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Financial Assistance Policy

I. PURPOSE

This policy establishes guidelines pursuant to which Abbeville General (AG) and its associated Rural Health Clinics will provide financial assistance, based on the ability to pay, for patients whose financial status makes it impractical or impossible to pay for the entire bill for medical services provided by AG. This policy applies only to AG's charges and those of Anesthesia and employed physicians, not the charges of other physicians or other healthcare providers, nor does this policy apply to non-medical services such as social or educational, or to elective services such as cosmetic surgery.

II. POLICY

It is the policy of AG to provide, without discrimination, emergency and other medically necessary healthcare to all patients, without regard to the patient's financial ability to pay. Care for emergency conditions, within the meaning of EMTALA, will be provided to individuals, regardless of whether they are eligible for financial assistance. Debt collection activities are prohibited from occurring in the Emergency Department or in other hospital venues if such activities interfere with the treatment of emergency medical conditions.

In order to promote the health and well-being of the community served, uninsured and underinsured individuals who are residents of Louisiana are eligible for discounted healthcare services based on established criteria. Eligibility criteria are based upon the Federal Poverty Guidelines (FPG) and are updated in conjunction with the FPG updates published in the Federal Register by the United States Department of Health and Human Services.

To be considered for the financial assistance program, the patient must cooperate with AG to provide the

information and documentation necessary to file claims for any available insurance coverage Patients are responsible for completing the required application forms and cooperating fully with the documentation gathering and assessment process needed to determine eligibility for financial assistance or to qualify for other programs.

Notification of the financial assistance program shall be publicized by various means, including written and verbal communication with patients regarding their bill. Billing statements to patients will inform patients of the availability of financial assistance, include the phone number at the hospital to contact for more information, and indicate the website address where copies of the policy, application form, and summary may be obtained.

At a minimum, signage shall be posted in all patient intake areas, including, but not limited to, inpatient, outpatient, ancillary, and Emergency Department areas, as well as in the hospital's rural health clinics.

The hospital will notify all patients of this policy as part of the admission process to the hospital.

Copies of the financial assistance policy, application, and a plain language summary of the financial assistance policy will be made available upon request and without charge. All public information and/or forms regarding the financial assistance program shall be available in English, Spanish, and Vietnamese, the primary languages spoken by the population serviced by AG.

The policy and financial assistance application are published on the hospital's website at http://www.abbevillegeneral.com.

Information sheets summarizing the financial assistance policy will be made available to local public agencies and at local health fairs and other venues as deemed necessary, but no less than four times a year, to reach those individuals in the community most likely to require financial assistance.

The hospital's Financial Aid Coordinator is available to answer any questions and/or provide information regarding the financial assistance policy at 337-898-6593.

III. DEFINITIONS:

Amount Generally Billed (AGB): The AGB for emergency and other medically necessary services which is calculated on an annual basis based on all past claims allowed by Medicare and/or Medicaid, or a combination of Medicare and/or Medicaid and all private insurers.

AGB Charges: An amount determined by multiplying the gross charges for the care provided to an individual by the AGB percentage of gross charges.

Extraordinary Collection Action: An action taken against a patient that involves 1) legal or judicial process; 2) selling an individual's debt to a third party; or 3) reporting adverse information about the individual to a consumer credit agency or credit bureau.

Federal Poverty Guidelines (FPG): Poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).

Financially Indigent: An individual whose family unit income is at or below two hundred percent (200%) of the Federal Poverty level for the size of the family unit, and who is uninsured for the portion of the bill for which the patient has financial responsibility.

Gross Charges: The full, established price for emergency treatment, medically necessary care, or elective procedures that is uniformly charged to all patients before applying any contractual allowances, discounts, or deductions.

Household: The patient, the patient's spouse, all of the patient's dependents, and anyone who may claim the patient as a dependent. If the patient is under the age of eighteen, the household includes the patient, the patient's natural or adoptive parent(s), anyone claiming the patient as a dependent, and the parent'(s) other dependents.

Household Income: A household's total income from all sources, including, without limitation, gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, family-owned business interests, royalties, estates, trust funds, child support, and alimony.

Notification Period: The period during which the hospital will notify individuals about the availability of financial assistance. The notification period begins on the first date care is provided and ends on the 120th day after AG provides the individual with the first bill for the care.

Nominal Fee: Patients receiving a full discount will be assessed a $10 nominal fee per visit. However, the patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus is not a minimum fee or co-payment.

Reasonable Efforts: The actions that AG will take to determine whether an individual is an eligible patient under this policy:

1. provide the patient with a plain language summary of this policy and offer an application for financial assistance to the patient before discharge;
2. include a plain language summary of the policy with all billing statements and other written communications regarding the bill that occur during the notification period;
3. inform the patient about the policy in all oral communications regarding the bill that occur during the notification period; and
4. provide the patient with at least one written notice regarding the extraordinary collection actions that AG may take if the patient does not submit an application for financial assistance or pay the amount due by a deadline specified in the notice that is no earlier than the last day of the notification period.

