Financial Assistance Policy

Document Purpose:

To describe UGH's policies for the provision of financial assistance to qualifying persons as outlined.

Policy:

Union County Hospital Authority, dba Union General Hospital, Inc. (UGH) (further known as “facility”) is committed to providing financial assistance to persons who have health-care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situation. Emergency care will be provided to all patients regardless of their or their family's ability to pay. Financial Assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with UGH, procedures for obtaining financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance, both free and discounted (partial charity) care;
- Describes the basis for calculating amounts charged to patients for financial assistance under this policy;
- Limits the amounts that the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to no more than the amount generally billed to commercially insured or Medicare patients for healthcare;
- Describes the method by which patients may apply for financial assistance under this policy;
- Describes actions that may be taken in the event of nonpayment, should it be required;
- Describes how the hospital will widely publicize the policy within the community served by the hospital;
- Identifies providers that may be encountered in receiving emergency or other medically necessary care, other than the hospital facility, covered under this policy and providers that are not covered under this policy.

Governance:

The Financial Assistance Policy is administered by the Business Offices of UGH, Inc. with authority and approval from the Executive Management and Union General Hospital, Inc. Board of Directors.

Definitions - as set forth in this policy, the following terms have the meanings set forth below:

- *Financial Assistance* – Free or discounted health services that are provided to persons who meet UGH, Inc. criteria for financial assistance and are unable to pay for all or a portion of qualified, eligible services provided by the facility. Financial assistance includes:
    - Indigent Care - is defined as providing health care for people who do not have enough resources to pay for medical expenses and other related expenses. It is a form of charity wherein the caregiver does not expect payment in return for medical services rendered. Household incomes that are at or below 200% of the FPG are eligible to receive free care. It is not a health insurance.

- Charity Care - is a reduction in fee for services provided, due to financial situation of a patient. Household incomes that exceed 200% of the FPG, but are at or below 400% of the FPG qualify for a discounted payment based on a sliding scale.
- Presumptive Charity - patient is deemed eligible for charity care discounts but there is not a complete financial assistance application on file or a lack of supporting documentation.

- *Federal Poverty Guidelines (FPG)* -Financial guidelines issued by the federal government at the beginning of each calendar year are used to determine eligibility for poverty programs. The current FPG can be found on the U.S. Department of Health and Human Services website at hhs.gov.
- *Family Unit Size* - is defined as the applicant, spouse/partner, and any dependents supported by or living together as unit. If the applicant is a minor, the family unit will include parent(s), legal guardian(s), and all household dependents.
- *Family Unit Income* - is defined as gross income for all members of the family unit for the last three months or the last calendar year. Examples of income are: salary and wages, social security benefits, retirement, pensions, veteran's administration, welfare, workers compensation, sick leave, disability compensation, alimony, child support, stock/certificate dividends, interest, or income from property. Non-cash benefits (such as food stamps and subsidies) do not count as income.
- *Disposable Income* - is defined as available income determined by subtracting the family unit income from the Federal Poverty Guidelines.
- *Gross Charges* - are defined as the total charges at the organization's full established rates for the provision of patient care service before deductions from revenue are applied.
- *Eligible Services* – Services eligible under this Policy include:
  - Hospital Facility emergency medical services
  - Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting and follow up care
  - Medical services solely for cosmetic purposes and services or procedures that are elective are not covered under this policy
- *Standard Collection Effort*- is defined as a period of 120 days of continuous collection effort from the date the first post discharge bill is sent to the patient or guarantor.
- *Extraordinary Collections Actions (ECAs)* – Actions that may be taken related to obtaining payment for services rendered include the following:

  - Selling an individual's debt to another party unless the purchaser is prohibited from engaging in any ECAs to obtain payment, prohibited from charging interest in excess under section 6621(a)(2) at the time the debt is sold, the debt is recallable upon determination the individual is eligible for financial assistance, and the individual does not pay or has no obligation to pay the purchaser and the facility together more than they are personally responsible for paying under this financial assistance policy.

  - Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

  - Deferring or denying, or requiring payment before providing Medically Necessary Care because of nonpayment of one or more bills for previously provided care.

