Policy Number:	CS-8211-02
Policy Title:	Regional Health Financial Assistance Policy
Applies To:	Regional Health
Department:	CS Patient Financial Services
Effective Date:	July 2016
Review/Revision Date(s):	January 2017 November 2016 September 2016
Supersedes:	Regional Health Financial Assistance Policy (CS-8211-02)
Referenced Policy(ies):	
Attachment(s):	
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POLICY STATEMENT

Regional Health is a not for profit organization that is committed to providing compassionate, high quality, affordable healthcare services to the communities we serve. As part of this mission, Regional Health recognizes our obligation to provide medical care to all persons in need, regardless of their ability to pay. The Regional Health Financial Assistance Program provides assistance to patients with a self-pay balance resulting from Episodic Care. This policy provides information as to the covered services. Financial assistance may consist of full or partial write off.

This policy sets forth the standards and guidelines by which Regional Health determines eligibility for the Financial Assistance Program. Persons who reside within the Regional Health defined service area that have healthcare needs and are ineligible for a government program, or otherwise unable to pay for **emergent or other medically necessary care,** may be eligible for assistance. Elective services which are **not** medically necessary are **not** eligible for the Financial Assistance Program.

Attachments to the policy:

A – List of Exclusions
B – Definitions
C – Family Medicine Residency
D – Charitable and 501 c3 Referrals

Please refer to regionalhealth.com for the following information:

- List of Providers
- Financial Assistance Program Application
- Income and Debt Reduction Matrix
- Financial Assistance Program Plain language summary

GUIDELINES

Financial Assistance Program Notification for Hospital Services:

I. Patient Access Process
   A. Financial Assistance Program brochures explaining the policy, a copy of the policy and Financial Assistance applications will be available at each point of entry.

   B. Signs alerting patients to the availability of Financial Assistance will be prominently displayed.

   C. A plain language summary describing the Financial Assistance program will accompany one billing statement for hospital services sent to the patient.

   D. The Financial Assistance policy, plain language summary and Financial Assistance application will be provided free upon request and are also available on the hospital website, www.regionalhealth.com.

II. Application process
   A. Patients and/or financially responsible family members may complete the Financial Assistance application prior to a service or after the service has been provided.
      i. Applications and all of the requested supporting documentation should be mailed to PO Box 3450, Rapid City, SD 57709, or the application may be dropped off at any of the Regional Health care sites.

   B. Reasonable effort will be taken in determining whether an individual is eligible for the Financial Assistance program.
      i. Payment source and patient's ability to pay will be evaluated upon admission/registration with consideration to EMTALA (Emergency Medical Treatment and Labor Act) obligations.
      ii. Government Assistance: In determining whether an individual qualifies for Financial Assistance, other county or governmental assistance programs should be considered first.
         1. Regional health provides and contracts with third party patient advocates (fund finders) to help individuals determine eligibility for governmental or other assistance as appropriate.
      iii. Patients will be required to apply for and exhaust payment sources for which they are or may be eligible, including coverage through any Third Party Payer, Medicare, Medicaid or similar Federal or state health insurance program, before qualifying for the Charity Care Program. Patient Financial Services staff will assist patients or financially responsible parties to make payment arrangements if no assistance is available, (i.e. federal, state, local, or private) or they are ineligible for Regional Health's Charity Care program.

   C. Reasonable effort will be made to notify a patient of the Financial Assistance Program, including a notification that the application period ends 120 days from the date the facility issues the first billing statement to the patient. During this notification period, Regional Health will:

i. Distribute a plain language summary and offer a Financial Assistance application prior to discharge.

ii. Distribute a plain language summary with one billing statement. Provide patients with at least one written notice describing the extraordinary collection actions that could be initiated if the patient fails to complete the Financial Assistance application or pay the amount due by a specified deadline, which is at least 30 days after the written notice is provided, but not prior to the end of the 120 day notification period. The extraordinary collection actions that may be taken are described in Regional Health's collection policy, CS-8211-19. A free copy of this policy can be obtained by accessing Regional Health's website at www.regionalhealth.com or by contacting Patient Financial Services.

