Hamilton-Madison House, Inc. Compliance Program Policies and Procedures	
SUBJECT: Waiving/Reducing Coinsurance, Copayment and Deductible Amounts	
APPROVED BY: Lilya Berns	**EFFECTIVE: November 20, 2024**
REVISED:	**PAGE 1 OF 4**

I. POLICY

Hamilton-Madison House, Inc. (the "Agency") strives to provide the highest quality services to all of its patients, consistent with ethical standards, and in accordance with all applicable laws. From time-to-time, the Agency may consider waiving, in whole or in part, our patients' coinsurance, copayment or deductible obligations in connection with the services we provide. However, there are certain legal considerations that govern when it may be appropriate to do so. Accordingly, all waivers/reductions of coinsurance, copayment or deductible obligations will be offered/given only in accordance with this Policy.

There are a variety of laws that govern the Agency's interactions with Federal health care program beneficiaries.[1] Contractual obligations to private insurers, as well as other laws, may also affect the Agency's ability to waive or reduce coinsurance, copayment or deductible obligations of privately insured patients. In order to comply with those laws and contractual obligations, it is the Agency's policy that waivers/reductions of coinsurance, copayment or deductible amounts may be offered to patients only when all of the following conditions are met:

- **No Advertising/Soliciting.** The waiver or reduction is not offered as part of any advertisement or solicitation by the Agency or any of its Personnel; and

- **May Not Be Routinely Offered.** The waiver or reduction is not routinely offered (that is, waivers/reductions may not be the Agency's general business policy and may only be offered occasionally); and

- **Good Faith Determination of Financial Need or Reasonable Collection Efforts Required.** The Agency waives or reduces the coinsurance, copayment or deductible **only** after (a) we have made a good faith and documented determination that the individual is indigent or in financial need; **or** (b) we fail to collect the coinsurance, copayment or deductible amounts after making reasonable collection efforts (that is, after such efforts, the Agency exercises its business judgment not to pursue the full legal remedies available to it to collect the amount(s) it is owed).

[1] For purposes of this Policy, "Federal health care program" means any plan or program that provides health benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part by the United States Government and includes certain State health care programs. Examples include, but are not limited to: Medicare, Medicaid, Veterans' programs and the State Children's Health Insurance Programs. The Federal Employees Health Benefits Program is not included in this definition.

II. PROCEDURE

A. If a patient requests that a co-insurance or deductible amount be waived, the patient must complete the Agency's Financial Aid Request Form (attached to this Policy as Appendix A), explain the nature and extent of the financial hardship, and provide the Agency with written documentation of his or her financial need. The Agency will maintain such documentation of patient financial need in an easily accessible central location.

B. If appropriate documentation is not obtained, the patient must be billed pursuant to the Agency's normal procedures. Coinsurance, copayment or deductible amounts will then be written off only if our normal procedures have failed to result in collection of those amounts.

C. All requests for waivers of coinsurance, copayment and deductible amounts will be determined on an individual basis and must be pre-approved by the Compliance Officer, or his or her designee.

III. FAILURE TO FOLLOW THIS POLICY AND PROCEDURE

A failure to follow this Policy and Procedure may result in disciplinary action in accordance with the terms of our Compliance Program.

Any questions concerning compliance with this Policy must be directed to the Agency's Compliance Officer.

APPENDIX A
HAMILTON-MADISON HOUSE, INC.

Financial Need Form

Patient Information	**Responsible Party** ***(if different than patient)***
Patient Name: _____	Name: _____
Address: _____	Address:_____
City/State/Zip: _____	City/State/Zip: _____

Do you currently have insurance coverage? _____ If yes, please indicate the type:

- □ Medicare
- □ Medicaid
- □ Commercial _____

Please indicate your current employment status:

□ Full-time employed
□ Part-time employed
□ Not currently employed

Occupation _____
Employer business name: _____
Employer address: _____
Employer phone number: _____

Please list your Adjusted Gross Income: $_____

- ➢ Your Income $_____
- ➢ Spouse's Income $_____
- ➢ Other Household Income $_____

Please give a brief description of your current financial situation, including monthly expenses and any special circumstances which you would like Hamilton-Madison House, Inc. to consider as you are evaluated for financial assistance:

_____

_____

_____

_____

I certify/attest that the information provided above is, to the best of my knowledge, true and accurate. If requested by Hamilton-Madison House, Inc., I will provide the necessary documentation to support the information provided on this form. I further understand that any waiver/reduction determination made by Hamilton-Madison House, Inc. applies only to the amount indicated below, and only for the services and care provided to me on the date specified below. Any future medical expenses are not included in this determination, and will be made on a case-by-case basis.

Signature: _____ Date:_____

Reviewed by: _____ Date: _____

Approved:

□ Yes

- □ Coinsurance amount of $ _____ for the services provided on _____.
- □ Copayment amount of $ _____ for the services provided on _____.
- □ Deductible amount of $ _____ for the services provided on _____.
- □ Fee/partial fee for self-pay patients, or patients with insurance that does not cover the services provided on _____ to $_____.

□ No