  - Actions that require a legal or judicial process, including but not limited to:
    Placing a lien on an individual's property except for any lien the facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which care was provided; foreclosing on an individual's real property; attaching or seizing an individual's bank account or any other

personal property; commencing a civil action against an individual; and garnishing an individual's wages

- *Self-Employment Income* - is defined as the amount remaining after business operating expenses. A personal monthly income and expense form and a previous quarterly income statement are needed to assist with the determination of eligibility.
- *Uninsured patients* -are defined as patients without third-party insurance coverage for health services.
- *Under-insured patients* - are defined as patients who have some level of insurance or third-party assistance but still has out of pocket expenses that exceed his/her financial abilities.
- *Emergency Medical Conditions* - is defined as a 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 individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ.
- *Medically necessary* – Healthcare 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 and that are in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
    - For these purposes, "generally accepted standards of medical practice" means:
        - Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community; Physician Specialty Society recommendations; the views of physicians practicing in the relevant clinical area; and any other relevant factors.
- *Medically Underserved*- is defined as populations "at risk of not receiving adequate medical care as a result of being under insured or uninsured or due to geographic, language, financial or other barriers."
- *AGB (Amounts Generally Billed) Percentage* - The percentage of Medicare gross reimbursement divided by total allowable charges for all claims allowed during the 12-month measurement period as calculated under the look-back method. The AGB percentage will be calculated each year using claims allowed from the twelve (12) month period beginning April 1 and ending March 30. The AGB percentages calculated will be applied on May 1st each year and remain in effect until April 30th of the following year. The AGB percentages for inpatient and outpatient services are as follows:
- *AGB (Amounts Generally Billed)* - The maximum amount charged to all patients meeting the eligibility criteria under this Policy. Amounts Generally Billed (AGB) will be calculated by multiplying gross charges for any eligible service by the appropriate AGB percentage as defined above.

Eligibility for Financial Assistance Consideration:

- Free care and discounted Financial Assistance applies to Eligible Services as defined in this Policy. A patient that qualifies for financial assistance under this policy is eligible for discounts to co-payments, coinsurance and deductibles. Financial assistance discounts do not apply to any amounts received or receivable from an insurance company for eligible services. The maximum amount a patient qualifying for Financial Assistance will pay is less than or equal to the AGB as defined in this Policy.
- Qualification for Financial Assistance based on income will be determined using the following methods:

- Presumptive Eligibility – Prior to collection activity (ECA), all self-pay patient accounts may be reviewed using predictive analytics to determine if the patient/guarantor qualifies for financial assistance. If there is adequate information provided by the patient or through other sources, the patient may be deemed presumptive charity without a formal application. The following types of accounts may be considered eligible for financial assistance without documentation under the presumptive charity program (1) Referrals from approved community agencies, (2) No estate (deceased), (3) Eligible for Medicaid in states other than Georgia, (4) Eligible for State/Federal Programs where program funding has been exhausted, (5) Low income or subsidized housing, (6) Participation in the Women, Infants, and Children's programs (WIC), (7) State funded housing programs, (8) Unemployed persons with no Third party insurance coverage; or persons deemed unable to pay by 3rd party systems, algorithms, or databases.

- Completion of the facilities Financial Assistance Application following the utilization of eligible services or within 90 days prior to the date of eligible services being rendered when net available liquid assets, greater than 100% of FPL based on family Size, are not sufficient and gross family income is between 0 and 400 percent of the Federal Poverty Guidelines adjusted for family size.

- If a patient/guarantor qualifies for Discounted Financial Assistance or does not qualify for financial assistance using the Presumptive Eligibility method, the patient/guarantor retains the ability to apply for financial assistance by completing the facility Financial Assistance Application.

Amounts Billed to Eligible Patients:

Once a patient has been determined by UGH, Inc. to be eligible for financial assistance, an approved patient should not receive bills based on undiscounted gross charges for a period up to one (1) year from the date of the approved application. UGH Inc. uses the Federal Poverty Guidelines (FPG) in effect at the time an application is completed and submitted to determine eligibility for financial assistance. In no event will the FAP approved individual be billed more than the calculated AGB for any emergency or medically necessary care. Criteria are set as follows:

Income:

- The following values shall be used to determine monthly income for the patient or guarantor seeking qualification for financial assistance: (1) Wages / Tips, (2) Supplemental Security Income (SSI), (3) Unemployment benefits, (4) Veterans Benefits, (5) Pensions / Retirement Benefits, (6) Child Support, (7) Interest /Dividends on investments, (8) Credit Card open to purchase.

