APPLING HEALTHCARE SYSTEM 163 EAST TOLLISON STREET BAXLEY, GEORGIA 315123	POLICIES AND PROCEDURES
RE: Financial Assistance Policy and Indigent and Charity Care Policy	Page: 1 of 6
DEPARTMENT: Patient Financial Services	EFFECTIVE DATE: 9/1/2009
PREPARED BY: Malorie Harvill	REVIEWED DATE:
	REVISION DATE: 06/14/2018

I. PURPOSE:

The Financial Assistance Policy of Appling Healthcare System serves to provide financial assistance to uninsured or underinsured patients based on the Federal Poverty Guidelines. This policy also administers the distribution of ICTF (Indigent Care Trust Fund) per state regulations. Appling Healthcare System is committed to providing quality health care services to the community. In order to provide necessary medical services, the Health System must maintain a viable financial foundation by seeking reasonable reimbursement for its services to the extent available while at the same time recognizing its obligations to provide free or discounted services to uninsured and underinsured patients who are eligible for financial assistance under this Policy. Appling Healthcare System is committed to providing emergency and medically necessary services to all patients without discrimination, regardless of their ability to pay.

Each request for financial assistance will be reviewed independently and allowances may be made for extenuating circumstances on a case by case basis.

As described below, this written financial assistance policy:

- Includes eligibility criteria for financial assistance for both free and discounted care;
- Describes the basis for calculating the amounts charged to patients;
- Describes the method used to apply for financial assistance and the process used for making determinations of financial assistance;
- Describes how Appling Healthcare System will widely publicize the policy within the community served by the hospital.

Definitions

Amounts Generally Billed (AGB) - the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. AGB is determined by dividing the sum of claims paid the previous fiscal year by Medicare fee-for-

service and all private health insurance, including payments received from beneficiaries and insured patients, by the sum of the associated gross charges for those claims.

Emergency services- Immediate care that is needed to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

Medically necessary services- those services provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity, and there is no other more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. Elective procedures such as cosmetic surgery are not considered medically necessary.

II. SCOPE: This policy covers emergency and medically necessary services provided by the Appling Healthcare System hospital, the ERx Group, any physicians or physician groups contracted to provide emergency services, and employed physicians who provide emergency and medically necessary services

III. ELIGIBILITY

A. ELIGIBILITY CRITERIA

Appling Healthcare System uses the Federal Poverty Guidelines (FPG) in effect at the time an application is completed and submitted to determine eligibility for financial assistance. If the family's income falls below the 200% of the guidelines, the patient is eligible for some level of financial assistance. The Federal Poverty Guidelines can be found on the government website, www.aspe.hhs.gov/poverty. Criteria are set as follows:

- Household incomes that are at or below 125% of the FPG are eligible to receive free care. This is classified as indigent care.

- Household incomes that exceed 126% of the FPG, but are at or below 200% of the FPG qualify for a discounted payment based on a sliding scale as shown below. This is classified as charity care. The patient may also be approved for a payment plan.

2018 FEDERAL POVERTY LEVEL GUIDELINES							
SLIDING SCALE							
DISCOUNT	100%	100%	90%	80%	75%	70%	60%
FAMILY SIZE	100%	125%	140%	150%	175%	185%	200%
1	$12,140	$15,175	$16,996	$18,210	$21,245	$22,459	$24,280
2	$16,460	$20,575	$23,044	$24,690	$28,805	$30,451	$32,920
3	$20,780	$25,975	$29,092	$31,170	$36,365	$38,443	$41,560
4	$25,100	$31,375	$35,140	$37,650	$43,925	$46,435	$50,200
5	$29,420	$36,775	$41,188	$44,130	$51,485	$54,427	$58,840
6	$33,740	$42,175	$47,236	$50,610	$59,045	$62,419	$67,480
7	$38,060	$47,575	$53,284	$57,090	$66,605	$70,411	$76,120
8	$42,380	$52,975	$59,332	$63,570	$74,165	$78,403	$84,760
*	$4,320	$5,400	$6,048	$6,480	$7,560	$7,992	$8,640

*For family units over 8, add the amount shown for each additional member.

- Household incomes that exceed 200% of the FPG, where the patient is medically indigent, or has unusual financial circumstances, such as catastrophic illness or accident, are evaluated based on their financial situation. Some examples include: (1) The size of the patient's medical bills based on a catastrophic illness or otherwise have resulted in patient liabilities for which payment is impossible based on current financial status of a household; or (2) The patient's subsistence is threatened resulting in an ability to meet patient liabilities. This is classified as medically indigent or charity hardship care. Self-pay patients may be eligible for a prompt pay discount of up to 50%. The patient may be approved for a payment plan.

For emergency and medically necessary services, the charges to individuals eligible under this Financial Assistance Policy are limited to no greater than the Amounts Generally Billed (AGB) for such services. Amounts Generally Billed will be calculated pursuant to the Look Back method described in described in section 501(r)-5(b)(4) of the internal revenue code meaning that Appling Healthcare System will look at actual past claims paid to the hospital facility by either Medicare fee-for-service alone or Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals) for the last twelve (12) months. The AGB percentage for Appling Healthcare is 60%.

