

Policy # CW F 50.1	Policy Name Financial Assistance
Policy Location Corporate Headquarters	Responsible Department Patient Financial Services
Policy Owner/Executive Owner Ken Ursin	Original Creation Date March 2006
Policy Effective Date January 1, 2023	Policy Review Date December 2022

Revisions to this policy are effective January 1, 2023. This policy also applies to any patient accounts with dates of service from January 1, 2021, through December 31, 2022 if the patient has submitted an application that is on file.

- I. **SCOPE:** This policy applies to all entities within AdventHealth, apart from AdventHealth entities located in the Colorado and Illinois market where a region-specific policy applies. Refer to the AdventHealth website for policy details, forms, and instructions. This policy also applies to any patient with a submitted financial assistance application. Applications can be re-processed retrospectively within eighteen months of application date.
- II. **PURPOSE:** AdventHealth is committed to excellence in providing high quality health care while serving the diverse needs of those living within our service area. AdventHealth is dedicated to the view that emergent care should be accessible to all, regardless of age, gender, geographic location, cultural background, physical mobility, or ability to pay. AdventHealth is committed to providing health care services and acknowledges that in some cases an individual will not be financially able to pay for the services received. This policy is intended to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder and shall be interpreted and applied in accordance with such regulations. This policy has been adopted by the governing body of AdventHealth in accordance with the regulations under Section 501(r).

AdventHealth provides emergent care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. Emergent care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to the health of a patient; b) serious impairment of any bodily functions; and c) serious dysfunction of any bodily organ or part. This is inclusive of care related to such conditions post initial treatment. If third-party coverage is not available, AdventHealth offers financial assistance for those who qualify. Wherever possible, a determination of eligibility for financial assistance will be initiated prior to, or at the time of service by a hospital or other organization. AdventHealth hospital facilities or a substantially related entity (a partnership providing emergent care or other medically necessary care in which AdventHealth has an ownership interest) will provide financial assistance to eligible patients receiving emergent services based on financial need.

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The financial assistance policy provides guidelines for financial assistance to eligible self-pay individual patients and eligible individual patients with balances after insurance receiving emergent or other medically necessary services based on financial need. This financial assistance policy also provides guidelines for discounted amounts that may be charged to all self-pay patients who receive medically necessary services.

Financial assistance discounts based upon financial need will not be provided for elective or non-emergent services, except as may be determined in the sole discretion of AdventHealth on a case-by-case basis. Patients may apply for financial assistance in accordance with the guidelines set forth in this policy.

- III. POLICY:** Individuals receiving emergent care may be considered for financial assistance if the patient presents with any of the following:
- No third-party coverage is available.
 - Medicare or Medicaid benefits have been exhausted or are considered not covered and the patient has no further ability to pay.
 - Patient is insured but qualifies for assistance based upon financial need with respect to the individual's balance after insurance or out-of-pocket remaining after all other payments from third parties.
 - Patient meets local and/or state charity requirements.
 - Patient is already eligible for assistance (e.g., Medicaid), but the services rendered are not covered.
- A. The Financial Assistance Policy, Financial Assistance Application, and Plain Language Summary of the Financial Assistance Policy are transparent and available to the individuals served at any point in the care continuum in languages that are appropriate for the AdventHealth service area in compliance with the Language Assistance Services Act and in the primary languages of any populations with limited proficiency in English that constitute the lesser of 1,000 individuals or 5% of the members of the community served by AdventHealth (limited proficiency in English populations meeting the criteria above will be referred to hereafter in this policy as the LEP defined populations). Note: The translations may be available for organizations in communities with fewer than the above referenced populations if another organization did have the requisite population.
- AdventHealth hospital facilities will prominently and conspicuously post complete and current versions of the following on their respective websites and provide paper copies to patients upon request:
 - Financial Assistance Policy
 - Financial Assistance Application (including Patient/applicant Financial Statement)
 - Plain Language Summary of the Financial Assistance Policy
 - Methodology for calculating the maximum amount billed to self-pay patients for Amounts Generally Billed (AGB).
 - Physicians who do and do not participate in the AdventHealth financial assistance policy.
 - Contact information for AdventHealth Financial Assistance Representatives.