- Household gross incomes that are at or below 200% of the FPG are eligible to receive free care. This is classified as Indigent Care.

- Household gross incomes that exceed 200% of the FPG but are at or below 400% of the FPG qualify for a discounted payment based on a sliding scale (see chart below). This is classified as Charity Care. The patient would be eligible to setup a payment plan for any remaining balance due according to approved Payment Plan Guidelines.

- If approval criteria is met, all discounts will be applied to the Gross Charges for approved patients based on household income.

- No patient approved for financial assistance will be required to pay more than the AGB amount calculated annually.

Household Income	Discount Percent
Less than or equal to 200% of FPG	100% Discount
More than 200% but less than or equal to 300% of FPG	85% Discount
More than 300% but less than or equal to 400% of FPG	70% Discount

Catastrophic Care - household gross incomes that exceed 400% 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. This is classified as Medically Indigent or Charity Hardship "Catastrophic Care". These patients may be approved for an extended payment plan or 60% discount. Some examples include:

  - 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 even if income exceeds 400% of FPG.
  - The patient's subsistence is threatened resulting in an ability to meet patient liabilities.

- Catastrophic Care will provide a discount to outstanding medical bills when:
  - The patient's household income exceeds 400% of FPG
  - The patient's total medical bills exceed 50% of their Gross Household Income
- Catastrophic Care Discounts will be calculated as follows:

Size of the Bill		Discount Percent
Greater than 50% of Total Household Income		60% Discount

Assets – available liquid assets including stocks, bonds, retirement accounts, checking/savings accounts, certificates of deposits, etc in excess of 100% of FPL based on Family Size will be required to be spent down towards outstanding Hospital medical debt before patient may be approved for Financial Assistance for any category.

Financial Assistance Application Methodology:

- Financial assistance requests must be submitted using the financial assistance application. The application must be completed in its entirety and all supporting documentation attached to the application.
- This Policy describes the way patients will be notified about the Financial Assistance available and this Policy. The notification period ends on the 120th day after the facility issues the first post-discharge billing statement to the patient. If, by the end of this 120-day period the patient has not submitted a Financial Assistance Application, the facility may begin collection actions against the

patient. The application period during which the facility will accept and process a Financial Assistance Application ends on the 240th day after the facility issues the first post discharge billing statement to the patient.

  - The facility may use external sources to help determine an applicant's ability to pay, and the value of assets. Non-physical assets such as bank accounts, bonds, etc., will be used to help determine ability to pay, while the physical assets such as real estate, automobiles, etc. will be used to help determine debt ratios.
  - A reasonable effort by the UGH facilities to explore and assist patients in applying for alternative sources of payment and coverage from public and private payment programs.
  - Use of a data analytics model (such as Propensity to Pay) may be used to identify patients who may qualify for financial assistance but have not requested this assistance.

- Applicant shall submit the following supporting documentation, if applicable, with a completed Application:
  - Check stubs or statements from your employer indicating the last three (3) months gross income.
  - If self- employed, please provide a copy of last quarter's Business Financial Statement along with the previous year's Business Tax Return.
  - Unemployment statement showing denial or eligibility including the weekly amount you have received during the last three (3) months.
  - Social Security and/or Disability Benefits current eligibility letter or copy of previous month's Social Security or Disability checks. (If you have direct deposit, send a copy of your last bank statement showing verification of this income).
  - Previous years signed income tax return.
  - Proof of any other income sources such as food stamps, child support, alimony, trust funds, or rental property received during the last three (3) months.
  - Last three (3) months detailed bank statements (checking and savings accounts)
  - Proof of residency. (Rental agreement, utility bill, property tax assessment notice)
  - Copies of any and all monthly expenses (water, electric, phone bill)
  - List of Assets including but not limited to: Savings Accounts, Checking Accounts, Stock/Bonds (market value), Face Value of Certificate of Deposit(s), Recreational Vehicles (boats, motorcycles, atvs, etc.), Cars and/or Trucks.
- If the applicant has no income, the following documentation should be provided:
  - A personal written statement, signed and dated, explaining the circumstances of your financial situation for the last 3 months.
- Falsifying information on the Application will be grounds for denying or revoking Financial Assistance. Falsifying an Application includes, but is not limited to, failure to disclose assets.