B. INCOME VERIFICATION:

1. Income verification for all working adults in the household is to include their IRS tax return for the most recent calendar year and the following:

    a. One month current pay stubs
    b. Copies of pension check or Social Security check

c. Child support
d. Social Security Statement/Verification
e. VA statement
f. Unemployment earnings
g. Self-employment earnings

2. If patient/guarantor is unable to provide the documentation to verify income, an original letter from his/her employer on company letterhead should be sent showing part-time or full-time status, length of employment and monthly income. Should the patient not be able to provide any documentation of income verification, the patient must supply a letter containing all facts supporting the need for financial assistance. Approval with this documentation will be on a case by case basis.

3. Food stamps do not count as income.

4. Total family income, based on income verification for all working adults in the household who are responsible for the patient, is compared to current federal poverty guidelines. However, do not count income from any person who is not financially responsible for the patient. For example, do not count income from one sibling as available to another sibling for purposes of paying medical bills. Likewise, do not count income from any child (minor or adult) in considering eligibility under the ICTF for the child's parent.

5. The family unit consists of individuals living alone; and any spouses, parents and their children under age 18 who are still in high school living in the same household.

C. **PRESUMPTIVE ELIGIBILITY** The patient may also qualify for Financial Assistance based on Presumptive Eligibility as discussed below

1. Presumptive Eligibility- If there is adequate information provided by the patient or through other sources, the patient may be deemed presumptively eligible for financial assistance without a formal application. In the event there is little or no evidence to support a patient's eligibility for financial assistance, Appling Healthcare System may use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility or potential discount amounts. Presumptive financial assistance will be determined prior to any outside collection activity. The following types of accounts may be considered eligible for financial assistance without documentation under the presumptive eligibility financial assistance program (1) Referrals from approved community agencies; (2) No estate (deceased); (3) Eligibility for Medicaid in states other than Georgia; (4) Eligibility for State/Federal Programs where program funding has been exhausted; (5) Food Stamp eligibility; (6) Low income or subsidized housing; (7) Participation in the Women, Infants and Children programs

(WIC); (8) State funded prescription programs; or (9) Unemployed persons with no Third Party insurance coverage.

D. MEDICAID APPLICATION The patient/guarantor is to apply for Medicaid and comply with Medicaid requirements, as applicable.

E. NON-ALLOWABLE:

The following are **NOT** covered by this policy:

1. Amounts due to the hospital and collectable from third parties such as insurance, workers compensation medical benefits, etc.
2. Patients who are Medicaid eligible and who have not applied for Medicaid.

F. PROCEDURE TO IDENTIFY ELIGIBLE PATIENTS:

1. Individual notification of this policy will be given at registration to all patients (or their representative) seeking services or having services at Appling Healthcare System. A plain language summary of this policy, a copy of this policy, and application shall also be posted on the Appling Healthcare System website.

2. Financial Counselor will review census activity reports Monday through Friday of uninsured or underinsured patients and a bedside interview will be conducted with patient or patient's representative. Patients remaining from weekend admissions will be seen if still inpatient on Monday.

3. Application will be taken pending return of required documentation for the final approval.

IV. APPLICATION PROCESS:

A. All patients applying for financial assistance must complete a Financial Assistance Application Form. The application must be signed by the patient/guarantor. Applications must be submitted by the 240th day from receipt of the first Appling Healthcare statement for the care provided.

B. Applications will be held until the account has final billed and necessary information has been obtained, and the service has been provided. If applicant is denied for one date of service and on another date of service financial circumstances have changed the applicant may re-apply but must provide require new proof of income. The Poverty

Income Guidelines in effect the day of the application will be used. The guidelines are revised annually.

C. If the income is more than the guidelines or the documentation required by this policy has not been submitted within 30 days of notification of an incomplete application, the application will be denied and referred to the appropriate department to set up payment arrangements. Each applicant will be given a copy of the Applicant's Financial Assistance Application Form and informed that a determination will be made based on policy guidelines. When a determination has been made, a letter indicating denial and/or amount approved for write off and patient balance, if any, will be forwarded to address on record.

D. Each application is on a case by case basis. The application will be approved for 9 months retroactively and 3 months prospectively from the date of approval.

E. Patients have the right to appeal if the decision is a denial. An appeal must be submitted in writing or in person to the financial counseling department within thirty (30) days after the determination date.

V. COLLECTIONS POLICY AND PROCEDURE

Appling Healthcare System does not engage in extraordinary collection actions (ECAs) against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for the care. ECAs are those actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus. In the event of non-payment by a patient for their portion of their account balance after financial assistance is processed, the account will follow normal collection process flow (see Billing and Collection Policy and Procedure).

VI. ADDITIONAL INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAM

Appling Healthcare System makes information readily available to patients about its financial assistance program by positing and distributing information in patient registration areas, other public places throughout the hospital, on patient bills and on its website. Additionally, anyone needing copies of the information may ask at Admissions Office, Business Office, or Financial Counseling department, or by calling (912) 367-9841, ext. 1278. Spanish translations of the financial assistance policy, the plain language summary, and the financial assistance application are available.