Policy Statement

It shall be the policy of St. Joseph's/Candler Health System ("SJ/C") to provide health care services to patients regardless of their ability to pay and to grant financial assistance to those who qualify. No patient shall be denied emergency or other Medically Necessary care based upon their ability to pay, race, color, religion, creed, sex, national origin, age, disability, gender identity or expression.

SJ/C provides financial assistance to those patients who need emergency or other Medically Necessary care, but can demonstrate an inability to pay for all or some portion of the charges normally due. Patients with no financial ability to pay SJ/C's charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against pre-established guidelines for financial assistance and provided information about how to apply for financial assistance.

SJ/C shall make such financial assistance available without regard to the patient's race, color, religion, creed, sex, national origin, age, disability, gender identity or expression of such person, or any other classification prohibited by law. In offering Discounts, SJ/C shall strive to treat similarly situated individuals in a substantially similar manner. SJ/C shall not offer any Discount for the purpose of generating business payable under a federal health care program or to influence such beneficiary's selection of a particular provider, practitioner or supplier.

The financial assistance policy contained herein is applied consistently to all emergency and other Medically Necessary care provided by SJ/C at the following facilities:

- St. Joseph's Hospital
- Candler Hospital
- SJ/C Medical Group (Medical Group)
- SJ/C Oncology Services (Oncology Services)
- SJ/C Home Health Services

This policy requires the adoption by the SJ/C Board of Trustees. Any material changes to this policy will require approval of such governing body or parties authorized by the governing body to act on its behalf as permitted under state law.

Purpose

- To provide a framework to inform patients or responsible parties of their financial obligations for health care services, to assist them in resolving their financial liability, and to counsel them regarding insurance coverage.
- To provide guidelines and objective, consistent eligibility criteria for use in determining the financial status of patients so that appropriate classification and distinction can be made between uncollectible amounts arising from a patient's inability to pay and those arising from a patient's unwillingness to pay.
- To identify those needing financial assistance at the beginning of the collection cycle and reduce the time it takes to resolve an account.
- To explain how patients may apply for financial assistance.
- To provide a Discount for Uninsured patients that results in charges that equal the Amounts Generally Billed (AGB) to Insured patients.
- To define the method used to calculate AGB and how to obtain this information free of charge.
- To facilitate cash flow by offering a Prompt-Pay Discount to patients with a self-pay balance.
- To simplify the process for patients and reduce paperwork for both the patient and SJ/C staff at the time of service.
- To gather and maintain data to substantiate a patient's inability to pay and meet the requirements of §501(r) of the Internal Revenue Code and the Affordable Care Act requirements for §501(c) (3) hospitals.

Entities to whom this Policy Applies

St. Joseph's Hospital, Candler Hospital, SJ/C Medical Group (a listing of SJ/C Medical Group can be found on the SJ/C website), SJ/C Oncology Services and SJ/C Home Health Services

Entities to whom this Policy Does Not Apply

Chatham Radiologists, Georgia Emergency Physicians, Pathology Associates, Coastal EMS, Southside Fire/EMS Ambulance Service, SemperCare, Candler Retail Pharmacy, American Anesthesiology Associates of Georgia, and any physician with admitting privileges that is not listed as part of the SJ/C Medical Group.

Definition of Terms

Amounts Generally Billed (AGB) - The amount by which charges for Uninsured patients are measured. Uninsured patients will not be charged more for emergency or other Medically Necessary care than the AGB for patients who have insurance coverage. To calculate AGB, SJ/C uses the look-back method inclusive of both hospital facilities experience. The look-back method utilizes data from Medicare and private health insurers based on the prior 12-month fiscal year to determine the AGB percentage applied. The AGB percentage utilized by SJ/C

and the method in which it was determined is available free of charge from the Customer Service Department. Customer Service may be contacted at 912-819-8455 or 800-374-7054.

Centralized Billing Office (CBO) – SJ/C co-workers who complete patient billing and collections on behalf of SJ/C employed physicians.

Discount - A reduction of the patient account balance (up to 100% of Gross Charges).

Extraordinary Collection Actions (ECA) - Any actions taken by the SJ/C (or any agent of SJ/C, including a collection agency) against an individual related to obtaining payment of a bill covered under this policy that requires a legal or judicial process, involves selling an individual's debt to another party, or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. Placing an account with a third party for collection is not an ECA.

Financial Assistance Policy (FAP) Discount - A percentage Discount of the patient account balance based on the patient's ability to pay.

Financial Solutions Advisors - SJ/C co-workers who verify proper insurance coverage, secure payment of deductibles and other estimated self-pay balances, provide assistance for those unable to pay by referral for Medicaid or other state programs, and provide guidance with the FAP.

Federal Poverty Guidelines (FPG) - Determined by the government of the United States and published annually in the Federal Register. FPG are based on the size of a family and family's income. FPG are used in determining a patient's eligibility for financial assistance under Medicaid and SJ/C's FAP.

Gross Charges - Full, established price for medical care that SJ/C entities consistently and uniformly charges all patients before contractual allowances, Discounts or other deductions.

