

Policy Name: <b>Financial Assistance Policy</b>	Originator: <b>VP Revenue Cycle</b>	Origination Date: <b>07/12/2023</b>
Policy Section: <b>Revenue Cycle POD</b>		
Approved By: <b>Nicole Clawson, VP Revenue Cycle</b>	Signature: 	Revised Date:
Revised By: <b>Deb Mumper, Dir. Patient Access</b>	Signature: 	<b>08/25/14, 7/27/15, 03/28/17, 04/16/17, 9/15/17, 1/22/18, 2/15/18, 2/12/19, 05/29/20, 06/25/20, 02/25/21, 2/22, 1/19/23, 1/17/24, 3/5/24, 06/11/24, 6/24/24, 8/26/24, 4/24/25, 3/20/26</b>
<b>Note:</b> The Financial Assistance Policy has historically been an inclusive part of the Patient Financial Obligations Policy. As of 6/11/24 it is a standalone policy.		

**Policy:** As a benefit and obligation to the community, the hospital recognizes its responsibility to provide medically necessary services and to provide financial assistance to patients paying for those services. As important, is the hospital's financial ability to provide future community benefits which necessitates that those with the ability to pay are required to do so and may be pursued to the fullest extent available within the laws of the Commonwealth of Pennsylvania governing debt collection. This policy will comply with all requirements of the IRS of a non-profit organization, and all other regulations, such as EMTALA, that relate to the provision of service. No one will be denied access to services due to inability to pay. There is a discounted /sliding fee schedule available based on family size and income (Appendix A).

**Purpose:** To provide a continuum of financial assistance/requirements across the entire patient experience, at all service entry/delivery points, that define the patient's financial obligations, provides the methodology for assistance, the available forms of assistance, and the processes to assist in the communication and understanding of the same by all involved.

**Definitions:**

Financial Assistance – Includes all forms of financial help for payment/resolution of patient liable balances including full or graduated reductions in liable balance or all payment arrangements.

Financial Liability - the amount calculated to reflect liability assigned to the patient. This may include full charges, discounted services after an appropriate approved self-pay discount is applied, or balance after patient's insurance has processed a claim. This may include unmet deductible, coinsurance, and copay assigned by the insurance carrier and is the patient's or guarantor's responsibility.

Pre-collect Amount – the amount of the patient liability that a hospital may require a patient to pay in advance of elective, non-emergent services. This will be determined by each individual POD hospital.

Hospital – "Hospital" referenced in this document refers to all entities and lines of business where patient care is provided under the hospital's tax ID, including outpatient clinics, physician offices, and urgent care centers.

Medically Necessary Services – Services provided that are supported by patient diagnoses that meet the current definitions as defined by Medicare and other accepted criteria used by the

hospital. Services not meeting this definition include personal cosmetic and other services not required to treat a medical condition.

Emergency Care – Care provided in the section of the hospital designated as Emergency Room and/or those areas subject to EMTALA.

Guarantor – The person who is financially obligated to pay for out of pocket expenses for services to the patient.

Financial Assistance Policy (FAP) – Term used by the IRS for the policy of providing assistance for those in need.

AGB – Amounts Generally Billed to those covered by insurance.

ECA – Extraordinary Collection Actions that cannot be taken before expiration of 240 days or when there is an open/unprocessed FAP application.

Presumptive Score – A numerical value of the guarantor's ability to meet financial obligations based on income and family size information adjusted for statistical validity for the community served by the hospital.

Surgical Services - All services that are defined in the HCPCS code range of 10000 – 69999 with the exclusion of venipuncture.

Underinsured – Your out-of-pocket healthcare costs (excluding premiums) represent 10% or more of your household income. If you're living under 200% of the federal poverty level, the threshold drops to 5% of your income (which is less than or equal to \$62,400 for a family of four in 2024).

Uninsured – You do not have health insurance coverage for any medical costs under Private health insurance under Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored plans or programs, or military health plans.

Family Size - Family is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family

Refusal to Pay – Verbal or written expression by a patient or guarantor of unwillingness to pay for service provided; failure to pay following the normal statement processing equal to or greater than 120 days following service.

## **I Requirements – General:**

- 1) Patient obligations and related financial assistance levels is a continuum that is segmented enough to provide consistency as a guarantor's financial position moves from 100% debt forgiveness to requiring the guarantor to seek alternative external financing.