- Applicant shall identify all known third party payment sources for services rendered. Applicant shall cooperate with the facility in filing of claims and collection of reimbursement from all third-party payment sources. Failure to cooperate will be grounds for denying Financial Assistance.

- Applicant shall cooperate in the application for Financial Assistance from other sources, such as Medicaid and other programs. Failure to cooperate will be grounds for denying Financial Assistance.

Financial Assistance Procedures

- Patients will be notified of the availability of financial assistance at time of registration by presentation of a free written copy of the plain language summary of the policy.

- A Financial Counselor is available to discuss the Financial Assistance program offered by the facility with the patient or the patient's designated representative. A free written copy of the Financial Assistance Policy and Financial Assistance Application may be obtained from the Financial Counselor. At the request of the patient or the patient's designated representative, the Financial Counselor will assist the patient with initiation and completion of the Financial Assistance Application.

- Financial Counselors may be reached Monday – Friday during regular business hours:

  Via telephone: **706-745-2111**
  Via email: **CBO-UGH@uniongeneral.org**

- The facility will assist, as requested, patients in becoming covered under state, local, federal or community-based assistance programs.

- When an application is received, the Financial Counselor will review the application for completeness, which shall include all supporting documentation. If it is determined that the application is incomplete, the facility will take the following actions:

    - Suspend any extraordinary collection actions that may have been initiated against the patient/Guarantor.

    - Provide the patient with a written notice that describes the additional information or documentation the patient must submit to complete his or her application.

    - Provide the patient with at least one written notice that informs the patient/Guarantor about any extraordinary collection actions that may be initiated or resumed if the application is not completed or if the amount due is not paid within 30 days from the date of the notice.

    - If all supporting documentation is not submitted or the amount due is not paid within 30 days of the written notice as described in the preceding paragraph, the request for financial assistance will be denied and the account will remain in the billing cycle. A new application may be submitted if the date of the application is within 240 days after the facility issues the first post discharge billing statement to the patient.

- Once a completed application has been received and reviewed, the Financial Counselor will make a recommendation for approval or denial on the application. The application is given to the appropriate individuals based on the account balance and amount of the financial assistance discount requested for approval. The facility will respond within five (5) business days from the receipt of a completed application.

- A credit check may be processed for applicants and household members to assist in determining the overall financial status and value of the assets. A credit report may be used solely in the determination of charity when a financial application cannot be obtained. If the applicant's credit report indicates the family unit income provided by the applicant is unrealistic, financial assistance may be denied.
- The patient will be notified in writing of the facilities decision to provide Financial Assistance.

Collection Practices and Polices:

- Patients will receive at least three (3) statements, one (1) notice letter and multiple phone calls requesting payment in full or payment arrangements be made.
- Initial Statement -
    - Patients will normally receive a statement for services rendered within thirty (30) days of discharge as an inpatient or treatment as an outpatient (excluding recurring visits).
    - Recurring visit patients will normally receive a bill for services rendered for the prior month within one month.
- Subsequent Statements –
    - The second statement will be issued thirty (30) days after the initial statement.
    - The third statement will be issued sixty (60) days after the initial statement.
    - The notice letter will be issued ninety (90) days after the initial statement requesting payment in full upon receipt. This letter will notify the patient that their account will be reflected as a bad debt and referred to an outside collection agency if payment in full is not received within thirty (30) calendar days of the statement date. The notification will specify any extraordinary collection actions that may be undertaken if the patient does not make full payment or complete a Financial Assistance Application.
    - One hundred twenty (120) days after the initial statement these accounts will be written off as a bad debt adjustment and sent to an outside collection agency.
- All statements will include language that informs the recipient about the availability of financial assistance and includes a telephone number and the website address to obtain additional information.
- Phone calls may be placed to patients after the initial statement, requesting payment in full or payment arrangements be made. The patient will be informed that financial assistance may be available and offered a copy of the plain language summary of the FAP.
- Use of Outside Collection Agency – when a Patient and/or Guarantor fails to pay the patient liability, the account will be referred to an outside collection agency after internal collection efforts have been exhausted.
- Reasonable Efforts - The Business Office Director will be responsible for ensuring that the facility has made reasonable efforts to determine whether a patient is eligible for financial assistance prior to engaging in any Extraordinary Collection Action (ECA).