Third-Party Payer: Any party other than the patient and/or family unit who is or may be legally liable for payment of incurred charges.

Underinsured Patient: An individual who has liability insurance, commercial insurance, or third-party insurance coverage for healthcare costs and expenses, but for whom the healthcare benefits of such insurance are limited in the scope of covered services (e.g., accident), the amount of coverage (e.g., exhaustion of benefits), or in the duration of coverage (e.g., pre-existing condition), and the limitation results in an out-of-pocket balance that is impractical for the patient to pay.

Uninsured Patient: An individual who is uninsured, having no coverage by 1) a commercial third-party

insurer, 2) an ERISA plan, 3) Federal or State healthcare program (Medicare, Medicaid, Champus), 4) workers' compensation, 5) medical savings accounts, 6) third-party liability coverage, or 7) other coverage for all or any part of his or her bill.

IV. PROCEDURE

A. Identification of Eligible Patient

1. **Point of Service Process**. Patients who are able to pay for services are required to pay a good faith deposit of the estimated patient responsibility for either the scheduled inpatient or outpatient services prior to or at the time of service and make arrangements for a payment plan to pay for the remaining balance after services are provided. During the pre-service discussion of the financial plan, if a determination is made that the individual is unable to meet the financial requirements, a referral will be made to the Financial Aid Coordinator for consideration of eligibility for the financial assistance program.
2. **Inpatient Admissions**. The Financial Aid Coordinator will consult daily lists of admissions, identify the uninsured individuals, and visit with these patients or their representatives to provide information on the financial assistance program and to assist in determining whether they qualify for financial assistance from the hospital or from outside sources.
3. **Emergency Admissions**. In the case of an emergency admission, evaluation of payment alternatives will not take place until the required stabilizing medical care has been provided.
4. **Referral of Patients**. Referrals may be made by any member of the AG staff or Medical Staff, including, e.g., physicians, nurses, social workers, case managers.
5. **Requests, Including Walk-Ins**. A request for financial assistance may be made by the patient or a family member on behalf of the patient. Requests may be made prior to, during, or after services are rendered.

Those patients who may qualify for financial assistance from a government program such as Medicaid will be assisted with completion of applications for such assistance.

B. Determination of Eligibility

Reasonable efforts will be made to determine whether a patient is eligible for financial assistance. All patients identified as potential financial assistance recipients will be offered the opportunity to apply for financial assistance.

During the first 60 days after the date of service, the hospital will notify an individual about the financial assistance policy. The patient will receive at least five billing statements that include language about applying for financial assistance and will receive one written notice that informs the patient of any potential extraordinary collection activity that might occur if financial assistance is not applied for or the account is not paid. The hospital will accept and process any financial assistance application submitted by an individual for up to 120 days after the patient receives the first notice regarding the financial assistance policy.

All patients seeking financial assistance will be required to, in addition to completing a financial assistance application, provide supporting data (as applicable) to verify eligibility:

- Federal Tax Return (1040) for the last calendar year
- Paycheck stubs for the most recent three (3) months
- Social Security benefits letter
- Disability benefits letter
- Unemployment benefits letter
- Workers' Compensation letter
- Child support letter
- Alimony letter
- Proof of identification
- Letter from person providing for needs for past year to present if no personal income, which must include name, address, and phone number
- • Proof of citizenship
    - NOTE: Non-Citizens are eligible for the following:
        - Emergency services ONLY
        - Prenatal Care under LaCHIP Phase IV

If the financial assistance application and supporting documentation are incomplete, the hospital will provide the individual with a written notice that describes the additional information and/or documentation needed to complete the application. A copy of the plain language summary of the financial assistance policy will be included.

The hospital will also provide the individual with at least one written notice that informs him or her of any possible extraordinary collection activities that may be initiated if the individual does not complete the application or pay the amount due within the later of 30 days from the date of the notice or the last day of the application period.

The Financial Aid Coordinator will also take steps to determine Federal/State financial assistance eligibility. If a patient is currently eligible for Medicaid but was not eligible for coverage (or had not previously applied for coverage) through such program as of a date prior to date of service, the Financial Aid Coordinator will facilitate application for coverage.

For Medicaid recipients, the financial assistance available under this policy is limited to those charges for which the patient has financial responsibility, i.e., patient spend-down portion and non-covered medical services. Financial assistance is not available to Medicaid recipients for any charges that do not comply with Medicaid requirements, i.e., failure to have a required referral from a primary care physician.

Patients with third-party insurance and incomes at and below 200% of the FPG should still be eligible for sliding fee schedule discounts on the remaining balance after insurance is applied as long as it is not explicitly prohibited by the third-party contract. All records including applications, documentation, and determination of eligibility will be maintained for a period of time in accordance with AG's recordkeeping policies.