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- The AdventHealth website will indicate that a copy of the financial assistance policy, financial assistance application, and plain language summary is available and how to obtain such copies in the primary languages of the LEP defined populations.
- Signage declaring the availability of financial assistance will be conspicuously displayed in public locations in AdventHealth hospital facilities including all admission and registration areas and the Emergency Department. All signage denoting that financial assistance may be available will contain the following elements:
 - The hospital facility or other applicable website address where the financial assistance policy, plain language summary, and financial assistance application can be accessed.
 - The telephone number and physical location that individuals can call or visit to obtain copies of the financial assistance policy, financial assistance application or plain language summary or to obtain more information about these documents, or the application process.
- Each AdventHealth hospital facility will make paper copies of the financial assistance policy, financial assistance application and the plain language summary available upon request and without charge, both in public locations in the hospital facility (including the Emergency Department and all admission and registration areas) and by mail. Paper copies will be available in English and in the primary languages of any LEP defined populations. A paper copy of the plain language summary is available to patients as part of the intake or discharge process.
- Financial assistance representative visits: Financial assistance representatives may upon patient request provide personal financial counseling to individuals admitted to an AdventHealth hospital who are classified as self-pay. Interpreters will be used, as indicated, to allow for meaningful communication with individuals who have limited English proficiency. Financial assistance eligibility criteria and discount information will be made available in physician practice, urgent care, and other settings as well.
- The Plain Language Summary should be distributed to members of the community served by the AdventHealth hospital facility in a reasonable manner to reach those members of the community who are most likely to require financial assistance. An example would be the distribution of copies of the plain language summary to organizations in the community that address the health needs of low-income populations such as but not limited to Healthcare Navigators.

B. AdventHealth and the individuals served each hold accountability for the general processes related to the provision of financial assistance.

- AdventHealth Responsibilities
 - AdventHealth has a financial assistance policy to evaluate and determine an

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individual's eligibility for financial assistance.

- AdventHealth has a means of widely publicizing and communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.
- AdventHealth workforce members in Patient Financial Services and Consumer Access understand the AdventHealth financial assistance policy and can direct questions regarding the policy to the proper hospital representatives.
- AdventHealth requires all contracts with third party agencies who collect bills on behalf of AdventHealth to include legally binding written contract provisions that provide that these agencies will follow AdventHealth financial assistance policies.
- The AdventHealth Revenue Cycle Department provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance and billing and collection processes.
- After receiving the individual's request for financial assistance, AdventHealth notifies the individual of the eligibility determination within a reasonable period.
- AdventHealth provides options for payment arrangements.
- AdventHealth upholds and honors individuals' right to appeal decisions and seek reconsideration.
- AdventHealth maintains (and requires billing contractors to maintain) documentation that supports the offer, an application, and provision of financial assistance for a minimum period of seven years.
- AdventHealth will periodically review and incorporate federal poverty guidelines published by the United States Department of Health and Human Services, where applicable.
- Individual Patient Responsibilities
 - To be considered for a 100% reduction in charges under the financial assistance policy, the individual must cooperate with AdventHealth to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.
 - To be considered for a 100% reduction in charges under the financial assistance policy, the individual must provide AdventHealth with financial and other information needed to determine eligibility (this includes completing the required application, provision of the requested supporting documentation, and cooperating fully with the information gathering and assessment process).
 - A self-pay patient who is not eligible for a 100% reduction in charges based upon

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financial need will be billed no more than the Amount Generally Billed (AGB) to individuals who have insurance covering such care and will cooperate with the hospital to establish a reasonable payment resolution.