- 2) The framework for the determination of 1) above is found in Appendix A. Each hospital and other covered entities will independently determine the percentages of the poverty level used for the graduated benefit/requirements as needed to meet their FAP and financial goals of their respective organizations.
- 3) Each hospital will also identify the calculations used for determining the AGB, identify an effective date, record this information on Appendix A, and distribute the information each time there is a change. This calculation can be adjusted as needed but should be reviewed at least annually. AGB discount should be applied consistently across all lines of business including hospital outpatient clinics.
- 4) All providers under the hospital's tax ID will be covered under the Financial Assistance Plan.
- 5) Any available health insurance must be billed prior to Financial Assistance being applied to an account. For patients with income greater than 200% of the Federal Poverty Level, Medical savings, reimbursement and all other similar accounts must be used prior to applying any type of financial assistance to qualified accounts. The exception to this rule is the utilization of a presumptive score for active lower balance accounts or for all accounts upon return from the primary bad debt agency.
- 6) All Charges will be posted in a consistent manner regardless of the available insurance, available coverage and/or the patient's ability to pay.
- 7) Patients with no insurance coverage will have an adjustment applied to the gross charges as determined by the individual hospital, identified as "Self-Pay Discount." The amount billed to a patient with no insurance represents each hospital's respective AGB – Amounts Generally Billed to those covered by insurance. AGB discounts may be separate amounts for inpatient and outpatient services. A separate adjustment code will be used for the reduction of the balance to the AGB. AGB amounts are not to be classified as bad debt or charity (PFA) but is classified as uncompensated care.
- 8) For patients that have insurance coverage, financial assistance is limited to defined patient liabilities (deductible, coinsurance, co-pay) and non-covered services. Patient liabilities include deductible and coinsurance required by both public and private insurance payers in which the hospital has a contractual relationship. An approved FAP may also include non-covered charges for days exceeding the length-of-stay limit for patients covered by Medicaid or other indigent care programs, known. For those with an approved PFA application at the time of the insurance payment, the amount of patient liability will be compared to the AGB as if the patient did not have any insurance. The patient liability will be reduced to the AGB when it exceeds the AGB.
- 9) Patients have the right to refuse insurance coverage for specific services. Due to the various legal requirements of this option, adherence to the following is required:
  - a. This is only an option for elective services. No emergency related services may use this option
  - b. This option is not available when government insurance is on the account regardless of payer priority.

- c. This option must be elected individually for each account.
  - d. An insurance named “Self-Pay by Request” (do not update Demo recall) will be added to the account so that:
    - i. Insurance is never added to the affected account after this option is elected.
    - ii. All other parties that process the account can easily identify that this option was elected.
  - e. Medical records for these services cannot be sent to the patient’s insurance carrier. Releasing medical records to their insurance for a patient selecting this option may create a HIPAA disclosure violation.
  - f. The option must be elected prior to the service and prior to providing insurance information that has been eligibility verified and/or used to obtain authorization.
- 10) An AGB adjustment is applied regardless of the guarantor’s ability to pay and will be reversed when insurance coverage payment becomes available on the account. This adjustment does not apply to patient liabilities identified through a claim adjudication process or for when the patient elects not to use insurance coverage that is valid at the time of service.
- 11) The amount of approved financial assistance (debt forgiveness) will be classified/adjusted as charity but referred to in all communications as patient financial assistance.
- 12) Financial assistance applicants that make any material misrepresentations will result in the reversal of approval and denial of open applications.
- 13) There are two independent approval processes to identify financial assistance: 1) an approved Financial Assistance Application, and 2), a Presumptive Charity Score. For each process, a unique transaction code will be used to relieve the financial obligation on the account
- a. The Financial Assistance Application process is available from the inception of the account to the 120<sup>th</sup> day from placement of any open balances with the Primary Bad Debt Collection Agency. Full and partial PFA benefits are available using this process.
  - b. The Presumptive Charity Score process occurs upon the return of uncollectable accounts from the Primary Bad Debt Collection agency. No reference is made to any Patient Financial Application processes or decisions as the score is a stand-alone independent identifier and approval of charity. Only full PFA benefit is available using this process. The utilization of the score is as follows:

