit as part of a FAP application.

VII. Approval Process

- A. The Financial Counselor will determine a patient's eligibility for financial assistance within 30 days of the date the application is received by the hospital, meaning that all required information and supporting documentation has been provided to the Financial Counselor and the application has been signed by on behalf of the patient.
- B. The Financial Counselor will complete and submit a Financial Assistance Approval Form to the Patient Financial Services Financial Assistance Committee for review, approval, additional needed information, denial and or signature.
Approval and Signature Authority for FAP:
 - Less than \$5,000 – Auto Approval
 - Greater than \$5,000 less than \$25,000 – Supervisor
 - Greater than \$25,000 less than \$50,000 – Manager
 - Greater than \$50,000 – Director or above
- C. Upon approval of a Financial Assistance Application, the Financial Counselor will submit the adjustment to a Patient Financial Services Manager or designee for entry into the patient accounting system. All supporting documentation will be scanned into the document imaging system and kept on file for seven years. Requests for Financial Assistance may be made at any point before, during, or after the provision of care, but preferably no later than 240 days after the receipt of the first post-discharge billing statement related to such care. The applications are valid for 365 days from the date a completed application (signed application and all necessary verifications) is received. Eligibility may change if, during the period, the patient's financial condition or insurance status changes. A new application and documentation must be submitted at the end of the 365-day eligibility period if financial assistance is needed for services received after the eligibility period.

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The Financial Counselor will document the disposition of the patient's Financial Assistance Application in the patient accounting system. The patient will be notified by letter of the eligibility determination. Patients who qualify for less than 100% financial assistance (other than those who are deemed presumptively eligible who receive a 100% discount on eligible services) will receive an estimate of the amount due and will be requested to set up payment arrangements. Financial assistance approval will apply to all current open account balances due from the patient. This may not be a standing approval for future visits. Future visits will require the patient and/or guarantor to be re-evaluated. Applications for assistance are available from JMC Financial Counselors between 8:00 a.m. and 4:30 p.m. (Monday through Friday) and/or with Customer Service, and Collection

Representatives in Patient Financial Services. Individuals may also obtain an application by calling the Patient Financial Services Department at 561-263-4440, or online at www.jupitermed.com/financialassistance. Services eligible for financial assistance are emergency or other medically necessary inpatient and outpatient services.

VIII. Basis for Calculating Amounts Charged to Patients

- A. Following a determination of eligibility under this FAP, a patient eligible for financial assistance will not be charged more for emergency or other medically necessary care than the AGB to patients who have insurance covering such care. JMC uses the Look-Back Method to determine AGB.
- B. See Appendix A. for the Basis of Calculating Amounts charged to patients as set forth in Internal Revenue Code Section 501(r)(5) and accompanying Treasury Regulations.

IX. Actions Taken in Event of Nonpayment

- A. The actions that JMC may take in the event of nonpayment are described in a separate Billing and Collection Policy.
- B. Members of the public may obtain a free copy of this separate policy from the JMC Customer Service Department by visiting or sending a written request to 1701 Military Trail, Suite 160B, Jupiter, FL 33458, by calling 561-263-4440, or click on the link below: Patient Billing and Collections Policy under Related Documents.

X. Measures to Widely Publicize the Financial Assistance Policy

JMC implements various measures to widely publicize this FAP in communities served:

- Posting FAP, Application, and Plain Language Summary on the public website
- Availability in Emergency Department
- Availability in Registration areas
- Inclusion of FAP notices on billing statements
- Availability by mail upon request
- Translation into languages meeting 501(r) thresholds
- Staff education regarding FAP availability

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Related Documents

[Patient Billing and Collections Policy](#)

[Plain Language Summary of the Financial Assistance Policy - Form](#)

[Appendix A - Basis for Calculating Amounts Charged to Patients - Financial Assistance Policy](#)

[Appendix B – Federal Poverty Guidelines 2026](#)

[Appendix C - List of JMC Providers and Applicability of Financial Assistance Policy](#)

References

- 1) Section 501(r) of the Internal Revenue Code of 1986, as amended, and the Final Treasury Regulations issued thereunder dated December 2014.
- 2) The Patient Protection and Affordable Care Act, Public Law 111-148, Section 9007(a) (creating new Section 501(r) of the Internal Revenue Code).

Approved by: Allison Viramontes

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