D. In addition to the notification period, reasonable effort will also include an application period of an additional 120 days, during which a patient may still complete a Financial Assistance application. The combined notification and application period is a total of 240 days from the date of the first billing statement. During the application period, Regional Health may pursue extraordinary collection actions, however, if Regional Health receives a FAP application during the application period, extraordinary collection actions will be suspended until it is determined whether the patient is eligible for the Financial Assistance program. In the event an incomplete Financial Assistance application is turned in during this period, the patient will be provided with information to aid in completing the application and/or the documentation required to complete the Financial Assistance application review, including a plain language summary of the Financial Assistance Policy. The patient will be provided with written notice advising extraordinary collection actions will resume if the application remains incomplete by the specified completion deadline, which is at least 30 days after the written notice is given.

E. If the patient does not return the Financial Assistance application during the notification period or by the deadline specified in the written notice, extraordinary collection actions may resume.

F. Applications will not be accepted for services exceeding 240 days from the date of the 1st statement.

III. Qualification Criteria and Processing Guidelines:

A. Financial Assistance determination process (Charity Care):

i. Regional Health will adhere to an established methodology to determine eligibility for the Financial Assistance Program. The methodology shall consider whether health care services meet Emergent definitions or other medically necessity criteria, as well as income, net assets, family size and resources, available to pay for care.

ii. Information from the applicant's financial application (See Form #20-8261-0022-0506, Financial Assistance Application on RCRH's internet site) and supporting documentation will be applied to the income matrix, as available on the Regional Health website, to determine the amount of qualified financial assistance to be granted.

1. Verification may include the applicant's most current federal tax return and/or three (3) months current pay stub, as well as the applicant's net worth and/or assets.

iii. Financial assistance debt reduction write-offs will be based on an income matrix, as available on the Regional Health website, utilizing the current Federal Poverty Level (FPL) income guidelines. The income matrix shall be updated annually as the FPL guidelines are released. A patient's liquid assets will be taken into account for eligibility and treated as income when determining eligibility.

iv. In compliance with the Internal Revenue Code 501(r) the amount charged for emergency or other medically necessary care that is provided to individuals eligible for assistance under the Financial Assistance Program, will be determined utilizing the prospective Medicare method, with the amount generally billed (AGB) being equal to the sum of the expected payments from Medicare and the Medicare beneficiary. This calculation will be figured for each type of service. Information regarding how the AGB is calculated may be obtained by contacting Patient Financial Services.

v. Eligible patients will not be charged more than the AGB for the covered services.

B. Notification of Financial Assistance Eligibility and Coverage Period for patients determined to be eligible for FAP :

i. The patient will be provided with notification showing the amount due, if any, an explanation of how the facility determined the amount the patient owes as a FAP eligible individual and an explanation of the method used to determine the amount generally billed (AGB) for the care provided.

ii. The facility will refund the patient any personal payment made in excess of the amount owed as a FAP eligible individual.

iii. The facility will take reasonable measures to reverse any extraordinary collection activities.

iv. Eligibility is determined and approved for each episode of care.

C. Patients/Guarantors who experience sudden loss of income may qualify for the Financial Assistance Program based upon three (3) months' pay stubs and/or documentation from sources such as Social Services, The Midland Group, etc. confirming the claim of Loss of Income.

D. Circumstances that may disqualify a patient for Financial Assistance are:

i. Fraud (providing false information on the Financial Assistance Application).

ii. Patient or legal representative/guarantor unresponsive to requests for information.

iii. Refusal to fully complete the Financial Assistance Application

iv. Refusal to provide the required documentation of income and assets

v. Sufficient income

vi. Withholding insurance payment and/or insurance settlement funds

vii. Failure to complete screening applications for Medicaid and County Poor Relief

viii. Failure to participate and cooperate with fund finders.

E. Presumptive Charity: Patients/Guarantors maybe approved for Financial Assistance by use of an oral application, without completion of a written application or without their knowledge. Presumptive Charity is used when RH personnel believe with a high degree of certainty the patient/guarantor does not have the ability to pay for the services provided. Presumptive Charity can occur in the following manner:

i. Patients with a history of bad debts closed and returned as inability to pay by our 3rd party collection agencies.

ii. Patients whose socio-economic data clearly indicates an inability to pay.