- i. Accounts with Medicare - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as indigent cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity –score transaction.
    - ii. Accounts with dual eligibility - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as dual eligible cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity–score transaction.
  - c. Under no circumstances are the same balances to be considered for both charity and Medicare bad debt (mutually exclusive).
  - d. Transaction codes will be established to differentiate/classify and support the varying definitions of charity and bad debt only when other information on the account cannot be used for such differentiation/classification. This position is necessary to keep the number and adjustment definitions at levels that promote accuracy and minimize confusion.
- 14) Patients may request the plain language summary and/or the entire Financial Assistance policy. Both will also be posted on the hospital’s web site. Although historically hospitals have provided non-interest-bearing loan arrangements in the form of accepting monthly payments (with or without approval), the patient liability shift necessitates the reinforcement of the following payment arrangement requirements:
- a. Each hospital may participate in debt financing of the patient liabilities, however all returned debt may immediately be placed with a collection agency as bad debt regardless of the time period (subject to governmental reimbursement requirements).
  - b. Agreed upon payment arrangements only include the debt at the time of the payment arrangement. The guarantor will need to discuss any new debt and seek a new payment arrangement.
- 15) Catastrophic circumstances may justify financial assistance to an individual that falls outside the score and/or income levels established in this policy. For these extenuating situations, patient financial assistance adjustments may be given upon documented recommendation of revenue cycle leadership and approval by the CEO or CFO. Criteria for determining such catastrophic circumstances is based on the judgement of the executive for the situation but should be a rare occurrence.
- 16) During the annual budget process, an estimated amount of Financial Assistance Program services will be placed into the budget as a deduction from revenue.

## II Patient Financial Assistance Application Approval Process:

- 1) Financial Assistance provided to the patient in the form of balance forgiveness (charity) may be determined by application that indicates the patient's ability to pay.
- 2) The Financial Assistance application process includes the following:
  - a. A completed application is presented to a Financial Counselor. The application form must be completed in its entirety. (See Appendix B)
  - b. All supporting documentation is required with the application form, including proof of income; and if applicant is over 200% of the Federal Poverty Guidelines, proof of assets
  - c. Financial Counselor will review and verify the completed application and supporting documentation (if required), using the Financial Assistance application checklist and guidelines. (See Appendix B)
  - d. Determination will be made as to the patient's eligibility and level of balance forgiveness for which the patient qualifies.
  - e. Copies of application and supporting documentation will be securely retained electronically by the facility for as long as record retention policies dictate, up to 10 years.
  - f. Applications and supporting documentation must be treated with highest confidentiality. Documents will be scanned to a secure electronic folder on the hospital's computer system with limited access. Original documents will be destroyed or returned to the applicant. A log of applications including date received, date of completion, and approval status will be maintained for each calendar year and retrievable upon request. Data may be reviewed for auditing purposes.
  - g. Open balance accounts will be reviewed for qualification of balance forgiveness and appropriate adjustments will be made.
  - h. Patient will be notified in writing of the determination whether they are approved or denied for Financial Assistance. Approval period will be 6 months or 12 months.
  - i. Patient will be instructed to present a letter of notification of eligibility or issued Financial Assistance card when registering for services at the respective facility. All letters presented with an expired date will be removed from the account and the patient advised to re-apply.
- 3) Automatic approval for financial assistance may occur using a charity scoring system under the following circumstances:

### **Reclassification of Bad Debt to Charity using Presumptive Charity:**

- a. Guarantors may be scored to determine a presumptive approval for charity at the time the account is returned from the primary bad debt agency.
- b. The referral for review of the scoring process will occur after the first placement collection agency has completed their attempts to collect and before placing the account with the second collection agency.
- c. A presumptive score will work independent of the application process for only this population of patients to avoid excessive administrative expense of reviewing each account for application history.
- d. A presumptive charity score may be used as an indicator to pursue/encourage the completion of an application for financial assistance.

This process should not be used to determine assistance eligibility for current or future services.