- A self-pay patient who does not qualify for a 100% reduction in charges based upon financial need must make good faith efforts to resolve their outstanding balance(s). The individual is responsible to promptly notify AdventHealth of any change in financial situation so that the impact of this change may be evaluated against policies governing the provision of financial assistance, their hospital bills, or payment plan provisions.
- C. Financial assistance eligibility determinations and the process of applying for financial assistance will be equitable, consistent, and timely.
- ◆ **Identification of Potentially Eligible Individuals.** Requests for financial assistance will be honored up to 240 days after the date of the first post-discharge billing statement for the care provided is sent by mail or electronically to the patient.
 - Registration and pre-registration processes promote identification of individuals in need of financial assistance.
 - Financial assistance representatives will make best efforts to contact all self-pay inpatients during the course of their stay or at time of discharge.
 - The AdventHealth hospital facility's plain language summary will be offered along with the financial assistance application form to every individual upon intake or upon discharge from the hospital facility.
 - A conspicuous written notice will be included on all billing statements that notifies and informs recipients about the availability of financial assistance under the AdventHealth hospital facility's financial assistance policy and includes the following: 1) the telephone number of the AdventHealth financial assistance department that can provide information about the financial assistance policy and the financial assistance application process; and 2) the web-site where copies of the financial assistance policy, the financial assistance application, and the plain language summary may be obtained.
 - Reasonable attempts will be made to notify individuals about the AdventHealth financial assistance policy and how the individual may obtain assistance with the financial assistance application. AdventHealth will use various resources to communicate with patients, including but not limited to e-mail, paper statements, letters, and phone calls, in addition to face-to-face interactions.
 - The individual will be provided with at least one written notice, along with a copy of the plain language summary, that notifies and informs the individual that financial assistance is available for eligible individuals and that AdventHealth may engage in other specified extraordinary collection actions if the individual does not submit a financial assistance application or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days from the date the hospital facility provides the first post-discharge billing statement for the care. The notice

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must be provided to the individual at least 30 days before the deadline specified in the notice.

- **Requests for Financial Assistance.** Requests or applications for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).
 - Requests received from third parties will be directed to a financial assistance representative.
 - The financial assistance representative will work with the third party to provide resources to assist the individual in the application process.

- **Eligibility Criteria**
 - AdventHealth offers different types of discounts to uninsured patients receiving emergent care. Self-pay patients reporting incomes above four hundred percent of the Federal Poverty Guidelines or for whom no income information is available are eligible for a discount that reduces the balance to the Amount Generally Billed (AGB) similar to individuals who have insurance coverage. This percentage will vary based on the specific entity or location and shall be updated annually – **see page 15**. These discounts may later be increased to a 100% reduction from applicable charges if the patient is determined to qualify as eligible under the policy and in need of financial assistance under this policy.
 - To be eligible for a one hundred percent (100%) reduction from applicable charges (i.e. full write-off for self-pay patients and full write-off of the patient responsibility portion of charges after insurance) the individual's household income must be at or below two hundred percent (200%) of the current Federal Poverty Guidelines for the prior twelve (12) months or full year preceding the date of service or the date a Financial Assistance Application is submitted, whichever is later. Alternatively, a patient may also qualify for a one hundred percent (100%) reduction from the applicable charges when the unpaid portion of the patient's hospital bill exceeds twenty-five percent (25%) of the annual family income, but only where the total annual family income is less than five hundred percent (500%) of the Federal Poverty Guidelines.
 - Federal Poverty levels are issued every year by the Department of Health and Human Services (HHS) and are used to determine eligibility for programs and benefits provided by the federal government such as but not limited to marketplace health insurance, Medicaid, or CHIP coverage. These income thresholds can be found here: <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/>
 - When determining an individual's household income, the following terms apply:
Household: one or more persons residing together in the same household whose needs, income and assets are included in the household budget, excluding roomers and boarders. Members include the applicant, legal spouse, dependent children, stepchildren, adopted children and blood relatives under twenty-five (25) years of age, unrelated minor children for whom the applicant, or the applicant's spouse has legal guardianship or custody; legal guardian or parents of minor

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children, and minor siblings children under the age of twenty-five (25). Students over twenty-five (25) years of age, dependent on the family for over fifty percent

(50%) support is also included in the household size.