Insured - The status of a patient with insurance or third-party coverage which pays all or a portion of the patient's Gross Charges for medical services. This category includes those patients covered by a governmental payor such as Medicare, Medicaid, Champus and authorized Veteran's benefits; as well as private payors such as Medicare Advantage, Medicaid managed care organizations, commercial or managed care, auto and worker's compensation.

Medically Necessary – Medical services based upon generally accepted medical practices in light of conditions at the time of treatment which is appropriate and consistent with the diagnosis of the treating physician and the omission of which could adversely affect the patient's condition. This classification does not infringe or encompass the classification of emergent or the EMTALA laws associated with that designation. If the patient feels that the service ordered requires immediate or urgent treatment, the patient may request review of the order by contacting the Office of Medical Affairs at 912-819-6670 or 912-819-3338.

Presumptive Charity – A Discount applied to the outstanding balance of a patient account based on FPG information provided by a scoring vendor. This Discount is applied at the end of the active self-pay billing cycle balance.

Prompt-Pay Discount - A 5% Discount of the patient's self-pay account balance (including any co-payment or deductible) is given before or at the time of service. The Prompt-Pay discount is available to Hospital and Oncology Services patients regardless of their ability to pay (this Discount is not available to Medical Group patients). This Discount is an administrative adjustment and is not considered financial assistance.

Scoring Vendor - The software company engaged by SJ/C to provide a financial rating (calculated based on credit bureau information such as assets, mortgage payments, auto loans, credit card debt, and other financial history) for patients. The financial rating is utilized as a factor in determining a patient's ability to pay. SJ/C currently contracts with Experian for this service.

Self-Pay Discount - A percentage Discount of the patient's self-pay account balance based on the patient's Uninsured status. Uninsured Hospital and Oncology Services patients are eligible for a Self-Pay Discount based on the most recent AGB. Uninsured Medical Group patients are eligible for a 50% Self-Pay Discount if paid at time of service regardless of their ability to pay.

Soft Inquiry – An inquiry reflective on a patient's credit bureau report, but not reportable to any outside entity, that can only be seen by the patient. This has no impact on a patient's credit score and is allowed by Federal Law due to the provider extending credit to the patient by not requiring the patient to pay upfront for any services the provider may render.

Uninsured - The status of a patient without insurance or third-party coverage who does not qualify for Medicaid or other state assistance. A patient may also be classified as "uninsured" if the patient is insured, but the insurer refuses to pay for medical services rendered for reasons such as pre-existing conditions, out-of-network provider, etc. Patients with access to auto insurance benefits of any kind, worker's compensation, victims of crime funds, etc. will be excluded as well as any patients who refuse or fail to comply with requirements that would allow coverage under a governmental or non-governmental program.

Procedures

I. ELIGIBILITY CRITERIA

SJ/C provides financial assistance to patients who need emergency or other Medically Necessary care, but can demonstrate an inability to pay for all or a portion of the amount charged for medical services.

Patients without the financial ability to pay are evaluated for eligibility under Medicaid or other state assistance programs. A patient is automatically eligible for financial assistance if they have Medicaid or if they qualify for EBT benefits. Proof of this eligibility must be obtained. Patients

ineligible for Medicaid or other state assistance programs are then evaluated for financial assistance under SJ/C's Financial Assistance Policy (FAP). SJ/C financial assistance is provided in the form of a FAP Discount or as free care.

Eligibility for financial assistance to Uninsured and Insured patients with a self-pay balance is based upon FPG, income of the patient's household, personal assets, and the amount of medical debt owed to SJ/C for which the patient is liable. Upon receipt of a patient's completed financial assistance application and proof of income, the level of financial assistance is determined using a sliding scale based on the Gross Charges or balance due after insurance payment. Exhibits A, B, C, D and E (attached) provide the tables used in determining the applicable income category and percentage Discount applied to a patient's account balance. Exhibits B and C apply only to services provided by the Hospitals or SJ/C Oncology Services – Hilton Head. Exhibits D and E apply only to services provided by the Medical Group, SJ/C Home Health Services, and SJ/C Oncology Services – Savannah. Gross Charges for all emergency and Medically Necessary treatment provided by SJ/C are eligible for an FAP Discount if the patient qualifies.

II. METHOD OF APPLYING FOR ASSISTANCE

To apply for financial assistance, patients must complete a one-page application (see Exhibit F attached) and provide proof of income. Applications are available from Registrars, Financial Solutions Advisors, Customer Service Representatives or on-line at www.sjchs.org. Financial Solution Advisors are available to answer questions and assist in the completion of the application.

Financial Solution Advisors may be contacted by calling any of the phone numbers below:

St. Joseph's Hospital	912-819-2434
Candler Hospital	912-819-8246
SJ/C Medical Group	912-819-5838
SJ/C Oncology Services	912-819-5838

Proof of income must be in the form of the following:

- A copy of most recent pay stub with year-to-date gross pay amounts for the patient and patient's spouse, if applicable, or for the parents of the patient if the patient is a minor child;
- A copy of most recently filed Federal Income Tax return, including all schedules; and
- Proof of any income enumerated as "other income" on the financial assistance application.
- If the patient is unable to provide proof of income information, a Financial Solution Advisors should be contacted for assistance.

