

Policy Title	Financial Assistance for Healthcare Services Policy	Policy ID	179
Keywords	patient, financial, assistance, charity, care, needed, services, NSA, Excluded, Financial Assistance Exclusions, FAA		

I. Purpose of Policy

To establish a policy for the administration of Dartmouth Health (DH) financial assistance for healthcare services program. This policy outlines the following with respect to all emergency or other medically necessary care provided by all DH facilities:

- eligibility criteria for financial assistance.
- method by which patients may apply for financial assistance.
- basis for calculating amounts charged to patients eligible for financial assistance under this policy and limitation of charges for emergency or other medically necessary care.
- DH's measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of NH RSA 151:12-b, Internal Revenue Code Section 501(r), VT's Act 119, and the Patient Protection and Affordable Care Act of 2010 and will be updated periodically to the extent required by applicable law.

II. Policy Scope

This policy applies to any DH provider working in any DH facility responsible for providing emergency and any other medically necessary care and billed by a DH provider.

For purposes of this policy, "financial assistance" requests pertain to the provision of emergency and other medically necessary care provided in any DH facility by any provider employed by DH.

III. Non-Discrimination Statement

Dartmouth Health does not discriminate on the basis of race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information in the provision of patient financial assistance or in the implementation of this financial assistance policy.

IV. Definitions

Amount generally billed means the amount a hospital generally bills to individuals for emergency or other medically necessary health care services, determined using the "look-back method" set forth in 26 C.F.R. § 1.501(r)-5(b)(3).

Credit reporting agency means a person who, for fees, dues, or on a cooperative basis, regularly engages in whole or in part in the practice of assembling or evaluating information concerning a consumer's credit or other information for the purpose of furnishing a credit report to another person.

Emergency Medical Conditions: As defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd), a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- with respect to a pregnant woman:
 - inadequate time to affect a safe transfer to another hospital before delivery.
 - a threat to the health or safety of the woman or the unborn child in the event of a transfer or discharge.

Federal Poverty Level (FPL) is a measure of income issued every year by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, Children's Health Insurance Program (CHIP), and hospital patient financial assistance.

Financial Assistance Exclusions: Services, which are not considered medically necessary or are considered elective. This policy applies to care provided by Dartmouth Health. These services are not covered by the DH Financial Assistance policy.

Financial Assistance Presumptive: The provision of financial assistance for medically necessary services to patients for whom there is not a completed DH Financial Assistance Form due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Gross Charges: The total charges at the organization's full established rates for the patient's healthcare services.

Health care provider means a person, partnership, corporation, facility, or institution licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual's medical care, treatment, or confinement.

Healthcare Services means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, or mental health condition or substance use disorder, including procedures, products, devices, and medications.

Hospital means a hospital licensed pursuant to Vermont Statutes Annotated (VSA) chapter 43 of title 18 or an outpatient clinic or facility affiliated with or operating under the license of a hospital licensed pursuant to VSA chapter 43 of title 18.

Household Income means income calculated in accordance with the financial methodologies for determining financial eligibility for advance premium tax credits under 26 C.F.R. § 1.36B-1 & 2, including the method used to calculate household size, with the following modifications:

- domestic partners, and any individual who is considered a dependent of either partner for federal income tax purposes, shall be treated as members of the same household;
- married individuals who file federal income tax returns separately but could file jointly, and any individual who is considered a dependent of one or both spouses for federal income tax purposes, shall be treated as members of the same household;
- married individuals who are living separately while their divorce is pending shall not be treated as members of the same household, regardless of whether they are filing federal income tax returns jointly or separately; and
- household income for individuals who are not required to file a federal income tax return, and for undocumented immigrants who have not filed a federal income tax return, shall be calculated as if they had filed a federal income tax return.

Household size is determined based on the definition of “Household income” above.

Liquid asset means an asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, stocks, bonds, and certificates of deposit. For the purposes of determining financial assistance eligibility, liquid assets do not include the household’s primary residence, any 401(K) or individual retirement accounts, or any pension plans.

Medical Creditor means hospital to whom a consumer owes money for health care services.

Medical debt means a debt arising from the receipt of health care services.

Medical debt collector means an individual or entity that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due, or asserted to be owed or due, to another individual or entity.