### **III Requirements – Communication:**

- 1) The hospital will widely publicize the Patient Financial Assistance policy by completing the following:
  - a. Make available paper copies of the application when requested and provide the Patient Financial Assistance Policy without charge to distribute by mail, in person and at patient entry point locations throughout the organization including outpatient clinics.
  - b. Notification by way of postings on hospital website and social media accounts, brochures at patient check-in points and on patient statements.
  - c. Document the activities used to inform the community about the program on a minimum of an annual basis. Information provided on the hospital web site and other electronic media on the policy and how to obtain additional information.
  - d. No one will be denied access to services due to an inability to pay. There is a discounted sliding fee schedule available based on family size and income. The Financial Assistance Policy is also available on our website at <https://www.acmh.org/Files/Admin/ACMH%2DPatient%2DFinancial%2DObligations%2DPolicy%2D03%2D05%2D24.pdf>

### **IV. Requirements – Collections:**

1. For those whose income is at or below 200% of the Federal Poverty Level, they will receive a 100% discount based on income and family size, therefore they will not be sent to collections.

## APPENDIX A

Fiscal Year	Calculation Method	Effective Date Claim Date	AGB Percent
	<b>EXAMPLE:</b> Annually updated based on data from cost accounting module of Meditech from the previously completed fiscal year. All accounts are included except Medicaid, Medicare, Medicaid Managed Care, and Self-pay. Total payments collected are divided by the total charges and that reciprocal is used as the respective 501R discount percentage.		
2026	Inpatient and Outpatient	July 2025	70%

Score					
Poverty Level	100%	200%	250%	300%	350%
<b>Family Size</b>					
<b>1</b>	15,960	31,920	39,900	47,880	55,860
<b>2</b>	21,640	43,280	54,100	64,920	75,740
<b>3</b>	27,320	54,640	68,300	81,960	95,620
<b>4</b>	33,000	66,000	82,500	99,000	115,500
<b>5</b>	38,680	77,360	96,700	116,040	135,380
<b>6</b>	44,360	88,720	110,900	133,080	155,260
<b>7</b>	50,040	100,080	125,100	150,120	175,140
<b>8</b>	55,720	111,440	139,300	167,160	195,020
<b>9</b>	61,400	122,800	153,500	184,200	214,900
<b>10</b>	67,080	134,160	167,700	201,240	234,780
	Add \$5,680 for each addt'l person at 100% FPL				
	Add \$11,360 for each addt'l person at 100% FPL				
<b>Source: Published February 1, 2026. <a href="https://aspe.hhs.gov/topics/poverty-economic-financial-assistance">https://aspe.hhs.gov/topics/poverty-economic-financial-assistance</a></b>					
<b>Financial Assistance</b>					
<b>Reduction</b>					
<b>Percent</b>	<b>100%</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>

## APPENDIX B

### FINANCIAL ASSISTANCE APPLICATION

#### APPLICANT INFORMATION

**Name:**

**Date of birth:**

**Phone:**

**Current address:**

**City:**

**State:**

**ZIP Code:**

Cell Phone:

E-mail Address:

#### EMPLOYMENT INFORMATION

*OPTIONAL:* Please indicate if you are Employed/Retired

Current employer (I/A):

Employer address:

City:

State:

ZIP Code:

Position:

**Annual income:**

#### HOUSEHOLD CO-APPLICANT INFORMATION

**Name:**

**Date of birth:**

**Phone:**

**Current address:**

**City:**

**State:**

**ZIP Code:**

#### EMPLOYMENT INFORMATION

*OPTIONAL:* Please indicate if the co-applicant is Employed/Retired

Current employer (I/A):

Employer address:

City:

State:

ZIP Code:

Position:

**Annual income:**

#### ADDITIONAL HOUSEHOLD MEMBERS AND INCOME, IF ANY

Name and Age

Annual Income

**ONLY IF INCOME >200% OF FPL. \*\*(SEE "PROOF OF ASSETS" ON CHECKLIST)\*\*  
OTHER ASSETS OR SOURCES OF INCOME –**

Description

Amount per month or value

## APPENDIX B

<b>FINANCIAL ASSISTANCE APPLICATION</b>			
<b>ACCOUNTS RELATED TO APPLICATION REQUEST    <b>** (FOR OFFICE USE ONLY) **</b></b>			
Patient Name:	Account no.	Date of Service:	Amount:
<p>I certify that the above information is true and accurate to the best of my knowledge. If income above 200% of FPG, I will exhaust all other sources of medical coverage and assistance that may be available for payment of my hospital related services.</p> <p>I understand that this application is completed so that the hospital can determine my eligibility for uncompensated health services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.</p>			
<b>Signature of applicant</b>			Date
<b>Signature of co-applicant, I/A</b>			Date