C. Notification of Eligibility Determination

A written decision regarding eligibility is provided to the patient. This notification includes the amount of the assistance (for approvals) or a reason(s) for denial.

The hospital will provide a billing statement to the individual that indicates the amount owed if any, shows or describes how the patient can get information regarding the amounts generally billed for the care provided, and how the discount was determined.

The patient continues to receive statements during the consideration of a completed financial assistance application or applications for other third party sources of payment, i.e., Medicare, Medicaid; however, the account is not classified as bad debt until a determination has been made. If the account was placed with a collection agency prior to the receipt of a completed application, the agency is notified to suspend collection efforts until a determination is made. This notification is documented in the account notes.

Patients are instructed to notify AG of a change in financial status. The patient may apply for financial assistance or request a change in payment plan terms upon experiencing a change in financial status, e.g., income change, family size change, etc.

D. Limitation on Charges

For emergency and medically necessary services, the charges to individuals eligible under this financial assistance policy are limited to the AGB for such services to individuals that have insurance coverage for such care. Such amount is determined by dividing the sum of all claims for emergency and medically necessary care paid in full by both Medicare or Medicare and Medicaid and all private health insurers by the sum of the associated gross charges for those claims. The resulting percentage determines the discount rate to be applied to the gross charges.

The discount will be annually calculated using a "look back" method. By July 15 of each year, claims for services provided during the prior fiscal year will be analyzed to compute the discount percentage.

E. Financial Assistance Guidelines

The main criterion used in determining applicable discount levels will be annual household income as of the date services were rendered.

Any patient with household gross income at or below two hundred percent (200%) of the FPG for the size of his or her family unit, and who has no other sources of payment will qualify for the following:

1. There is a sliding fee schedule based on family size and income appended to this policy.
2. Any patient with household gross income that is greater than 200% of the FPG for the size of his or her family unit will not qualify for financial assistance under this policy and will be responsible for the full amount of the charges. **(Exception: Exceptional Medical Circumstances as defined below.)**
3. For those patients who have the ability to pay, i.e., whose annual family income exceeds 200% of the FPG, and do not qualify for financial assistance, a good faith payment for the uncovered

balance is required as well as the development of a monthly payment plan for 10% the amount owed monthly but no less than $25 monthly. In circumstances where the patient is unable to pay, the Chief Financial Officer will have the authority to reduce the patient's monthly payment. If monthly payments are not made consistent with this policy, the account will age consistent with the hospital's bad debt policy.

4. Eligibility may be re-evaluated every 90 days for additional services provided after the initial consideration which may change the patient's eligibility status.

F. Exceptional Medical Circumstances

A patient may qualify for catastrophic financial assistance under exceptional circumstances. If the patient's annual family income exceeds 200% of the FPG, and the patient supplies information to support exceptional medical circumstances, i.e., terminal illness, excessive medical bills and/or medications, etc., the patient will be considered for assistance if the balance remaining after all third party payments have been taken into account and the patient's financial responsibility is greater than 20% of the annual family income.

Patients who incur more than one such event in a 12-month period will be evaluated on a case-by-case basis for assistance. Patients must fulfill the application requirements to be considered for assistance under this clause.

G. Extraordinary Collection Actions

Those persons who are determined not to be eligible patients for financial assistance shall be processed in accordance with AG's billing and collection policies. Collection activity is conducted within the applicable Federal and State laws and regulations governing patient collections.

AG will not impose extraordinary collections actions such as legal or judicial process; selling an individual's debt to a third party; or reporting adverse information about the individual to a consumer credit agency or credit bureau without first making reasonable efforts to determine whether a patient is eligible for financial assistance under this policy.

"Reasonable efforts" include notifications by the hospital of this financial assistance policy upon admission and in written and oral communication with the patient regarding the patient's bill, including invoices and telephone calls before collection action or reporting to credit agencies is initiated. Such action will also take into account the patient's good faith efforts to apply for governmental assistance programs or financial assistance from AG; and the patient's good faith effort to comply with his or her payment agreements with AG.

Written communication will be made with the patient at least 30 days in advance of initiating collection actions. Such communication will provide notice of the availability of financial assistance; a list of the specific collection activities the hospital intends to initiate; a deadline after which the action may be initiated that is no earlier than 30 days after the date the notice is provided; and a summary of the financial assistance policy.

Attachments

- Abbeville General Hospital Rural Health Clinics Sliding Fee Scale Table
- Abbeville General Hospital Sliding Fee Scale Table

Approval Signatures

Step Description	Approver	Date
CEO	Michael Bertrand: CHIEF EXECUTIVE OFFICER	Pending
Policy Owner	Abbey Palombo: EXECUTIVE ASSISTANT	07/2026

Standards

No standards are associated with this document