A. Reside at a homeless shelter

B. Deceased and no estate is located

C. Health condition of patient, age of patient employment status, size of debt and marital status combined to present a high likelihood of inability to pay
D. Other circumstances which a reasonable person would conclude the debt for services will not be paid.
E. Experian Scoring tool
F. Prior FAP approval

IV. Other Financial Assistance Program considerations:

Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate Regional Health to provide continuing care unless as may be otherwise required by federal or state law or regulation.

Factors Not Considered:
The following factors will not be considered when making a recommendation for financial assistance and/or in granting of assistance: Bad Debt, as defined in attachment B, contractual allowances, perceived underpayments for operations, cases paid through a charitable contribution, community service or outreach programs, or employment status. In other words, these monetary sources have no bearing on the patient's eligibility.

Equal Opportunity:
When making decisions on financial assistance, Regional Health is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service or any other classifications protected by federal, state or local laws.

Entities Not Covered Under the Financial Assistance Program Policy:
Long Term Care, Assisted Living Center, HME/DME (exclusive of Respiratory therapy supplies), and any other service not typically provided by the traditional acute care hospital are not eligible for inclusion in the Financial Assistance Program.

Hospice House:
Patients seeking admission to the Hospice House as either a General Inpatient or Resident status may be eligible for Financial Assistance. The services provided by the Hospice House shall be considered non-emergent, therefore, may be excluded from Financial Assistance eligibility. The Director of the Hospice House and the Director of Revenue Cycle shall review all applications for assistance prior to admission into the Hospice House.

Other considerations
The Chief Financial Officer of Regional Health may approve Financial Assistance reductions for patients who do not meet the specific requirements set forth in this policy.

FINANCIAL ASSISTANCE PROGRAM EXCLUSIONS – ATTACHMENT A

Abortion. Charges for abortion procedures, unless **medically necessary** due to rape, incest or when the mother's life is endangered if carried to term. Complications from a non-covered abortion are covered.

Acupuncture and Acupressure. Shiatsu, electrical stimulation to the periosteum, chelation therapy, immunoaugmentive therapy (IAT), thermography, joint reconstruction therapy, joint sclerotherapy, prototherapy, or ligamentous injections with sclerosing agents, Osteopathic manipulative treatment, spinal manipulative treatment and kebiozen.

Alcohol. Charges incurred as a result of **illness** or **injury** that occurred as a result of a **covered individual's** illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for an injured **covered individual** other than the person illegally using alcohol. Expenses will be covered for Substance Abuse treatment as specified in this plan. This exclusion does not apply if the **injury** resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Amniocentesis. Amniocentesis to determine the gender of the newborn or in the absence of known risk factors including but not limited to, maternal age, previous child with chromosomal disorder, or family history or other documented risk of a detectable, single gene disorder.

Biofeedback. Charges related to biofeedback training.

Convenience Items. Convenience items such as telephones, televisions, guest meals, guest beds, haircuts, manicures, etc.

Cosmetic Procedures. Cosmetic procedures are not covered unless necessary for one or more of the following reasons:

- To improve the function of a part of the body, or
- As the result of an **injury** or **illness** and performed within one year of the **illness** or **injury**, unless there is a medical reason to delay the repair, or
- Due to post-mastectomy breast reconstruction, or
- To treat a **congenital defect** and performed within one year, unless there is a medical reason to delay the repair, or
- For scar revision as a result of **illness** or **injury** and performed within one year of the **illness** or **injury**, unless there is a medical reason to delay the repair.

Custodial care. Charges/confinements for custodial care (services which primarily help and individual perform daily living activities), unless specifically provided.

Dental treatment. Routine dental treatment, unless medically necessary due to a serious medical condition or an accidental injury.

Dietary Supplements. Charges for oral dietary supplements that contain a dietary ingredient intended to supplement the diet.

Educational Training/Testing. Educational testing and training, except as otherwise provided or when **medically necessary**.