Medically necessary health care services means health care services, including diagnostic testing, preventive services, and after care, that are appropriate to the patient’s diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medically necessary care must:

- be informed by generally accepted medical or scientific evidence and be consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition;
- be informed by the unique needs of each individual patient and each presenting situation; and
- meet one or more of the following criteria:
 - help restore or maintain the patient’s health;
 - prevent deterioration of or palliate the patient’s condition; or
 - prevent the reasonably likely onset of a health problem or detect an incipient problem.

Out of Pocket Cost means patient expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Patient means the individual who receives or received health care services and shall include a parent if the patient is a minor or a legal guardian if the patient is a minor or adult under guardianship.

VT Resident means an individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in this State in the normal course of the employee's employment, or attends school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time that services are received but who lacks stable permanent housing.

NH Resident: Under New Hampshire law, a resident is anyone who is domiciled in the state with the intent to make it their principal place of physical presence, for the indefinite future, to the exclusion of all other places.

Uninsured Patient: A patient with no insurance or other third-party source of payment for his/her medical care.

Underinsured Patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses nevertheless exceed his/her ability to pay in as determined according to this policy.

Dartmouth Health: For purposes of this policy Dartmouth Health System Members (DH) are Alice Peck Day Memorial Hospital, Cheshire Medical Center, Dartmouth Hitchcock Clinic, Mt. Ascutney Hospital and Health Center, New London Hospital, Mary Hitchcock Memorial Hospital, Visiting Nurse and Hospice for Vermont and New Hampshire (VNH), Valley Regional Hospital (VRH), and Southwestern Vermont Medical Center (SVMC). All other hospitals in New Hampshire and Vermont are considered Non-Member facilities.

This policy applies to those DH member facilities using the Epic system.

V. Policy Statement

Dartmouth Health (DH), is committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay for services or balances that are their responsibility.

DH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided, including after an account has been referred to an outside collection agency.

DH will provide care for emergency medical conditions and medically necessary services to individuals regardless of their ability to pay or eligibility for financial or government assistance, and regardless of age, gender, race, social or immigrant status, sexual orientation, or religious affiliation. In accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), no patient shall be screened for financial assistance or payment information prior to the rendering of services for emergency medical conditions.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with DH procedures for obtaining financial assistance or other forms of payment, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance are encouraged, but not

required, to do so, as a means of ensuring access to health care services, for their overall personal health, and for the protection of their individual assets.

DH will not impose extraordinary collections actions for any patient.

For information on actions DH may take in the event of nonpayment, please refer to our credit and collections policy. A copy of the [Credit and Collection Policy](#) is available online, can be requested at the Patient Financial Services Offices, or can be mailed to you by calling 844-808-0730.

A. Method by Which Patients May Apply for Financial Assistance

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this policy, such patients may nevertheless be considered for eligibility for presumptive financial assistance.

1. DH will explore alternative sources of coverage and/or payment from federal, state, or other programs and assist patients in applying for such programs. With respect to any balances remaining after such other sources have been exhausted, DH will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:
 - A patient or guarantor is encouraged to apply on a form approved by DH management, and provide such personal, financial, and other information and documentation as required for DH to determine whether such individual qualifies for assistance, including, but not limited to, documentation to verify Family Income and available assets or other resources. If DH is unable to obtain an application or any required supporting documentation from the patient or the patient's guarantor, DH may consider whether the patient is eligible for presumptive financial assistance.
 - In lieu of an application and supporting documentation from the patient, staff may use any of the following to support a recommendation for approval of a financial assistance application:
 - DH may utilize one or more vendors to screen individuals for eligibility using publicly available data sources that provide information on a patient's or guarantor's capacity and propensity to pay.
 - Current eligibility for Medicaid.
 - Current statement from a federal or state housing authority.
 - Verification from a homeless shelter or a Federal Qualified Health Center.
 - Verification of incarceration with no source of payment from the correctional facility.
 - For an individual patient, a patient's verbal attestation of income and assets, in lieu of a written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than \$1,000.
2. It is preferred, but not required, that a request for financial assistance and a determination of financial need occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies

to all balances for which the patient has applied for charity, in addition to emergency and other medically necessary care provided for a period, dates of service prior to receipt of the financial assistance application, including balances placed at a collection agency, and any services provided before or on the expiration date listed on the acknowledgement letter if the service is not listed below. After that time, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known, DH will re-evaluate the individual's financial need in accordance with this Policy.