<b>ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)</b>	
Date Received: _____	Verification Completed: Yes ____ No ____
The applicant was approved for a reduction of _____% of allowable charges. Date approved: _____	
The applicant was denied for the following reason(s)	
Date of Denial _____	
Date Applicant Notified of Determination _____	
Individual Completing Review: _____	

## APPENDIX B

### Financial Assistance Application Checklist

Verification of the following applicable information is needed to complete your application for Financial Assistance. Failing to provide all the requested/required documents will cause a delay in application processing.

#### Proof of Income:

- Household income, defined as all income for individuals in the household who have a tax/taxable relationship to the patient. (File joint return or is a dependent not on another individual's return) This follows the same definition guidelines as PA Medicaid.
- IF EMPLOYED: pay stubs for most recent three months.
- IF SELF EMPLOYED: Most recent Income Tax return (for applications January through June). Most recent three months of bank statements – checking and savings accounts.
- IF UNEMPLOYED: Pay Stubs and/or Unemployment Compensation Income statements for the most recent three months, most recent three months of bank statements – checking and savings accounts. If no income and living with someone else, Attestation of Provided Support required. (See Form included)
- Social Security income verification (plus most recent three months bank statements)
- Pension
- Workers' Compensation
- Sick Benefits
- Rental Income
- Child Support
- Interest or Dividends
- Any other income into the household
- MA162 with income information
- Payments from personal insurance policies that provide additional income or payment to defray medical related incident costs.
- Current Photo ID (Driver's license, State issued ID, Work Visa)

- **Proof of Assets does not apply to applicants at or below 200% of the current Federal Poverty Level.**
- **Proof of Assets: **\*\***(Balance over \$10,000/person or \$15,000/couple not qualified for Financial Assistance.**
  - Checking Account – most recent statements
  - Savings Account – most recent statements
  - Certificate of Deposit (CD)
  - US Savings Bond
  - Stocks or Bonds
  - HRA, HSA, FSA, or any medical savings or reimbursement account

#### **Stipulations:**

1. Patients with self-pay balances can apply at any time. If approved, discount can be applied to any accounts 240 days old from date of approval.
2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed.
3. Noncovered: For medically necessary services, Financial Assistance covers patient liability after insurance such as deductible, coinsurance and copays assigned by an insurance plan. It does not cover services deemed to be “noncovered” by an insurance plan, “unauthorized” services, or services exceeding a benefit plan allowance. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance. Dental O.R. procedures, Specialty Lenses, and DME (Durable Medical Equipment) are not covered under the Financial Assistance Program.
4. **Elective** services provided to an individual at a facility deemed by the insurance carrier to be “out of network” or “noncontracted” will not qualify for the Financial Assistance discount *unless* the pt has out of network benefits in their insurance plan. If the applicant has insurance, patient must follow the terms of the insurance plan, including use of an in-network facility. Financial Assistance cannot be used as a substitute or secondary to an out of network insurance plan in lieu of following the terms of the primary plan.

5. Medical savings, reimbursement and all other similar accounts must be depleted prior to approved discount being applied to accounts.
6. A PA Medical Assistance denial **may** be required before Financial Assistance eligibility can be determined.
7. Applications and supporting documents at one Mountains Health facility (ACMH, IRMC, PAH) may be shared with other Mountains Health facilities for verification and auditing purposes.
8. A new Financial Assistance application will not be accepted prior to the expiration of a previously approved application period.
9. Hospitals are reimbursed for financial assistance primarily through government subsidies, specifically federal and state Medicaid and Medicare Disproportionate Share Hospital (DSH) payments.



### ATTESTATION OF PROVIDED SUPPORT

I, \_\_\_\_\_, have been providing support for  
 living expenses on behalf of \_\_\_\_\_ since \_\_\_\_\_.  
 (Name of applicant)

- I claim \_\_\_\_\_ as a dependent on my income tax return.
- I do not claim \_\_\_\_\_ as a dependent on my income tax return.
- I give him/her \$ \_\_\_\_\_ in cash per month.
- I give him/her no additional cash support per month.

Name	Relationship to Applicant
Address	
Phone No.	Date