Environmental Control Equipment. This plan does not pay benefits for equipment such as air conditioners, air filters, humidifiers, vaporizers, etc.

Experimental/Investigational. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

Felony. Charges incurred as a result of committing, or attempting to commit, an assault or felony, unless the **illness** or **injury** is a result of a physical or mental condition.

Fertility Expenses. Treatment, counseling or any procedure to correct **infertility** or to bring about or enhance the probability of conception.

Foot care. Charges for foot care, including treatment (other than **surgery**) of corns, bunions, toenails, calluses, flat feet, fallen arches, weak feet and chronic foot strain when performed in the absence of a localized illness, injury or symptoms involving the foot.

Hair Analysis. Charges for hair analysis

Health Club Membership. Membership costs included, but not limited to health clubs and weight loss programs, except as otherwise provided.

Hearing Expenses. Charges for:

- Hearing aids, devices, implants, cochlear implants, unless loss of hearing was due to an accidental **injury** or **illness** or congenital permanent childhood hearing impairment.
- Treatment for degenerative hearing loss
- Earwax removal, unless medically necessary
- Routine hearing testing, unless the testing is specifically provided under the **required preventive care** benefit.

Home Testing. Charges for home testing kits.

Homemaker Services. Charges for homemaker or housekeeping services.

Homeopathic Care. Herbal medicines, holistic or homeopathic care, including drugs.

Hospice. Charges for bereavement counseling, funeral arrangements, pastoral counseling, financial/legal counseling, sitter or companion services, maintenance of the house or voluntary services.

Hypnotherapy. This plan does not pay benefits for hypnotherapy.

Illegal Activity. Charges incurred as a result of **illness** or **injury** occurring directly or indirectly, as a result of a Serious Illegal Act or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the **illness** or **injury** resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Illegal Drugs or Medications. Charges incurred as a result of **illness** or **injury** occurring from a **covered individual's** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a **physician**. Expenses will be covered for injured **covered individuals** other than the person using controlled substances. Expenses will be covered for substance abuse treatment as specified in this plan. This exclusion does not apply if the **injury** resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Injections. Charges for:

- Vitamin injections, unless the injections are for a diagnosed medical condition or when substitution with over-the-counter medication would endanger the patient's well being.
- Travel or employment purposes.

In-Vitro. Artificial insemination, in-vitro fertilization and embryo transfer.

Marital Counseling.

Massage Therapy. Services from a masseur, physical culturist, physical education instructor, or health club attendant.

Medical Equipment. Rental charges that exceed the purchase price of the equipment.

Medical Supplies. Charges for exercise equipment, blood pressure kits, diet scales, cotton balls, adhesive tape, etc.

Medical Treatment outside the United States or Canada. Expenses incurred for medical expenses if the **covered individual** traveled outside the United States or Canada for the sole purpose of receiving medical treatment.

Military Services. Treatment or services resulting from or prolonged as a result of performing a duty as a member of the military service of any state or country.

Not Required to Pay. Charges that you would not be required to pay if you did not have group health coverage.

Occupational Therapy – Outpatient. Supplies used in occupational therapy.

Orthodontic Appliances. Expenses for dental guards, orthodontic braces and similar appliances.

Paternity. Charges for paternity testing.

Physical Exams and Other Expenses for Marriage, Employment, Licensing or Regulatory Purpose. Physical exams and other expenses for pre-employment, premarital, or any examinations required by licensing, regulatory or other such purpose.

Pregnancy Related Expenses. Pregnancy related expenses for the following:

- Confinement of the mother in excess of the normal recovery period, due solely to a medical condition affecting the baby.
- Confinement of the baby in excess of the normal recovery period, due solely to a medical condition affecting the mother.
- Fetal **surgery** and related charges.

Private Duty Nursing. Charges for nursing:

- Services rendered at home, unless it is part of home health care program.
- Care on a 24-hour shift basis is not covered.

Recreational, Music, and Remedial Reading Therapy.

Sexual Conversion. Surgical and other related medical charges associated with sexual conversion, gender reassignment, or disturbance of gender identification.

Sexual Dysfunction. Expenses relating to the care and treatment of sexual dysfunction.

Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

Skilled Nursing Facility. Confinements for custodial care.

Standby Physician. Charges for a standby **physician**, except when required because of a **hospital** policy or state law or ordered by the delivering **physician** or surgeon.

Sterilization of a Dependent Male Child. Sterilization of a male **dependent** child.

Sterilization Reversal. Sterilization reversal and all related charges.

Surrogacy. Any service associated with any type of surrogacy agreement or arrangement, including traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement or gestational or in-vitro fertilization surrogacy.

Thermography. Charges for thermography, thermogram, or thermoscribe.

Travel. Any type of travel whether or not recommended by a **physician**, except in connection with covered ambulance and transplants.

Travel and Transportation. The plan does not pay benefits for anything other than professional ambulance transportation charges, such as:

- Travel charges for regularly scheduled plane or train transportation,
- Transportation for the convenience of the patient, and
- Transportation by other than a professional ambulance service.

Vision. Charges for

- Routine eye exams
- Eyeglasses and contact lenses
- Testing to determine errors in refraction, unless due to an **injury** or following a covered **surgery**.
- Radial keratotomy, LASIK, refractive keratoplasty or similar procedures.

Wage or profit. Expenses relating to an illness or injury when the covered individual receives a profit or wage (other than employer based disability payments), such as surrogate pregnancy.

War. Services for an Illness or Injury incurred by a patient who sustains that Illness or Injury while participating in war, whether declared or undeclared, civil war, insurrection, rebellion, or revolution, or to any act or condition incident to any of the foregoing.

Worker's Compensation. Services rendered for treatment of any **injury** or **illness** that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the **covered individual** waives or fails to assert his/her right under the Laws or expenses resulting from wage or profit. One example of this is if the individual is self-employed and experiences an **injury** or **illness**, which arises out of or in the course of that employment, the charges will not be covered by the plan if the self-employed individual elected not to participate in a Worker's Compensation program, as consistent with any applicable State or Federal law.

Plan's Right To Request A Physical Examination

This plan, at its own expense, will have the right and opportunity to have an individual whose medical or dental treatment is the basis of a claim under this plan, examined by a physician designated by this plan as often as it may be reasonably required, during the review of a claim under this plan.

FINANCIAL ASSISTANCE PROGRAM DEFINITIONS – ATTACHMENT B

Amounts Generally Billed (AGB): The amount generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with Section 1.501(r) – 5(b). The Prospective Medicare Method is used to determine AGB

Amounts Returned by Collection Agencies: After a certain time period as elapsed, the collection agency will return any accounts deemed to be uncollectable. Their returned accounts should be written off as Financial Assistance provided the professional agency has determined that the patient is unable to pay the bill.

Application Period: The period during which a hospital facility must accept and process an application for assistance under its financial assistance policy (FAP) submitted by an individual in order to have made reasonable efforts to determine whether the individual is FAP-eligible. With respect to any care provided by a hospital facility to an individual, the application period begins on the date the care is provided to the individual and ends on the 240th day after the hospital facility provides the individual with the first billing statement for the care.

Bad Debt: Gross charges incurred in providing services to patients who were determined to have the ability to pay for such services, but eventually do not. This determination can be made upon admission or any time subsequent thereto.

Bankruptcy: Outstanding accounts for a person, who declares bankruptcy, should be written off as Financial Assistance.

Deceased With No Estate: Outstanding accounts for person, who expires with no estate, should be written off as Financial Assistance. If partial payment from the estate is received, the remainder of the bill should be considered Financial Assistance.

Episode of Care: Course of treatment prescribed by a Physician or Ancillary Provider delivered over a finite period of time.

Extraordinary Collection Action (ECA): As described in Section 501(r)(6) of the Internal Revenue Code, it is an action that requires a legal or judicial process or involves selling an individual's debt to another party or reporting adverse information to a credit reporting agency or credit bureau. Examples of ECAs include, but are not limited to, placing a lien on an individual's property, foreclosing on an individual's real property, attaching or seizing an individual's bank account or any other personal property, commencing a civil action against an individual, causing an individual's arrest or causing an individual to be subject to a writ of body attachment.