DH recognizes decisions made by the following assistance programs without requesting copies of applications. DH shall not use a determination from another organization to deny eligibility for financial assistance at DH. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

- Good Neighbor Health Clinics
- Amoskeag Health
- Lamprey Health
- Mobile Community Health
- Teen Health Clinic
- Current Medicaid eligibility if not retroactive to cover past services
- Deceased patient with no estate (as confirmed by executor or state)

3. DH will process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application.

B. Eligibility

Dartmouth Health offers two types of financial assistance: general and catastrophic financial assistance.

- **General financial assistance:** A patient must meet three tests to be eligible for general financial assistance: (1) the residency test, (2) the general income test, and (3) the liquid asset test.”
- **Catastrophic financial assistance:** A patient must meet two tests to be eligible for catastrophic financial assistance: (1) the residency test and (2) the catastrophic income test.

- C. Residency test:** To be eligible for general or catastrophic financial assistance, a patient must, at the time services are rendered, be a Vermont resident or New Hampshire resident as defined in the “Definitions” section of this policy and copied here:

Vermont resident means an individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in this State in the normal course of the employee's employment, or attends school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time that services are received but who lacks stable permanent housing.

NH resident: Under New Hampshire law, a resident is anyone who is domiciled in the state with the intent to make it their principal place of physical presence, for the indefinite future, to the exclusion of all other places.

There is no durational requirement for Vermont residency. It is irrelevant how long the patient has been a Vermont resident, and Dartmouth Health explicitly recognizes that persons with unstable housing can be Vermont residents (even if they just moved to Vermont).

- D. General income test:** To be eligible for general financial assistance, a patient's household income must be equal to or less than 400% of the Federal Poverty Level (FPL). To determine the applicant's FPL, Dartmouth Health shall use the "Household Income" definition in the "Definitions" section of this policy, which also contains guidance on determining household size. See also the "Application Processing" section of this policy for further guidance. The applicable FPL standard shall be for the year in which services were or are rendered.
- E. Asset test:** To be eligible for general patient financial assistance, a patient's household must not have liquid assets which have a combined value of 400% FPL or more for the applicable household size. What constitutes a liquid asset is defined in the "Definitions" section of this policy.
- F. Catastrophic income test:** To be eligible for catastrophic financial assistance, a patient's household income must be equal to or less than 600% FPL. To determine the applicant's FPL, Dartmouth Health shall use the "Household Income" definition in the "Definitions" section of this policy, which also contains guidance on determining household size. See also the "Application Processing" section of this policy below for further guidance. The applicable FPL standard shall be for the year in which services were or are rendered.
- G. Eligibility and health insurance sign-up requirements:** If a patient is an undocumented immigrant, the patient's refusal to apply for public health insurance shall not be used as a reason to deny them financial assistance. For all patients, regardless of immigration status, the patient's refusal to apply for private health insurance shall not be used as a reason to deny them financial assistance.
- H. Documentation of Residency:** Dartmouth Health will not ask an applicant to provide proof of residency. A signed financial assistance application will be considered sufficient attestation that the applicant meets the definition of Vermont or New Hampshire residency.
- I. Income:** A patient must provide proof of income along with their financial assistance application. A patient may provide their most recent state or federal income tax return, or in lieu of submitting a tax return, they may provide paystubs, documentation of public assistance, or other documentation accepted as valid documentation of income by the Vermont Department of Health Access, such as a bank statement, profit and loss statement, letter from an employer, or self-attestation in extenuating circumstances in which no other documentation is available.

Note: Patients who are undocumented immigrants shall be given the option to submit other documentation of household income, such as a profit and loss statement, in lieu of a state or federal income tax return.

Dartmouth Health does not require any other source of income verification aside from the

documentation listed above.

Dartmouth Health may rely on other evidence of eligibility but will not require a patient to provide any forms of documentation that are not listed in this policy.

Dartmouth Health may presumptively deem a patient eligible for financial assistance based on information in the hospital's possession. We will not use information in our possession to presumptively deny an application.

We may waive documentation requirements at our discretion. Please call (844) 647-6436 to request a waiver or indicate this request on the financial assistance application.

Determining household income

Regardless of what type of income documentation the applicant submits, Dartmouth Health shall calculate household income using the financial methodologies for determining financial eligibility for advance premium tax credits under 26 C.F.R. § 1.36B-1 & 2e.