Income is considered the patient's household gross income or, if self-employed, the gross income less work expenses directly related to producing the goods or services. Temporary Assistance for Needy Families (TANF), and financial assistance from friends and family is excluded from

income.

The completed application and proof of income can be mailed to:

SJ/C Patient Accounts
5353 Reynolds Street
Savannah, GA 31405

Applications may also be dropped off with the Financial Solution Advisors at either hospital or faxed to 912-819-8639.

Upon receipt of a patient's financial assistance application, the application will be screened for the required information and attachments. Hospital financial assistance applications are screened by the Financial Solution Advisors, and Medical Group and Oncology Services applications are screened by the CBO Financial Counselor. In addition, the financial ratings for patients with account balances in excess of $25,000 are validated with Scoring Vendor data. If applicable, Scoring Vendor data is added to the patient's financial assistance application. SJ/C will not deny financial assistance due to the applicant's failure to provide information that is not specified on the application form. Patients who submit incomplete financial assistance applications will receive a letter within 15 working days detailing the information needed.

Within 30 working days of receipt of a complete application, patients will receive a notification letter. An approval letter will show the percentage FAP Discount from Gross Charges or the balance after insurance payment. A denial letter will list the reason for the denial. If an individual approved for FAP Discount at 100% has previously made payment(s) that exceed the amount he or she is determined to be liable for based on the approved application, the amount of overpayment greater than $5 will be refunded.

A patient may apply for financial assistance at any time, even if the account has been referred to a collection agency.

III. BILLING PROCEDURES

A. Insurance coverage for all patient accounts is reviewed within 24 hours of the pre-admission interview or actual admission date. SJ/C attempts to meet all managed care pre-certification requirements; however, it is ultimately the patient's responsibility to obtain pre-certification/referral authorization prior to admittance. SJ/C will not be held liable if a pre-certification/referral is not properly obtained, unless SJ/C is contractually obligated to obtain the pre-certification/referral.

B. Uninsured patients are screened for eligibility under Medicaid or other state programs as soon after admission as possible. Financial Solution Advisors meet with Uninsured patients in a bed to make payment arrangements and/or to provide information regarding the FAP. Financial counseling is available to all patients to address concerns regarding financial options.

C. Co-payment and deductible and/or estimated co-insurance amounts are requested from Emergency Department patients at the time of discharge. Co-payment and deductible amounts (or estimated amounts thereof) are requested from Inpatient, Observation, Imaging, and Same Day Surgery patients at pre-registration, registration or prior to discharge.

D. It is the patient's responsibility to provide SJ/C with all necessary information to bill the patient's insurance(s). SJ/C staff will complete and submit claims on the patient's behalf. Patients will be billed for balances remaining after third-party payments and adjustments are applied. Even though insurance is carried, the patient is ultimately responsible for providing payment for services rendered. If the patient's insurance rejects or denies payment for services, SJ/C will bill the patient, unless SJ/C is contractually prohibited from doing so.

E. The Self-Pay Discount is available to all Uninsured patients regardless of their ability to pay, and therefore is not considered financial assistance. However, if an uninsured patient is unable to pay the remaining balance after the Self-Pay Discount is applied, the patient may apply for financial assistance. If an Uninsured patient receives a Self-Pay Discount and subsequently provides valid insurance information, the Self-Pay Discount will be reversed when SJ/C bills the third party. If an Uninsured patient receives a Self-Pay Discount and subsequently qualifies for financial assistance, the Self-Pay Discount will be reversed before the FAP Discount is applied so the adjustment is properly classified.

F. Uninsured Hospital and Oncology Services (Hilton Head) patients are eligible for a Self-Pay Discount based on the most recent AGB. This Discount is provided at the time of final billing and is reflected on the first bill. Uninsured SJ/C Medical Group, SJ/C Home Health Services, and Oncology Services (Savannah) patients are eligible for a 50% Self-Pay Discount. This Discount will be processed by the Practice Manager or designee at the time charges are processed or reviewed.

G. All Hospital and Oncology Services (Hilton Head) patients are eligible for a 5% Prompt-Pay Discount if they pay in full before or at the time of service. Prompt Pay Discounts are classified as administrative adjustments.

H. Billing functions for self-pay balances are performed by our Extended Business Office. The patient billing cycle begins with the production of a final bill (in the case of Uninsured patients) or with payment or denial by the insurer (in the case of Insured patients). The billing cycle is as follows:

Day 5	–	1st statement
Day 30	–	2nd statement
Day 60	–	3rd statement
Day 90	–	Final notice
Day 120	–	Returned to SJ/C and referred to collection agency or written off as Presumptive Charity based on financial rating from Scoring Vendor on final statement.

Outbound calls are placed throughout the billing cycle. The availability of financial assistance is on all billing statements.

I. Our Business Office also establishes and monitors patient payment plans according to the following guidelines:

Account Balance	Maximum Number of Monthly Payments Allowed
$1,000 - $3,000	12
$3,001 - $6,000	24
$6,001 - $9,000	36
$9,001- $12,000	48

Statements are provided on a monthly basis to patients on approved payment plans.

