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.
- 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 Counselors - 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 may be applied if a financial assistance application was not submitted in a timely manner. This Discount is applied at the end of the active self-pay billing cycle and is not applied to any account containing a self-pay payment.

Prompt-Pay Discount - A 5% Discount of the patient's self-pay account balance (including any co-payment or deductible) if paid in full within 30 days of the initial statement date. 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. 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 Counselors, Customer Service Representatives, or Avadyne, SJ/C's self-pay collection vendor (by mail); and on-line at www.sjchs.org. Financial Counselors are available to answer questions and assist in the completion of the application.

Financial Counselors 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 Counselor 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), child support payments, 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 Hospital Cashiers 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 Avadyne, 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 15 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 and the balance still due from the patient, if any. A denial letter will list the reason for the denial. If an individual approved for an FAP Discount 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. If a patient is making payments on a payment plan and their income situation changes, the patient may apply for financial assistance on their remaining balance. A patient may apply for financial assistance even after their patient 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 (except when the patient is admitted during the weekend). 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 Counselors meet with Uninsured patients and patients with deductibles and co-insurance to identify the payment source, 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 at the time of service or within 30 days of their first statement. Prompt Pay Discounts are classified as administrative adjustments.

H. Billing functions for self-pay balances are performed by Avadyne. 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 1	–	1st statement
Day 30	–	2nd statement
Day 80	–	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

Outbound calls are placed throughout the billing cycle and patients are informed of the Prompt-Pay Discount on the first billing statement and the availability of financial assistance on all billing statements.

I. Avadyne also establishes and monitors patient payment plans according to the following guidelines:

Account Balance	Maximum Number of Monthly Payments Allowed
$0 - $50	2
$51 - $250	3
$251 - $1,000	6
$1,001 - $2,500	12
$2,501 - $5,000	18
$5,001 - $7,500	24
> $7,500	Patient must secure outside financing or apply for financial assistance

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

Any and all exceptions to the above procedure must be approved by the Director of Patient Financial Services (for patient account balances of up to $75,000) or the Chief Financial Officer (for patient account balances of $75,000 and above).

J. Patient concerns are handled by the Patient Accounts Customer Service staff. Any unresolved patient concerns are referred to the Customer Service Team Leader 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 Director of Patient Financial Services 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., the Director of Patient Financial Services or designee must approve all Hospital FAP Discounts under $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 by

Avadyne on-site staff. 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 Director of Patient Financial Services. 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 any account that has been returned by Avadyne 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. <u>NON-PAYMENT</u>

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 to engage in an "extraordinary collection action" (ECA) with the exception of reporting to the credit bureaus on a patient account. The Director 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 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 will also inspect the patient's billing file prior to approving ECAs on the patient's account. The Director 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: 02/20/2021
Originating Department/Committee: Patient Accounts
Reviewed: 06/15, 04/16, 02/17, 07/17, 02/18
Revised: 06/15, 04/16, 02/17
Rescinded:
Former Policy Number(s): # 8221-02 (SJ)
Administrative Policy #1069-A Credit Collection
Administrative Policy #1194-A Financial Assistance
Cross Reference: Administrative Policy #1102-A EMTALA – Emergency Medical Treatment and Labor Act

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

EXHIBIT A

2018 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 C**	**Category D**	**Category E**	**Category F**	
Family Size	**Poverty Guidelines**	**125%**	**200%**	**250%**	**300%**	**350%**	**400%**	**450%**	**>450%**	
1	12,140	15,175	24,280	30350	36,420	42,490	48,560	54,630	60,700	
2	16,460	20,575	32,920	41,150	49,380	57,610	65,840	74,070	82,300	
3	20,780	25,975	41,560	51,950	62,340	72,730	83,120	93,510	103,900	
4	25,100	31,375	50,200	62,750	75,300	87,850	100,400	112,950	125,500	
5	29,420	36,775	58,840	73,550	88,260	102,970	117,680	132,390	147,100	
6	33,740	42,175	67,480	84,350	101,220	118,090	134,960	151,830	168,700	
7	38,060	47,575	76,120	95,150	114,180	133,210	152,240	171,270	190,300	
8	42,380	52,975	84,760	105,950	127,140	148,330	169,520	190,710	211,900	
*	4,320	5,400	8,640	10,800	12,960	15,120	17,280	19,440	21,600	
		* For family units over 8, add the amount shown for each additional member.								
Effective: 02/1/18										

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: 2/1/18

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: 2/1/18

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 2/1/18

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: 2/1/18

EXHIBIT F

ST. Joseph's/Candler Financial Assistance Application

www.sjchs.org

Patient Name ______________________ SS# ____________ Date of Birth ____________

Address ____ Phone ____________
(STREET) (CITY) (STATE) (ZIP)

Parent Name (if patient is a child) ______________________ SS# ____________

Are you employed? ☐ Y ☐ N If yes, name of employer ______________________

Please list your hourly wage, number of hours per week, and date of hire $ _____ ____ hrs. ____/____/____

Are you married? ☐ Y ☐ N Spouse's Name ______________________ SS# ____________

Is your spouse employed? ☐ Y ☐ N If yes, name of employer ______________________

Please list his/her hourly wage, number of hours per week, and date of hire $ _____ ____ hrs. ____/____/____

How many dependents live in your household? ________ Please list total family members in household ________
(A dependent is someone you claim as a personal exemption on your Federal Income Tax Return. If you are a student and were claimed on your parent's Federal Tax Return, their income information needs to be included.)

Do you own your home? ☐ Y ☐ N If yes, what is the estimated value? $ ____________ .
Do you own other real estate? ☐ Y ☐ N If yes, what is the estimated value? $ ____________ .
Do you have other assets listed below? ☐ Y ☐ N If yes, please list:

Automobiles			Checking/Savings/Money Market Accounts	
Make ________	Yr ______	Value $ ________	Bank ____________	Balance $ ________
Make ________	Yr ______	Value $ ________	Bank ____________	Balance $ ________
Make ________	Yr ______	Value $ ________	Other ____________	Balance $ ________

Please list other monthly income:

Social Security/SSI $ ________ $ ________ $ ________
Patient Spouse Children

Pension $ ________ $ ________
Patient Spouse

Investment Income $ ________

Rental Income $ ________

Alimony/Child Support $ ________

Grants/Educational Loans $ ________

Public Assistance $ ________

Trust Fund $ ________

Other $ ________

Explain ________

The documents listed below are required, if applicable. Please include them with your application.

____ Copy of most recent pay stub with year-to-date amounts; include pay stubs for patient, spouse and parents (if child)
____ Copy of most recent Federal Income Tax Return, including all schedules
____ Proof of any income listed as other income in the section above

If you cannot provide proof of income, please explain ______________________

If you did not file a tax return for the previous year, please explain ______________________

Patients applying for financial assistance must first apply for all other available medical benefits, including Medicaid.

I certify that all of the above information is true and complete. I understand that this application is made so the hospital can judge my eligibility for financial assistance, based on the established criteria on file in the hospital. I hereby grant permission and authorize any agent of the Georgia Department 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.

I understand that the information which I submit is subject to verification by the hospital, including credit reporting agencies, and others as required. I understand that this application pertains to hospital charges and not physician's charges.

______________________ ____________
Signature of Applicant **Date**

FN 40111 (1/11)