This is the applicant's "modified adjusted gross income" (MAGI), defined at 26 CFR § 1.36B-1(e)(1) - (2), and summarized by the Internal Revenue Service:

"Modified adjusted gross income is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI)." (See Q8 on the [IRS Fact Sheet: Questions and Answers on the Premium Tax Credit](#))

Determining household size

Dartmouth Health shall calculate the household size in accordance with the guidelines set forth in the definition of "Household Income" (see "Definitions" section above).

J. Provision of Policy Documents to Patients

In-Person: Free paper copies of this policy and the financial assistance application are available in the following locations:

- the patient admissions area,
- Eligibility and Enrollment Services at any site

We will offer a free copy of this policy to patients as part of their first visit or, in the case of services delivered at the hospital, during the intake and discharge processes.

By Phone: Patients can call (844) 647-6436 to request a free paper copy of this policy and the financial assistance application.

Online: This policy, the financial assistance application, and related materials are available online at [Financial Assistance | Patients & Visitors | DHMC and Clinics](#). Patients may also access these documents by signing into their patient portal and select BILLING, then FINANCIAL ASSISTANCE.

By Mail: Free copies of this policy and the financial assistance application are available, upon request, via mail. Individuals can request paper copies by writing to the following address:

Dartmouth-Hitchcock
One Medical Center Drive
Lebanon, NH 03756

K. Patient Billing or Collection Statements

All billing statements, whether sent by this hospital or a medical debt collector, shall include a conspicuous written statement that some patients may be eligible for financial assistance. This statement shall include the telephone number a patient can call to obtain more information about our policy and the application process. It shall also include the web address where this policy, the financial assistance application, and the plain language summary are posted

All oral or written communication attempts by a medical creditor or a medical debt collector, for any Dartmouth Health site to collect a medical debt arising from health care services delivered at this facility shall include information about our financial assistance policy.

Dartmouth Health does not sell any medical debt.

L. Determination of Amount of Financial Assistance

All insurance payments and contractual adjustments as well as the uninsured discount are taken prior to the financial assistance adjustment being applied. See DH Uninsured Patient Discount Policy: Revenue Management Division (linked below).

If an individual is approved for financial assistance, the amount of such assistance to be provided for applicable care will be as follows:

Insured patients: Insured patients shall have a discount applied to their out-of-pocket expenses.

For insured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) all out-of-pocket costs for emergency and medically necessary services rendered (i.e., the care is free). For insured patients whose household income is:

- 251%-300% of FPL, the discount will be 75%
- 301%-350% of FPL, the discount will be 50%
- 351%-400% of FPL, the discount will be 40%

Uninsured patients: Uninsured patients who are eligible for financial assistance shall have a discount applied to the amount generally billed for the emergency and medically necessary services rendered.

For uninsured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) the amount generally billed for emergency and medically necessary services rendered (i.e., the care is free). For uninsured patients whose household income is:

- 251%-300% of FPL, the discount will be 75%
- 301%-350% of FPL, the discount will be 50%
- 351%-400% of FPL, the discount will be 40%

In catastrophic situations, for uninsured or insured patients: If the total amount owed for emergency and medically necessary services rendered exceeds 20% of the household income, then the amount owed shall be reduced so that it is equal to 20% of the patient's household's income.

- Any discounts other than those described above must be approved by the Financial Assistance Appeals Committee based on a written appeal from the patient or responsible party.
- Patients meeting criteria for Presumptive Financial Assistance, will receive 100% financial assistance.
- Financial Assistance is effective for the following timeframes, based on the date of the application signature:
 - Working Family – Six (6) Months
 - Fixed Income Family – Twelve (12) Months
 - Unemployed Family – Three (3) Months
 - Out of State Residents (patients not residing in NH or VT) – One (1) Month

Patients without insurance, including uninsured patients who qualify for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Dartmouth Health applies a discount against gross charges to all balances for patients who have no insurance, resulting in a discounted balance which the patient is expected to pay.