Any and all exceptions to the above procedure (up to $25,000) must be approved by the Manager of Patient Accounts or the Supervisor of Customer Service, Director of Patient Financial Services or Vice President of Revenue Cycle (for patient account balances of up to $75,000) or the Chief Financial Officer (for patient account balances of $75,000 and above).

J. Accounts with patient balances greater than $10,000 may qualify for a "catastrophic adjustment" if the patient does not otherwise qualify under our financial assistance policy. This adjustment plan may be applied to balances after insurance or if greater than the standard uninsured discount of 70%. In order to receive this adjustment, the patient must formally set up a payment plan that equals 20% of the patient's disposable income over the twenty-four months. During the timeframe of the catastrophic adjustment plan, any new balances will be adjusted. If the patient's income changes or the patient defaults on the payment plan, the patient's balance will be evaluated and the discount may be reversed.

K. Patient concerns are handled by the Patient Accounts Customer Service staff. Any unresolved patient concerns are referred to the Customer Service Team Leader, Customer Service Supervisor or Patient Accounts Manager. If questions regarding patient charges arise, the manager of the clinical department is consulted. If there is a material dispute regarding the charges on the patient's bill, the collection process may be put on hold until the dispute is resolved. Write-offs done as resolution to a patient concern or patient care issue must be approved by the Manager of Patient Financial Services (up to $25,000), the Director of Patient Financial Services or Vice President of Revenue Cycle or Director of Risk

Management (up to $75,000), the Chief Financial Officer ($75,000 to $150,000) and the President/Chief Executive Officer ($150,000 or more).

IV. FINANCIAL ASSISTANCE PROCEDURES

A. Hospital FAP Discounts receive the appropriate level of approval, i.e., Manager of Patient Financial Service up to $25,000, the Director of Patient Financial Services or Vice President of Revenue Cycle approve up to $75,000, the Chief Financial Officer those over $75,000, and the President & Chief Executive Officer those over $150,000. The CBO Director or designee must approve Medical Group and Oncology Services FAB Discounts under $25,000. Oncology Services Discounts over $25,000 must be approved by the Executive Director of the Lewis Cancer & Research Pavilion.

B. Approved Hospital FAP Discounts are processed by Payment/Resolution staff. A notification regarding the level of FAP Discount is provided by mail to the patient. Approved FAP Discounts for the Medical Group and Oncology Services are processed by the CBO Financial Counselor who will mail notification to the patient. FAP Discounts are classified by SJ/C as charity care.

C. Patients who are denied financial assistance have the right to appeal. Appeals should be submitted to the Manager of Patient Accounts. An appeal will initiate re-evaluation of a financial assistance application. If SJ/C chooses again to deny a patient's request for financial assistance, a patient has the right to ask the Georgia Department of Community Health for approval.

D. To make a reasonable effort to determine FAP eligibility for patients who do not submit an application, SJ/C will request scoring for self-pay account that has been returned by Extended Business Office for placement to a bad debt collection agency. By requesting scoring, a Soft Inquiry will be placed on the patient's credit bureau report. This scoring will be used as proof of eligibility for Presumptive Charity. The Discount percentage will be based on the Hospital's sliding fee scales. Balances that do not qualify for a Discount will be referred to a collection agency.

E. The placement of a Presumptive Charity adjustment on the account does not prevent an account from being placed with a bad debt collection agency. A notification will be sent to patient of this additional Discount along with the summary FAP. The patient will be given 30 days in which to submit a financial assistance application with supporting documentation if the patient feels that they might be eligible for a greater discounted amount.

F. Any patient who falls outside the SJ/C guidelines to receive a Discount or whose financial situation has changed, but still feels that they are unable to pay or set up appropriate payment arrangements, can apply for assistance by completing the financial assistance application and furnishing proof of income. These requests will be considered on a case-by-case basis. The same authority for approval listed in Section IV (A) above will apply and Customer Service will process the write-off and notify the patient.

G. If a patient receives debt relief under bankruptcy, the account balance is written off and classified as charity. The Hospital uses adjustment codes AWAGEARNER and ABANKRUPTCY. If the account is already in a bad debt status and at the collection agency, the same codes will be used to adjust the account using the Bad Debt Recovery journal. These will be reclassified to charity in the General Ledger.

H. In addition to financial assistance, the Chief Financial Officer may approve an adjustment to a patient account balance based on goodwill, public relations or risk management concerns, so long as there is no intention to influence patient referrals or induce any federal health care program beneficiary to receive services from SJ/C.

V. NON-PAYMENT

Patient accounts for which no payment has been received and financial assistance has not been requested are referred to a collection agency 120 days after the patient bill is produced. Patients whose accounts have been referred to a collection agency are still able to request financial assistance.