- Extraordinary Collection Actions (ECAs) - The patient and/or Guarantor shall be provided at least thirty (30) days written notice prior to any ECAs being taken. The written notice will include a plain language summary of the financial assistance policy, notification of any ECAs that may be initiated against the patient and/or Guarantor, and the date after which any ECAs will be initiated. Oral notification to the patient and/or Guarantor will be attempted via a phone call prior to any ECAs being initiated. The oral notification will inform the patient and/or Guarantor about the Financial Assistance Policy and how to obtain help with the financial assistance application process.

    - Legal Actions – Legal actions may be initiated against the patient and/or Guarantor who default on payment to the facility. These legal actions may include:

    - Placing a lien on an individual's property except for any lien the facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which care was provided; foreclosing on an individual's real property; attaching or seizing an individual's bank account or any other personal property; commencing a civil action against an individual; garnishing an individual's wages.

    - All legal actions taken by any collection agency on behalf of the facility shall have had prior review and approval from the facility.

    - The facility or any collections agency working on behalf of the facility shall not pursue enforcement of a judgment lien, whether by Sheriff's levy and sale or otherwise, on a primary residence, pursue an involuntary bankruptcy proceeding against a patient and / or Guarantor, or take any action that would cause a bench warrant (an order issued by a judge or court for the arrest of a person) to be issued. However, the facility may pursue appropriate court orders, including contempt of court, for a patient/judgment debtor failing to respond to post-judgment discovery as required by law. See Official Code of Georgia Annotated Sect. 9-11-69 and Official Code of Georgia Annotated Sect. 9-11-37.

- Payment Options

    - Patients are required to pay their accounts by Check, Money Order, Credit Card (HSA or FSA cards); payments in cash are accepts at the Payment Windows at the Hospital. Exceptions may only be made with management approval.

    - Monthly Payment Plans can be setup according to the following schedule:

Account Balance	**Minimum Monthly Payment**	**Maximum # of Payments**
$2,700 or Less	$100	18
$2,701 - $4,800	$150	24
$4,801 – $9,000	$200	36

$9,001 or Greater	$250	48

* Payment arrangements longer than 48 months should seek outside financing.

Appeal Process for Financial Assistance Denials:

- An applicant may appeal a financial assistance determination within 15 days of a denial notice. Appeals must be submitted by letter or email, and sent to the Business Office:

  Union General Hospital, Inc.
  Attention: Director of Revenue Cycle
  35 Hospital Road
  Blairsville, GA 30512
  CBO-UGH@uniongeneral.org

- The Director of Revenue Cycle will respond to the appeal within 10 business days.

Covered and Non-Covered Entities:

- Approved financial assistance will be applicable only to the charges of the facility. This FAP applies to select services that you may encounter while receiving emergency or other medically necessary care at the facility, as seen in addendum A (attached).
- The facility cannot make any financial arrangements for the charges of any private physician practice or contracted physicians, including but not limited to the following list of common medical providers participating in care as described in ***Addendum 'A'*** (attached). Patients will need to make payment arrangements directly with these physician practices.
- The facility will assist the patient in qualifying for any Georgia, North Carolina, or Tennessee Medicaid or Social Security (SSI or SSD) benefits. Facility utilizes the services of outside vendors to assist patients in obtaining these benefits.

Attachments:

- *Financial Assistance Application* (available in Spanish)
- *Financial Assistance Worksheet*
- *FAP Addendum 'A'*

Additional Information: Director of Revenue Cycle, Chief Financial Officer

Approval Bodies: Union General Administration**,** Compliance Department**,** Union General Board of Directors

Annual Revision Dates: 7/25/2024, 7/25/2024, 3/4/2021, 9/10/2019, 4/26/2018, 4/7/2017, 2/27/2017, 1/19/2016

Approval Signatures: Nick Townsend: Chief Financial Officer

Applicability: Chatuge Regional Hospital, Chatuge Regional Nursing Home, Union County Nursing Home, Union General Hospital