The discount is based on the “look-back Medicare fee for service plus private payors” method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount doesn’t apply to any copayments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

For fiscal year FY26 -10/1/26 to 9/30/27, the following discount rates apply:

	FY24	FY25	FY26	FY27
Dartmouth-Hitchcock Clinic	64%	65.7%	69.4%	70.5%
Mary Hitchcock Memorial Hospital	64%	65.7%	69.4%	70.5%
Alice Peck Day Memorial Hospital	44.0%	45.8%	46.1%	48.6%
Cheshire Medical Center	68.5%	70.8%	72.4%	73.4%
New London Hospital	50.6%	53.8%	54.3%	54.6%
Dartmouth Health Home Care (VNH)	0%	0%	0%	0%
Mt Ascutney Hospital			44.8%	51.0%
Vally Regional Hospital				39.9%

M. Communication Regarding the DH Financial Assistance Policy to Patients and Within the Community

- Referral of patients for financial assistance may be made by any DH staff member or agent, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
- Information regarding financial assistance from DH, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning DH's patient collection policies and procedures, will be available to the public and to DH patients through at least the mechanisms described below:
 - On the DH websites

- Posted in patient care areas
 - Available on Information Cards in the registration and admitting departments
 - Available in other public spaces as determined by DH
 - Social Workers
 - Provided in the primary languages spoken by the population serviced by Dartmouth Health; translation services are utilized as needed
- If the balance is approved for Financial Assistance, the patient is sent a letter indicating approval.

N. Assistance in Completing the Applications

You can receive in person assistance completing this application at the following locations:

Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756 (603) 650-8051	Dartmouth-Hitchcock Clinic Concord 253 Pleasant Street Concord, NH 03301 (603) 229-5080	Dartmouth-Hitchcock Clinic Manchester 100 Hitchcock Way Manchester, NH 03104 (603) 695-2692
Dartmouth-Hitchcock Nashua 2300 Southwood Drive Nashua, NH 03063 (603) 577-4055	Dartmouth-Hitchcock Keene 580-590 Court Street Keene, NH 03431 (603) 354-5454 ext:4444	Cheshire Medical Center 580 Court Street Keene, NH 03431 (603) 354-5430
Alice Peck Day Memorial Hospital 10 Alice Peck Day Drive Lebanon, NH 03766 (603) 443-9579	New London Hospital 273 County Road New London, NH 03257 (603) 526-5082	Visiting Nurse and Hospice for Vermont and New Hampshire (VNH) 88 Prospect Street White River Junction, VT 05001 (888) 330-8853
Mt Ascutney Hospital and Health Center 289 County Road Windsor, VT 05089 802-674-7471	Valley Regional Hospital 243 Elm Street Claremont, NH 03743	

You will continue to be financially responsible for any services you receive until your completed application is received.

Additional options can be obtained through New Hampshire Health Access Network (<https://www.healthynh.com/nh-health-access-network.html>)

O. Financial Assistance Appeals Process

- If the balance is not approved, the patient will be sent a denial letter or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction. The patient has 60 days to appeal this decision.
- A committee of three DH Leaders not involved in the original process will review the appeal and make recommendations on all denial appeals monthly.

P. Presumptive Eligibility for Financial Assistance

DH may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socioeconomic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Dartmouth Health system.

Information from the predictive model may be used by DH to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Presumptive financial assistance is not available for balances after Medicare.

Presumptive screening is used, without respect to outstanding balance, on eligible accounts greater than 120 days after statements, after notices to collect the debt and prior to referral of the account to an outside collection agency to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application. Probate accounts that have exceeded time limits are eligible for presumptive screening.

Presumptive Charity does not replace traditional FAP processes; it is used to supplement these efforts, and meant for those patients who are otherwise unresponsive to the traditional FAP process. To remove barriers for these patients, and improve our benefit to the patient, the hospital uses an electronic screening process prior to bad debt placement. Patients found eligible for presumptive charity will not be placed with a bad debt collection agency.

Inclusion in this program is based on a scoring algorithm using public record information and does not typically use a sliding fee scale. Partial discounts are not allowed with Presumptive Charity. Specific demographic populations are intended to include:

- Deceased with no estate or known family
- Transient, homeless person
- Persons estranged from family with no support group
- Patients unresponsive or incapable of completing the traditional process

Presumptive charity scoring incorporates a socio-economic factor and non-credit based data. The screening process leverages public databases that contain the following information:

- Consumer transactions

- Court records
- Asset ownership
- Home ownership vs. renter
- Demographics, economics of the region
- Employment status
- Utility files
- Governmental
- Files (Bankruptcy, SSN, deceased individuals)

Presumptive charity does not rely on credit bureau reporting data and leaves no soft hits on credit reporting. The information obtained incorporates a Presumptive Charity score of 0 (most needy) to 1000 (least needy). The information predicts the need of the guarantor based on the known factors including but not limited to Income, Assets and Liquidity.