SJ/C requires the approval of the Director of Patient Financial Services or Vice President of Revenue Cycle to engage in an "extraordinary collection action" (ECA) with the exception of reporting to the credit bureaus on a patient account. The Director or Vice President has the final authority and responsibility for determining whether SJ/C made reasonable efforts to decide whether a patient is FAP-eligible prior to engaging in ECAs. The Director or Vice President will confirm the following actions were taken with regard to a patient prior to approving ECAs on the patient's account:

- The patient received the notice of an ECA no earlier than 120 days after first billing;
- The notice of a potential ECA specified the potential ECA(s) that would be taken if the patient did not submit a completed financial assistance application or pay the amount due by the deadline (specified in the notice); and
- The potential ECA notice was provided to the patient 30 days prior to the ECA deadline.

The Director or Vice President will also inspect the patient's billing file prior to approving ECAs on the patient's account. The Director or Vice President will confirm the following communications with the patient are noted in the billing file:

- A plain language summary application for financial assistance was provided before discharge;
- All billing statements and other billing communication were provided in plain language;
- Any oral communication with the patient provided financial assistance information in plain language; and
- At least one notice of potential ECAs was provided to the patient.

The collection agency is authorized by SJ/C to take the following ECAs to obtain payment of a

patient bill. The collection agency is not authorized to pursue these ECAs at any time SJ/C itself would be prohibited from pursuing ECAs:

- Placing a lien or foreclosing on an individual's property;
- Attaching or seizing individual's bank account or any other personal property;
- Garnishing wages; or,
- Filing a civil lawsuit.

VI. FAP PUBLICATION

The Financial Assistance Policy, financial assistance application, and plain language summary are widely available on the SJ/C website at www.sjchs.org. The FAP, financial assistance application, and plain language summary are also available by request, free of charge, by mail or at all SJ/C patient registration and cashier areas in paper form in both English and Spanish.

The availability of financial assistance is advertised with conspicuous displays in all intake and discharge areas in all facilities. Additionally, the plain language summary is provided to SJ/C's community outreach affiliates, the African American Resource Center, the Georgia Infirmary, St. Mary's Community Center and the Good Samaritan Clinic.

Co-workers shall refer any patient who requests financial assistance or who indicates he/she is unable to pay the entire amount of his/her account balance to Patient Accounts Customer Service. Co-workers other than those persons working in the Patient Accounts Department shall not make specific representations or promises to patients concerning whether a patient may qualify for any type or amount of financial assistance.

VII. EMERGENCY MEDICAL CARE POLICY:

SJ/C maintains an EMTALA policy **(Administrative Policy #1102-A EMTALA – Emergency Medical Treatment and Labor Act)** and all co-workers are trained as such. Co-workers in the Emergency Department shall follow EMTALA policies and procedures in responding to inquiries from Emergency Department patients regarding charges and related financial matters.

Approved:

Signature

Original Implementation Date: 10/21/2010
Next Review Date: 07/22/2022
Originating Department/Committee: Patient Accounts
Reviewed: 06/15, 04/16, 02/17, 07/17, 02/18, 07/19
Revised: 06/15, 04/16, 02/17, 07/19

Rescinded:
Former Policy Number(s): # 8221-02 (SJ)
Cross Reference: Administrative Policy #1102-A EMTALA – Emergency Medical Treatment and Labor Act
Administrative Policy #1069-A Credit Collection
Administrative Policy #1194-A Financial Assistance

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

EXHIBIT A

2019 Annual Income Guidelines for Financial Assistance Eligibility Determination

For St. Joseph's Hospital, Candler Hospital, SJ/C Medical Group, SJ/C Home Health and SJ/C Oncology Services

				INCOME LEVEL			
		Indigent	**Charity**	**Category A**	**Category B**	**Category D**	
Family Size	**Poverty Guidelines**	**125%**	**200%**	**250%**	**300%**	**400%**	
1	12,490	15,613	24,980	31,225	37,470	49,960	
2	16,910	21,138	33,820	42,275	50,730	67,640	
3	21,330	26,663	42,660	53,325	63,990	85,320	
4	25750	32,188	51,500	64,375	77,250	103,000	
5	30,270	37,713	60,340	75,425	90,510	120,680	
6	34,590	43,238	69,180	86,475	103,770	138,360	
7	39,010	48,763	78,020	97,525	117,030	156,040	
8	43,430	54,288	86,860	108,575	130,290	173,720	
*	4,420	5,525	8,840	11,050	13,260	17,680	
		* For family units over 8, add the amount shown for each additional member.					
Effective: 02/01/19							

EXHIBIT B

Financial Assistance Income Level Categories and Discount Percentages

Insured Patient

For St. Joseph's Hospital, Candler Hospital, and SJ/C Oncology Services - Hilton Head

	Adjustment % for Patients with Insurance						
	Indigent/Charity	**Category A**	**Category B**	**Category C**	**Category D**	**Category E**	**Category F**
Billed Charges	**<200%**	**201 - 250%**	**251 - 300%**	**301 - 350%**	**351 - 400%**	**401 - 450%**	**> 450%**
> $50,000	100%	95%	85%	75%	65%	55%	0%
$40,000 - $50,000	100%	90%	80%	70%	60%	50%	0%
$30,000 - $39,999	100%	85%	75%	65%	55%	45%	0%
$20,000 - $29,999	100%	80%	70%	60%	50%	40%	0%
$10,000 - $19,999	100%	75%	65%	55%	45%	35%	0%
$ 5,000 - $9,999	100%	70%	60%	50%	40%	30%	0%
$ 2,500 - $4,999	100%	65%	55%	45%	35%	25%	0%
$500 - $2,499	100%	60%	50%	40%	30%	20%	0%
< $500	100%	55%	45%	35%	25%	15%	0%

