PURPOSE:

Taylor Regional Hospital (TRH) seeks to provide emergency care to all patients regardless of the ability to pay. TRH does not discriminate on the basis of age, disability, national origin, race, color, religion or sex.

The Hospital recognizes that some patients are unable to pay their hospital bills due to financial considerations. TRH will assist those individuals who cannot pay for all or part of their care by extending Financial Assistance to qualifying patients. The Policy provides a mechanism for payment for a qualifying patient that has no third party coverage. The purpose of this Policy is:

A. To define the forms of financial assistance available to patients.
B. To describe the eligibility criteria for each form of financial assistance.
C. To establish the procedure that patients must follow in applying for Financial Assistance.
D. To establish the process the hospital will follow in reviewing applications for Financial Assistance.
E. To provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance.
F. To provide a means of review in the event of a dispute over a Financial Assistance determination.

GOVERNANCE:

The Financial Assistance Policy is administrated by the Business Office with the authority and approval from the Board of Trustees.

DEFINITIONS:

1. **Financial Assistance** – The term Financial Assistance refers to Full Charity Care, Partial Charity Care, and Special Circumstances Charity Care. Guidelines for determining when Financial Assistance should be provided to patients are set forth in this policy.
2. **Uninsured Patients** – An Uninsured Patient is a patient who has no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability, or whose benefits under insurance have been exhausted prior to the admission.
3. **Insured Patients** – An Insured Patient is a patient who has a third-party source of payment for a portion of their medical expenses.
4. **Covered Service(s)** – Covered Services for Full Charity Care, Partial Charity Care, and Special Circumstances Charity Care are emergency care and other medically necessary care provided by TRH. Services do not include elective, cosmetic, or non-medically necessary services.
5. **Full Charity Care** – Full Charity Care is a complete write-off of TRH's undiscounted charges for Covered Services. Full Charity Care is available to patients:
    a. Whose household income of patient and/or Guarantor is either equal to or less

than 125 percent of the most recent Federal Poverty Level (FLP); and

b. Who are Uninsured, as defined above.

6. **Partial Charity Care –** Partial Charity Care is a partial write-off of TRH's undiscounted charges for Covered Services available to patients:
    a. Whose household income of a patient and/or Guarantor is in excess of 125 percent and equal to or less than 200 percent of the most recent FPL;
    b. Who are Uninsured, as defined above.
    c. And to whom the CFO, or his/her designee, has determined the discount should be applied.
7. **Special Circumstances Charity Care** – Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance Criteria, or who are unable to follow specified hospital procedures to receive a full or partial write-off of the hospital's undiscounted charges for Covered Services, with the approval of TRH's Chief Financial Officer, or his/her designee. The hospital must document the decision, including the reasons why the patient did not meet the regular Financial Assistance criteria. The following is a non-exhaustive list of some situations that may qualify for Special Circumstances Charity Care:
    a. **Bankruptcy** – Patients who are in bankruptcy or recently completed bankruptcy.
    b. **Homeless Patients** – Emergency room patients without a payment source if they do not have a job, mailing address, residence, or insurance.
    c. **Deceased Patients** – Deceased patients without insurance, an estate, or third party coverage.
    d. **Medicare Denied Services** – Income-eligible Medicare patients may apply for Financial Assistance for denied stays, denied days of care, non-covered services, and Medicare cost shares.
8. **Amounts Generally Billed Percentage** – The percentage determined by dividing the total claims allowed by Medicare and all private health insurers (including all copayments and deductibles owed by the patient) during the 12 month look-back measurement period by total gross charges for these claims. The measurement period for the AGB percentage will be calculated at the end of each calendar year using the allowed claims from the preceding twelve month period. This AGB percentages calculated will be updated January 1 each year and remain in effect until December 31st of the following calendar year.
9. **Amounts Generally Billed** – The maximum amount for which all patients meeting the eligibility criteria under this Policy are individually responsible for paying. Amounts Generally Billed (AGB) will be calculated by multiplying gross charges for any eligible service by the appropriate AGB percentage.
10. **Co-Payments, Coinsurance and Deductibles** – The amount determined by the patient's insurance policy as being due from the patient and/or any Guarantor. This amount is normally a required payment due from the patient or Guarantor by contract.