- Self-pay patients with household incomes that exceed two hundred percent (200%) of the current Federal Poverty Guidelines but are less than four hundred percent (400%) shall be granted the below discounts:
 - Self-pay patients who are between two hundred percent (200%) and four hundred percent (400%) of Federal Poverty level would be granted a ninety-seven percent (97%) discount.
 - Patients with insurance who are between two hundred percent (200%) and four hundred percent (400%) of the Federal Poverty Guidelines and possess out-of-pocket remaining balances may at the discretion of the Finance Review Committee receive a fifty percent (50%) discount off ONLY the remaining patient out-of-pocket balance which represents the remaining balance after all other third-party payers have paid. The fifty percent (50%) reduction in out-of-pocket for these patients shall be categorized as financial assistance.
- In the event the service is not emergent AND the self-pay patient has income greater than four hundred and one percent (401%) of Federal Poverty Guidelines or for whom no income information is made available; will be offered the consumer shoppable discount in accordance with CWF 50.5 Self Pay Discount policy, which is facility specific, updated annually, and published in the online shoppable estimator per CMS Price Transparency guidelines.
- The amount charged to any self-pay patient for emergency or all medically necessary care will be based on amounts generally billed (AGB) to individuals who have insurance covering such care at each specific AdventHealth hospital. AdventHealth will determine its AGB by determining an AGB percentage and multiplying that percentage by the gross charges for the services provided to the individual. AdventHealth utilizes one of the five unique Amounts Generally Billed Calculation types described in §1.501(r)-5(b)(3) and listed below:
 - i. Lookback method Medicare only
 - ii. Lookback method Medicare and private insurance
 - iii. Lookback method Medicaid only OR Medicaid and private insurance
 - iv. Prospective method Medicaid only
 - v. Prospective method Medicare only
- Each AdventHealth facility shall elect one of the five methods and calculate a discount annually accordingly listed on Attachment 1. A document detailing AdventHealth's methodology for calculating AGB can be found on the AdventHealth web site or can be requested in person, by phone, or mail.
- Charges to an individual eligible for financial assistance under the AdventHealth financial assistance policy for any medical services will always be less than the gross charges for that service.

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- In addition to evaluation of income level outlined above, an asset means test may also be applied to Medicare recipients only. This asset evaluation's purpose is to determine eligibility for financial assistance for applicants who are retired with fixed incomes less than or equal to two hundred percent (200%) of the federal poverty guideline. An asset for the purposes of this policy evaluation shall represent any cash or cash-equivalents the applicant possesses in the bank along with the value of certain non-retirement investment accounts (i.e., stocks, bonds, and real estate). However, the home applicant's live in and one vehicle including motor home or motorcycles, are excluded from the asset test. Furthermore, any household items are excluded from the calculation of assets. Notably, retirement accounts such as but not limited to 401(k), 401(a), 403(b) and/or 457(b) are not considered assets for purposes of the financial assistance asset test. These guidelines mirror the Medicare Savings Program and may be revised accordingly by the Center's for Medicare and Medicaid Services (CMS). The specific details are found at <https://www.medicare.gov/basics/costs/help/medicare-savings-programs>
 - The asset limit if exceeded shall disqualify an applicant from total write-off, at which point less discount shall be applied. The asset limits are included in Attachment 2 – Asset limit.
- Income can be verified by using a personal financial statement or by obtaining copies of that applicant's most recent Form W-2, most recent Form 1040, tax transcripts, bank statements or any other form of documentation that supports reported income. Income is defined as any of the following: a) wages and salary; b) child support; c) alimony; d) unemployment compensation; e) worker's compensation; f) veteran's pension; g) social security; h) pensions or annuities; i) dividends; j) interest on savings or bonds; k) income from estates or trusts; l) net rental income or royalties; m) net income from self-employment; n) contributions from any source, including any amount contributed toward the support of any individuals in the household as defined above.
- Documentation supporting income verification and available assets shall be maintained in patient files for future reference.
- In addition to relying on information obtained from the patient's Financial Assistance Application and/or Patient/Applicant Financial Statement, and any other documentation provided by the patient to support the patient's resources, AdventHealth may also rely on an additional Independent Eligibility Assessment (IEA), to substantiate the patient's resources or may rely on third-party information to verify information supplied by the patient. That information may include documentation from credit reports available through the credit reporting bureaus, and information regarding prior full year's income as reflected on IRS tax transcript for verification of income through databases that organizations can use to verify employment and income information. These databases consist of large central repositories of payroll information in the United States, with millions of employers contributing payroll records. The income information from these

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tools assists in developing a full understanding of the individual's financial circumstances.