Effective: 2/1/19

EXHIBIT C

Financial Assistance Income Level Categories and Discount Percentages

Uninsured Patients

For St. Joseph's Hospital, Candler Hospital, and SJ/C Oncology Services - Hilton Head

	Adjustment % for Uninsured Patients						
	Indigent/ Charity	Category A	Category B	Category C	Category D	Category E	Category F
Billed Charges	**<200%**	**201 - 250%**	**251 - 300%**	**301 - 350%**	**351 - 400%**	**401 - 450%**	**> 450%**
> $50,000	100%	95%	90%	85%	80%	70%	70%
$40,000 - $50,000	100%	90%	85%	80%	75%	70%	70%
$30,000 - $39,999	100%	85%	80%	75%	70%	70%	70%
$20,000 - $29,999	100%	80%	75%	70%	70%	70%	70%
$10,000 - $19,999	100%	75%	70%	70%	70%	70%	70%
$ 5,000 - $9,999	100%	70%	70%	70%	70%	70%	70%
$ 2,500 - $4,999	100%	70%	70%	70%	70%	70%	70%
$500 - $2,499	100%	70%	70%	70%	70%	70%	70%
< $500	100%	70%	70%	70%	70%	70%	70%

Effective: 2/1/19

EXHIBIT D

Financial Assistance Income Level Categories and Discount Percentages
Insured Patients
For SJ/C Medical Group, SJ/C Home Health, and SJ/C Oncology Services - Savannah

	Adjustment % for Patients with Insurance						
	Indigent/ Charity	Category A	Category B	Category C	Category D	Category E	Category F
Billed Charges	**<200%**	**201 - 250%**	**251 - 300%**	**301- 350**	**351- 400%**	**401 - 450%**	**> 450%**
>$2,500	100%	90%	75%	60%	45%	30%	0%
$1,000-$2,500	100%	80%	65%	50%	35%	20%	0%
$500-$1,000	100%	70%	55%	40%	25%	10%	0%
$100$500	100%	60%	45%	30%	15%	0%	0%
$25-$100	100%	50%	35%	20%	5%	0%	0%
< $25	100%	40%	25%	10%	0%	0%	0%

Effective 2/1/19

EXHIBIT E

Financial Assistance Income Level Categories and Discount Percentages
Uninsured Patients
For SJ/C Medical Group and SJ/C Oncology Services - Savannah

	Adjustment % for Patients without Insurance						
	Indigent/ Charity	Category A	Category B	Category C	Category D	Category E	Category F
Billed Charges	**<200%**	**201 - 250%**	**251 - 300%**	**301 - 350%**	**351 - 400%**	**401 - 450%**	**> 450%**
>$2,500	100%	90%	80%	70%	60%	50%	50%
$1,000-$2,500	100%	80%	70%	60%	50%	50%	50%
$500-$1,000	100%	70%	60%	50%	50%	50%	50%
$100$500	100%	60%	50%	50%	50%	50%	50%
$25-$100	100%	50%	50%	50%	50%	50%	50%
< $25	100%	50%	50%	50%	50%	50%	50%

Effective: 2/1/19

EXHIBIT F

Financial Assistance Application

Need assistance call 819-2434 or 819-8246

Patient's Name _____ MRN #_____Date:_____

****** IMPORTANT*******

In order for a Financial Assistance request to be processed, the following financial information MUST be returned with this completed and signed application. If you cannot provide the following please explain: (I certify that the information provided is true & complete)

☐Most recent pay stubs or Supplemental Security Income (SSI provided by Social Security)

☐Most recent statements from checking, savings, certificates of deposit, stocks, bonds, money market, etc.

☐Most recent Federal Income tax forms including schedules C, D, E, & F

☐Most recent W2 statement or 1099

Do you own your Home ☐Yes ☐No Estimate value _____ Monthly Mortgage/rent _____

Guarantor Name: _____Relationship to Patient _____SS#_____
(head of household)

Spouse's name if Married _____SS#_____ Phone#_____

Street Address: _____ City_____ State_____ Zip Code_____

How many Dependents live in household? _____ Please list total family members in household_____

List monthly Income:

Employment: _____SSI_____ Alimony/Child support_____ Pension _____

Trust fund _____ Public Assistance _____ Investment Income _____ Rental income _____

I certify that the information provided is true and accurate. I hereby grant permission and authorize any agent of the Georgia Dept. of Community Health to disclose to the hospital all information regarding the status of my Medicaid application; and if such application is not approved, the reason for disapproval.