11. **Emergency Medical Conditions** – Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)
12. **Family Unit** – For patients 18 years of age or older, the family unit consists of the applicant, spouse and all legal dependents as allowed by the Internal Revenue Service. For patients under 18 years of age, the family unit consists of the parent(s), legal guardian(s) and other children less than 21 years of age of the parent(s) or legal guardian.
13. **Federal Poverty Level (FPL)** – FPL means the measure of income level that is published annually by the U.S. Department of Health and Human Services (HHS) and is used by TRH for determine eligibility financial Assistance.
14. **Medically Necessary** – Health care services that a Physician, exercising prudent clinical judgment would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
15. **Patient Liability** – Patient Liability is the amount owed by the individual patient and/or Guarantor after first applying any insurance benefits and then applying any financial assistance discounts.
16. **Extraordinary Collection Efforts (ECAs)** – Legal and credit related actions taken by the Hospital against the patient and/or guarantors in order to obtain payment of a hospital bill that are defined as extraordinary by the Federal Guidelines. These include negative credit bureau reporting, liens, judgments, law suits, and wage garnishments.

SCOPE:
The Financial Assistance Policy covers emergency and medically necessary hospital services only. Patient may receive services from certain third parties during their course of treatment that may or may not fully participate in the Hospital's Financial Assistance Policy.

PROCEDURE:

1. **Eligibility**
   a. **Eligibility Criteria** – During the application process, TRH shall apply the following eligibility criteria for Financial Assistance:

Financial Assistance Category	Patient Eligibility Criteria	Available Discount
Uninsured Discount	1. Patient is an Uninsured Patient; and 2. Patient does not completed Financial Assistance Application.	Write-off of TRH's charges to Amounts Generally Billed.

Full Charity Care	1. Patient is an Uninsured Patient; and 2. Patient has Household Income at or below 125% of the most recent FPL.	Complete write-off of TRH's undiscounted charges for Covered Services.
Partial Charity Care	1. Patient is an Uninsured Patient; and 2. Patient has household income between 125-200% of most recent FPL 3. The CFO, or designee, has approved the discount.	Partial write-off of TRH's undiscounted charges for Covered Services.
Special Circumstances Charity Care	1. Patient is an Uninsured Patient or Under-Insured Patient; and 2. Does not meet the Financial Assistance Criteria; and 3. A special circumstance exists; and 4. The CFO, or designee, has approved the discount; and 5. TRH documents the decision, including the reasons why patient did not meet the regular Financial Assistance criteria.	Full or partial write-off of the hospital's undiscounted charges for Covered Services.
Public Benefit Program	1. Patient is an Uninsured Patient; and 2. Patient identified as eligible for Medicaid or other state-funded or local assistance program. 3. Other benefit program noted on patient's account and 4. Patient not required to complete application	Full or partial write-off of the hospital's undiscounted charges for Covered Services.

2. **Calculating Household Income** – To determine a patient's eligibility for Financial Assistance, TRH shall calculate the Patient's Household income, as follows:
    a. **Household Income** – See supporting documentations listed in Application Process section. Income converted to an annual amount used to compare to FPL.
    b. **Household Income for Expired Patients** – Expired patients with no surviving spouse, may be deemed to have no income for purposes of calculating Household Income. Documentation is not required for expired patients; however, documentation of estate assets may be required. The surviving spouse of an expired patient may apply for Financial Assistance.
    c. **Household Income determined by third party**- Patients eligible for Medicaid or other state-funded or local assistance programs are deemed eligible for Full or Partial Charity Care. Full or Partial Charity Care is determined by other assistance programs eligibility criteria. Patients, who are identified by third party are not required to complete the Financial Assistance Application.
3. **Calculating Patient's Household Income as a Percentage of FPL** – After determining Patient's Household Income, TRH shall calculate the Patient's Household income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the FPL for a household of three is $20,000, and a Patient's Household Income is $50,000, TRH shall calculate the Patient's Household income to be 250% of the FPL. This calculation shall be used to determine whether a patient meets the criteria for Financial Assistance.
4. **Financial Assistance Exclusions/Disqualification** – The following are circumstances in which Financial Assistance is not available under this policy:
    a. **Insured Patient Does Not Cooperate with Third-Party Payer** – An Insured Patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance.
    b. **Payer Pays Patient Directly** – If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance.
    c. **Information Falsification –** TRH may refuse to award Financial Assistance to patients who falsify information regarding income, household size, or other information in their eligibility application.
    d. **Third Party Recoveries –** If the patient receives a financial settlement or judgment from a third-party that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances, and is not eligible for Financial Assistance.
    e. **Professional (Physician) Services –** Services of physicians such as anesthesiologists, radiologists, hospitalists, pathologists, etc. are not covered under this policy.
    f. **Failure to Cooperate –** TRH often uses a third-party to assist applicants with

determining eligibility from other financial assistance programs, such as Medicaid and other state or federal funded programs. Failure to cooperate will be grounds for denying financial assistance.