Refunds:

If a patient has paid an outstanding balance and subsequently submits a completed Financial Assistance Application which is approved for financial assistance through the application process, the hospital will refund any amount the individual has paid for the care.

Q. Charity Determination Levels

- Approval levels are as follows:

Position	Dartmouth-Hitchcock	Member Hospitals
Vice President/ CFO/President	>\$350,000	>\$100,000
Director Revenue Management	>\$50,000	>\$50,000
Director – Conifer	Up to \$50,000	Up to \$50,000
Manager – Conifer	Up to \$10,000	Up to \$10,000
Supervisor – Conifer	Up to \$1000	Up to \$1000
Account Rep – Conifer	Up to \$500	Up to \$500

R. Financial Assistance Exclusions – Services

a. Special Considerations

- The below medical procedures are not meant to be all inclusive.
- Non-medically necessary services, as deemed by the Provider could be excluded.
- All best efforts will be made to inform the patient prior to service of any new treatments not covered under the Financial Assistance Program.
- Procedures below are usually screened and identified by the Financial Information Coordinators.
- Exceptions to this policy, as deemed medically necessary by care teams, will be reviewed on a case-by-case basis.

b. Elective Cosmetic Procedures (not covered)

- Breast Capsulectomy w/implants

- Mastopexy (Breast lift)
- Gynecomastia (Male Breast Removal)
- Mastectomy (Cosmetic)
- Rhytidectomy (Face Lift)
- Blepharoplasty (Eyelids)
- Brow Lift (fat/wrinkles on forehead)
- Augmentation Mammoplasty (breast implants)
- Reduction mammoplasty (breast reduction if not covered by insurance)
- Rhinoplasty (nose)
- Dermatology Procedures
- Abdominoplasty (tummy tuck)
- Lipectomy of any kind (liposuction) – can also be listed as removal of excess skin or fat which is not deemed a medical necessity

c. Artificial Insemination

- Microreanastomosis (tubal reversal)
- Vasovasostomy (vasectomy reversal)
- Laparoscopy for treatment of infertility (IUI - IVF - GIFT Programs)
- Infertility treatment

d. Other

- Acupuncture
- Chiropractic Services
- Hearing aids and repairs
- Eye glasses
- Massage therapy
- Toric Lens
- Pharmaceuticals – prescription and over-the-counter medication
- Travel Clinic
- Blood Cord Study
- Retail Sales
- Services provided by Renaissance Psychiatry of New England, LLC

e. Financial Assistance ONLY after Medical Necessity has been approved

- a. Bariatric Surgery

f. Financial Assistance Exclusions – Non-DH Providers

Alice Peck Day Memorial Hospital

Amoskeag Anesthesia	Envision (ED and Hospitalist)	
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Cheshire Medical Center

Radiology Associates of Keene	Surgicare – Medical Equipment	Monadnock Family Services
Amoskeag/Medstream Anesthesia	Orthocare	

Concord

Riverbend Community Mental Health	Services provided by Concord Hospital	
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Manchester

Foundation Medical Partners		
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Nashua

Greater Nashua Mental Health Center (Social Worker)	Nashua Anesthesiologist Group	St. Joseph's Hospital (PT/Rehab Services)
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New London

Dr. Richard Rosato– Oral and Maxillofacial Surgery (professional)	Dr. Payal Verma - Oral and Maxillofacial Surgery (professional)	
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Mary Hitchcock Memorial Hospital

Orthocare Medical Equipment		
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Mt Ascutney Hospital

HCRS	Orthocare	ForMotion Clinic
The Medical Store	Peraza Dermatology Group	

Valley Regional Hospital

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VI. References N/A

Responsible Owner:	Finance Division Corporate	Contact(s):	Kimberly Mender
Approved By:	Office of Policy Support - Organizational Policies Only; Cohen, Lisa; Fielding, Wendy; Mathiesen, Matthew; Muhlen, John; Roberts, Todd; Rockwell, Tamara; Sanders, Tamara	Version #	16
Current Approval Date:	08/18/2026	Old Document ID:	RMD.0031
Date Policy to go into Effect:	08/18/2026		
Related Polices & Procedures:	Uninsured Patient Discount Policy - Revenue Management Division Credit and Collection Policy Budget Payment Policy - Revenue Management Division		
Related Job Aids:			