Signature of Applicant _____ Date _____

For St. Joseph's/Candler Use Only

Adjustment totals _____Adjustment code _____ Financial Assistance Category _____

Approvals: Director: _____Date _____

VP of Revenue Cycle: _____Date_____

CFO: _____Date_____

CEO: _____Date_____

Percentage of Federal Poverty Guidelines is _____Approved if below _____of Federal Poverty Guidelines

Policy Statement

It shall be the policy of St. Joseph's/Candler Health System (SJ/C) to determine the financial ability of patients to pay for services provided by SJ/C at or before the point of service. This process will ensure that patients are properly educated as to their financial responsibility and that SJ/C maximizes collections of patient residual balances. In order to do this, we will require the physicians practicing at SJ/C to identify an order for services as Emergent, Urgent or Elective. This designation will assist in making financial decisions regarding the provision of services.

Emergent health care services will be provided to patients regardless of their ability to pay and are eligible for financial assistance to those who qualify. No patient shall be denied emergency care based upon their ability to pay, race, color, religion, creed, sex, national origin, age, disability, gender identity or expression. Criteria will be the same as those established under Emergency Medical Treatment and Labor Act (EMTALA) Laws and Regulations. For Urgent and STAT services, SJ/C will identify any patient financial responsibility prior to service and the patient/guarantor will be requested to pay or make acceptable payment arrangements prior to services being rendered. Patients seeking Elective services will be required to pay their portion at the time of service which could result in a combination of a time of service payment and payment plan that would then deem the patient financially cleared.

Purpose

- To provide a means by which health care services are available in a consistent, equitable and effective manner.
- To assure that those who require health care services are able to obtain such services while ensuring that appropriate financial arrangements are made prior to service being rendered.

Entities to whom This Policy Applies

Candler Hospital and St. Joseph's Hospital, including all off campus outpatient facilities.

Definition of Terms

Amounts Generally Billed (AGB) – The amount by which charges for U*ninsured* patients are measured. Uninsured patients will not be charged more for care than the AGB for patients who have insurance coverage. To calculate AGB, SJ/C uses the look-back method. The look-back method utilizes data from Medicare and private health insurers based on the prior 12-month fiscal year to determine the AGB percentage applied. The AGB percentage utilized by SJ/C and the method in which it was determined is available free of charge from the Customer Service Department. Customer Service may be contacted at 912-819-8455 or 800-374-7054.

Elective – Service that is beneficial to the patient, but is not considered urgent. Any service scheduled greater than 30 days out will be considered Elective.

Emergent – Service is needed immediately due to injury or sudden illness. Examples include difficulty breathing, suspected heart attack, uncontrolled bleeding or possible stroke.

Financial Assistance Policy (FAP) Discount – A percentage discount of the patient account balance based on the patient's ability to pay.

Financial Counselors – SJ/C co-workers who secure payment of deductibles, co-insurance and other estimated self-pay balances, provide assistance for those unable to pay by referral for Medicaid or other state programs, and provide guidance with the FAP.

Insured – The status of a patient with insurance or third-party coverage which pays all or a portion of the patient's gross charges for medical services.

Prompt-Pay Discount – A 5% discount of the patient's self-pay account balance (including any deductible or co-insurance) if paid in full at the time of service or within 30 days of the statement date. This discount is an administrative adjustment and is not considered financial assistance.

Self-Pay Discount – A percentage discount of the patient's self-pay account balance based on the patient's Uninsured status. Uninsured patients are eligible for a Self-Pay Discount based on the most recent AGB.

STAT – Services ordered by a physician that should be performed without delay.

Underinsured – Patients who are covered by high deductible plans or the remaining patient balance is greater than the patient is able to pay.

Uninsured – The status of a patient without insurance or third-party coverage who does not qualify for Medicaid or other state assistance. A patient may also be classified as "uninsured" if the patient is insured, but the insurer refuses to pay for medical services rendered for reasons such as pre-existing conditions, out-of-network provider, etc.

Urgent – Unexpected illness or injury that needs prompt medical attention, but not an immediate threat to your health. Examples include headaches, back or joint pain, flu symptoms or ear aches.

Procedure

SJ/C will provide Emergent services to all patients. After EMTALA requirements are met, SJ/C will request payment of any deductible or co-insurance amounts prior to the patient being discharged.

Financial Clearance will be utilized for any patient who is self-pay or has coverage by only one insurance plan. Patients who are covered by Medicaid, Workers Compensation or by two insurance plans will not be screened unless the service provided is not covered by their insurance plan.

Post inpatient discharge care for certain individuals frequently include, but are not limited to Home Health, Wound Care Clinic and Physical Therapy for ongoing outpatient services and shall be considered medically necessary. These individuals are listed as Medicaid pending, Good Sam, St. Mary's or pending charity and will be considered cleared for financial clearance.

For all non-emergent care provided to patients, an estimate will be provided based on the services to be rendered and any out of pocket cost including deductibles, co-pays and/or co-insurance.

SJ/C **requests** payment of the deductible, co-pays, and co-insurance amounts for all Urgent services rendered to patients, with the exception of those who qualify for financial assistance under **Administrative Policy #1220-A Billing, Collection and Financial Assistance**.