COMMUNITY HEALTH NEEDS ASSESSEMENT (CHNA):

The Hospital conducts a community health needs assessment (CHNA) at least once every three years and will revise this FAP to ensure the Hospital is meeting the community health needs identified through the CHNA.

The CHNA will take into account input from persons who represent the broad interests of the community served by the Hospital including those with special knowledge of expertise in public health.

The CHNA will be made available to the public upon request and accessible on the Hospital website, www.taylorregional.org.

APPLICATION PROCESS:

1. Admissions personnel will ask every patient potentially eligible for financial assistance if they require assistance with their Hospital bill. If the patient does not wish to complete the application upon registration, the Registrars will ask them to complete it and return it to the Financial Services Manager within 30 days of the date of service. A new Financial Assistance Application should be submitted every six months unless changes have occurred.
2. Free copies of the Financial Assistance Policy will be made available in the Emergency Department, Financial Services Manager's Office, and Admissions areas to all patients who request it.

The Hospital will apply standard eligibility criteria for each person requesting financial assistance according to the following:

1. Patient must be identified as an Uninsured Patient, as defined above.
2. A patient or guarantor must complete a Hospital FAP application when required.
3. Applicant must be a resident of the State of Georgia.
4. The combination of family income and total number of family members must fall within guidelines given in this policy.
5. Charges must be in conjunction with an inpatient stay or hospital-based outpatient service. Screening tests, elective or not medically necessary procedures, Sleep Studies, and non-hospital based Physician fees are not covered under the Hospital's FAP.
6. TRH makes reasonable efforts to determine whether an individual is FAP eligible prior to engaging in any ECAs. ECAs will not be initiated during the 120-day period beginning

with the issuance of the first post-discharge billing statement to the patient. If, by the end of the 120-day period the patient has not submitted a Financial Assistance Application, TRH may begin collection actions against the patient, providing the patient has been notified in writing of the specific ECAs to be initiated at least 30 days prior to such actions. The application period during which TRH will accept and process a Financial Assistance Application ends on the 240th day after the first statement date

7. Applicants are required to verify the income set forth in the FAP application in accordance with the documentation requirements identified below. Any of the following documents is appropriate for verifying income, if applicable:
    - Proof of Income – IRS Form W-2, the most recent federal income tax return, pay stubs covering the last 90 consecutive days as of the date of application, proof of Social Security, unemployment receipts, investment income, alimony, worker's compensation, rental/royalty income, retirement income, and any other documentation that supports household income.
    - Checking and savings account statements for the most recent 3 months. The statements are required to verify an applicant's income.
    - If the annualized family unit income has decreased since the most recent federal income tax return, the applicant must submit written documentation verifying the decrease amount.
    - Unemployment Denial Letter
    - Participation in Public Benefit Program - Income level may be established utilizing a third-party to help identify patients that qualify for financial assistance based on publicly available patient information (e.g., participation in state-funded prescription programs, participation in the Women, Infants and Children (WIC) program, participation in the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), subsidized school lunch program eligibility, or eligibility for other state or local assistance program). Patients identified as eligible to receive financial assistance by a third-party will not be required to complete the Financial Assistance Application.
8. **Denials:**
    - All patients denied Financial Assistance for Full Charity Care or Partial Charity Care due to not meeting the income guidelines are not supplying necessary documentation will be notified and given the option of an appeal. The appeals procedure will enable the applicant to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the hospital's CFO or equivalent.
    - Patients shall be notified that they have thirty calendar days within which to request an appeal of the final determination of Financial Assistance. After the fourteen-day within this period, if no appeal has been filed, the hospital may initiate collection activities if appropriate.

LIMITATION ON FUNDS AVAILABLE:
The Hospital makes a certain amount of funds available for Financial Assistance in compliance with State and Federal requirements. When the funds have been exhausted for a given period, applications for financial assistance may be denied for lack of funds even though an applicant may otherwise meet the approval criteria. Within the scope and allowable timeframes given in this policy and according to Federal Guidelines, the applicant may reapply.

COMMUNICATIONS:
The Hospital will effectively advise the public of the Hospital's participation in the FAP, the availability of services provided, the terms of eligibility for free and discounted financial assistance, the application process, and the person or office to whom questions about the Hospital Program may be directed.