Financial Assistance (Charity Care): AGB incurred in providing services to patients who *were* determined *not* to have the ability to pay for such services for which Regional Health ultimately does not expect payment. This determination can be made upon admission or any time subsequent thereto.

Hospital Setting: Services and supplies provided at or on the campus of any Regional Hospital and billed under the name of the hospital.

Income: Cash equivalent received/earned by household.

Liquid Assets: Resources/Possessions other than income. To include but not limited to savings, checking, and investment assets readily convertible to cash.

Medically Necessary: Medically necessary care and services include procedures and treatments necessary to diagnose and provide curative or palliative treatment for physical or mental conditions, ordered by a qualified health care professional, in accordance with professionally recognized standards of health care. The term "medically necessary" does **not** include the list of exclusions found on Attachment A. For purposes of this policy, Regional Health reserves the right to determine, on a case-by-case basis, whether the care and services meet the definition and standard of "medically necessary" for the purpose of eligibility for financial assistance. For patients seeking non-emergent services to be covered by the Financial Assistance policy, Patient Financial Services will screen the service prior to scheduling it to determine whether the service is medically necessary and notify the patient of its determination.

Miscellaneous Write-Offs: Gross charges incurred in providing services to patients who it was determined had the ability to pay but, based upon litigation's, disputes, etc., an administrative decision was made not to require payment.

MPPR- Medicare Participating Provider Rate

Notification Period: The period during which a hospital facility must notify an individual about its FAP in accordance with Section 501(r)-6(c)(2) in order to have made reasonable efforts to determine whether the individual is FAP eligible. With respect to any care provided by a hospital facility to an individual, the notification period ends on the 120th day after the facility provides the individual with the first billing statement for the care.

Plain Language Summary: A written statement that provides information to the individual about the Financial Assistance Policy in a clear, concise and easy to understand format.

Presumptive Charity: In lieu of a completed application, Financial Assistance may be approved based upon the information gather from the patient's history and current socio-economic data.

Service Area: The service area of the hospital for the purpose of this policy is considered to be a geographical area extending 200 miles in any direction from the Regional Health facilities.

Third Party Payer: Any commercial insurance, health benefit plan, employer-sponsored program, health maintenance organization or similar arrangement that is or may be legally liable for payment of charges incurred for medical services is referred to in this policy as a Third Party Payer. Third Party Payers for purposes of this policy do not include Medicare, Medicaid or similar Federal or state health insurance programs.

FAMILY MEDICINE RESIDENCY – ATTACHMENT C

Regional Health Charity Care Policy will cover to all services performed at Family Medicine Residency including, but not limited to, services performed by dietitians, endocrinologists and clinical psychologists (residents or physician faculty).

Any items purchased by Family Medicine Residency, such as devices for birth control (IUD, Nexplanon, etc.) and injectable medications, will be excluded from Regional Health's Charity Care policy.

Charitable and 501 c3 REFERRALS – ATTACHMENT D

Professional Fee office visits which do not meet criteria as defined in the general Financial Assistance Policy will be covered under the Financial Assistance Policy if the referral is from groups such as Good Shepard Clinic located in Spearfish, South Dakota.

Professional Fee office visits which do not meet criteria as defined in the general Financial Assistance Policy will be covered under the Financial Assistance Policy when the patient is referred by the Community Health Center of the Black Hills in accordance to the following:

1) Regional Health will use the fee schedule structure from the Community Health Center of the Black Hills.
2) Regional Health must obtain a fax/email notification of the referral to a Regional Health provider.
3) Only those services identified in the fax/email will be covered by Attachment D.
4) A copy of the fee schedule is available on the Regional Health Uninsured Discount Policy CS-8211-03

Other charitable and 501 c 3 organizations seeking to have services provided by Regional Health covered under this section must seek approval from the Chief Financial Officer, Regional Health.

RESOURCES *(The Resources used during the creation of the policy)*

A. Not Applicable

REFERENCES *(The References used during the creation of the policy)*

A. Not Applicable

REGULATIONS / STANDARDS

A. Not Applicable