SJ/C **requires** payment of any remaining deductibles, copays, and/or co-insurance amounts for any service deemed Elective by the patient's ordering physician. For Elective surgical services, patients will be required to pay 50% of the estimate to reserve the surgical time at time of pre-registration or a minimum of 14 days prior to the date of service, whichever is less. The remaining balance will be due on the date of service. Patients not willing to make a down payment or set up a payment plan to reach to the 55% required to reserve the surgical service will be informed that the surgery will need to be delayed.

Patients who wish to appeal the Elective determination may do so by contacting the Office of Medical Affairs at 912-819-6670 or 912-829-3338.

Exceptions will be made for screening services, such as mammograms and colonoscopies. All radiation oncology and chemotherapy services will be considered Urgent under this policy.

Except where prohibited by law or contract, SJ/C will look to the patient/guarantor for payment in full or financial clearance as defined below on all accounts. A brochure, outlining SJ/C payment guidelines, is available to patients and physicians.

A. Financial Clearance

Financial clearance is defined as the patient/guarantor making satisfactory financial arrangements for payment of the patient's estimated deductible/co-insurance amounts as outlined below:

1. Payment in full for Elective services is required at the point of service. A Prompt Pay Discount of 5% of the estimated amount due is available for accounts paid in full at time of service.
2. Payment arrangements can be made for Urgent services. A down payment equal to one monthly payment amount should be requested at the point of service. In-house payment arrangements will not extend beyond 6 months. Payment plans beyond 6 months can be established with our partner AccessOne

Internal Payment Plan - OnPlan

Account Balance	Optimal Term	Secondary Term	Minimum Monthly PMT
$100 - $250	3 Months	4 Months	$25.00
$250.01 - $500	3 Months	6 Months	$41.67
$500.01 and up	6 Months	-	$83.34

Payment Plan with Partner, AccessOne

Account Balance	Number of Equal Payments
$1,000 - $3,000	12 Months
$3,001 - $6,000	24 Months
$6,001 - $9,000	36 Months
$9,001 - $13,000	48 Months

3. For Urgent services, if neither option above can be satisfied, the patient will be referred to a Financial Counselor.
   a. Uninsured or Underinsured patients will be screened for Medicaid or other state programs. If determined eligible for these programs, the patient will be considered financially cleared.

   b. If determined ineligible for those programs, the patient will be provided a Financial Assistance Application (Form #FN40111 found on the Forms Repository). Completion of the Financial Assistance Application, if ineligible for Medicaid or other state programs, will allow the patient to be financially cleared for services.

4. Being financially cleared for services in no way prevents the patient from being responsible for any remaining balances after insurance processes or if the patient is only deemed eligible for a partial Financial Assistance discount.

   Patients seeking Elective services will be eligible for Financial Assistance or payment plans if the 55% estimate for the service is secured.

B. Scheduled Services

Scheduled services shall be defined as Urgent or Elective services that are scheduled at least 48 hours prior to the time of service. An estimate of the patient liability based on average charges per service and individual insurance benefit coverage will be calculated and communicated to the patient. Patients must be financially cleared prior to the services being rendered.

C. Unscheduled Services

Unscheduled services shall be defined as services that do not require scheduling or are scheduled less than 48 business hours prior to the time of service. The estimated patient liability for unscheduled services will be provided by the Patient Access Staff at the time of service. For unscheduled Urgent services, payment in full of the estimated amount due will be requested or the patient will be required to be financially cleared prior to services being rendered. It is recognized that in these instances, upfront financial counseling is not always possible; consequently, service may be delayed until the patient can be financially cleared. For unscheduled Elective services, payment in full of the estimated amount is required prior to services being rendered or service will be deferred. Payment in full can be defined as a combination of initial payment and meeting the appropriate terms of a payment plan in order to reach the 55% of estimate required for services to then be rendered.

D. Financial Counseling

Financial Counselors may be contacted by calling any of the phone numbers below:

St. Joseph's Hospital	912-819-3840
Candler Hospital	912-819-5083
SJ/C Oncology Services	912-819-5838

A financial clearance determination will be made as soon as it is feasible to do so. It may become necessary to postpone services until the patient is financially cleared.

E. Payment Options

Payment by check, debit card or credit card are accepted. SJ/C accepts Visa, MasterCard, American Express, and Discover Card. Payroll Deduction is available for co-workers receiving services.

F. Co-worker Accounts

Co-worker patient accounts will be handled in a manner consistent with the financial expectation of any SJ/C patient. In addition, co-workers may utilize payroll deduction as an alternative payment option for urgent services. If a co-worker elects to use payroll deduction, they will be responsible for completing a payroll deduction form for any new or additional accounts prior to services being rendered. Co-worker payroll deductions should be set established following the monthly payment guidelines stated above, withholding on a bi-weekly basis.

RESPONSIBILITY FOR INTERPRETATION

The Director of Patient Financial Services will be responsible for interpretation of this Policy.

Approved:

Original Implementation Date: 2/22/2017
Next Review Date: 04/03/2022
Originating Department/Committee: Patient Accounts
Reviewed: 03/17, 07/17, 03/19
Revised: 03/17, 07/17, 03/19
Rescinded:
Former Policy Number(s):
Cross Reference: Administrative Policy #1220-A Billing, Collection and Financial Assistance