PATIENT BILLING AND COLECTIONS:
At any point during the billing process, a patient may apply for financial assistance by contacting the Business Office at 478-934-6211 or the Financial Services Manager at 478-783-0421. The Hospital provides a billing statement to all patients with a balance due.

As a patient you are responsible for:

- Providing to the best of your knowledge, accurate, honest and complete information regarding billing and insurance.
- Contacting your insurance company prior to receiving services when pre-certification or prior authorization is required by your insurance plan.
- Contacting your insurance company when notification of urgent care services, emergency room visits or hospitalization is required by your insurance plan.
- Paying deductibles and co-pays at the time of service.
- Assisting us in collecting from your insurance carrier by providing all requested information and calling your insurance company if the claim remains unpaid after 60 days. Should they delay payment beyond 90 days, you may be billed and expected to pay the charges.
- Paying your account promptly or contacting us if payment is a concern.
- Making sure the hospital bill is paid promptly, regardless of any pending litigation resulting from an injury caused by a third party.

Please remember that patients/guarantors are responsible for the charges for services received. Any unpaid balances, including co-payments, deductibles and non-covered services are the patient's responsibility and must be paid within the timeframes outlined on our statements

Statements are printed on a 30-day cycle with payment due upon receipt.

At 30-90 days past due, the Hospital may attempt to contact patients with outstanding balances through various channels including phone calls and letters.

At 90-120 days past due, patients will receive notification from the Hospital that their account is at risk of going to collections if the balance due is not resolved.

At 150+ days past due, accounts may be referred to a third party collections vendor.

The Hospital employs various third party agencies to collect unpaid debts from patients. These Third Party agencies are charged with using strategic and legal means to seek to resolve unpaid balances. Strategic means include contacting the patient and/or guarantor through phone calls and letters in conformance to the Fair Debt Collections Practices Act in an attempt to resolve unpaid balance through payment in full or agreements to a payment plan.

The following guidelines are to be used when a patient/customer requests to set up a payment plan; either self-pay or self-pay balances after insurance. Payment plans shall not be less than the allowable maximum monthly schedule:

Amount Owed	Minimum Payment	Maximum Months
≤ $100	Payment in full	N/A
$101-$500	$1/12^{th}$ of the total	12
$501-$1,000	$1/18^{th}$ of the total	18
$1,001-$5,000	$1/32^{nd}$ of the total	32
$5,001-$7,500	$1/42^{nd}$ of the total	42
Over $7,501	To be determined	N/A

TAYLOR Regional Hospital	Title / Description:	Credit & Collections	
	Filing Number:	BIZ.508.Credit.Collections	
	Effective Date:	09/1976	Page ***1*** of ***2***
	Date of Last Review:	04/2020	
	Date of Last Revision:	04/2020	
	Approved by:	Business Office Manager	

PURPOSE:
To ensure fair billing and collection practices of patient accounts from the responsible guarantor.

SCOPE:
This policy is designed to adhere to CMS guidelines regarding timely and accurate collection of patient accounts.

RESPONSIBILITY:
Compliance with this policy under the direct supervision of the Business Office Manager. The Business Office Manager reports to the Director of Reimbursement. The Director of Reimbursement reports to the CFO or equivalent. The CFO or equivalent reports to the CEO.

POLICY:
To ensure that all patients are treated equitably, with dignity, and with respect with regards to pursuing payment on their hospital bill.

PROCEDURES:

The immediate objectives of the hospital's Credit and Collections Policies will be to:

1. Provide the patient with his account information as accurately as possible.
2. Bill either the patient, in the case of self-pay situations, or his third party payer promptly, accurately, and timely.
3. Inform the patient by way of regular statements as to the status of his/her account.
4. Provide any patients who are in-house with information pertaining to their bill upon request.
5. Respond promptly to patients' questions regarding their hospital bill.
6. Insure that collections are followed through on a consistent and fair basis.
7. To offer and assist patients in applying for any type of financial assistance available through the hospital.

The procedures that will be enforced to ensure the hospital is making every attempt to meet its credit and collection objectives will be as follows:

1. Hospital patient accounts will receive a statement/collection letter every 28 days.
2. The collections department will assist patients with any available financial assistance or financial arrangements that are offered by the hospital.
3. The hospital will offer financial counseling to patients about their bill.
4. The patient financial advisor will inform and supply appropriate information to in-house patients regarding their hospital bill.
5. Once our collection efforts have been exhausted the Business Office Manager or

Collections Coordinator will then determine whether the patient account needs to be referred to an outside agency for further collection efforts.