- Independent Eligibility Assessment (IEA), tools may be used to justify financial assistance eligibility. Independent Eligibility Assessment may be conducted to include credit reports and other publicly available information shall be used to determine, consistent with applicable legal requirements, estimated household size and income amounts for the basis of determining financial assistance eligibility when a patient does not provide an assistance application or supporting documentation or is otherwise uncooperative in providing financial assistance determination documentation. These tools including but not limited to credit reports, other third-party asset information, and income verification which may be used to demonstrate financial need on the part of an uninsured patient without the completion of a financial assistance application.
- Financial assistance application forms will be considered up to 240 days after the date the first post-discharge billing statement for the care is provided.
- Presumptive eligibility: Individuals who are uninsured and are represented by one or more of the following may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application form:
 - Individual is self-identified as homeless.
 - Individual is deceased and has no known estate or spouse able to pay hospital balance or debt.
 - Individual is incarcerated for a felony.
 - Individual is mentally incapacitated.
 - Individual is currently eligible for Medicaid but was not at the date of service.
 - Individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act.
 - Individual has via Independent Eligibility Assessment been deemed to have a payment capability score of low or unknown. The Independent Eligibility Assessment consist of algorithms that incorporate data from credit bureaus, demographic databases, and hospital specific data. The third-party credit report data and other publicly available data sources utilize healthcare industry-recognized, predictive model that is based on the public record databases to calculate a socio-economic and financial capability score. Information gleaned from this Independent Eligibility Assessment will constitute adequate documentation of financial need under this Policy to infer and classify individuals into respective economic means categories irrespective of whether complete documentation has been voluntarily provided.
 - Individual was previously approved for financial assistance, and service date falls within twelve (12) months prior or twelve (12) months

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after original application approval date.

- For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in this Section C and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application Form. However, some of the patient population may not engage in the traditional financial assistance application process. If the patient does not submit the Financial Assistance application, AdventHealth may choose to provide Financial Assistance in lieu of sending the patient to collections based upon the above referenced Independent Eligibility Assessment (IEA).
- Every reasonable effort will be used to secure written income information, and if not provided, we will use the patient's attestation and stated income to determine eligibility if unable to verify through IEA.
- **Method for Applying for Financial Assistance**
 - AdventHealth Financial Assistance Application Form. To apply for financial assistance, the individual must complete the AdventHealth Financial Assistance Application form. The individual will provide all supporting data required to verify eligibility, including supporting documentation verifying income. Acceptable forms of income verification include, but are not limited to, the most recent W-2, the most recently filed 1040 Tax Form, Tax Transcripts related to 4506-T requests, bank statements, and signed letters of support when household income is zero. If documents verifying an applicant's income are included, an approved financial assistance application will apply to dates of service twelve (12) months prior and twelve (12) months after approval date and will not have to be repeated. Service dates outside this window will require a new application for assistance.
 - An individual can obtain a copy of the AdventHealth Financial Assistance Application form by accessing it on the AdventHealth hospitals' website, by requesting a free copy by mail, from the financial assistance department, or by requesting a copy in person at any AdventHealth admission/registration location.
 - A completed AdventHealth Financial Assistance Application form will be submitted to Patient Financial Services for processing. Proof of income (POI) may be required from the individual. In addition, Medicare beneficiaries are subject to an additional asset test in accordance with federal law. A review is completed to determine individual eligibility based on the individual's total resources (including but not limited to family income level, assets as required for Medicare patients and other pertinent information). POI is required for balances greater than \$25,000 for insured patients. Written attestation will be accepted on uninsured patients and for balances under \$25,000.
- **Actions that May be Taken in the Event of Non-Payment:** One hundred twenty (120) days from the date the hospital facility provides the first post-discharge billing statement for the care, AdventHealth may engage in extraordinary collection actions (ECA's) including but not limited to selling debt to a third party (see section E of this policy for more information regarding debt sale) only after the following notifications have been

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provided to the individual at least 30 days before initiating any ECA's: 1) a written notice, along with the plain language summary, is provided to the individual indicating that financial assistance is available for eligible individuals and stating the specific ECA's that

may be initiated after a stipulated deadline (the deadline may not be earlier than 30 days after the written notice is provided), and 2) a reasonable attempt is made to notify an individual about the AdventHealth hospital facility's financial assistance policy and how the individual may obtain assistance with the financial assistance application process.

- ***No Financial Assistance Application Form Submitted:*** If no Financial Assistance Application Form has been submitted within one hundred twenty (120) days from the date the hospital facility provides the first post-discharge billing statement for the care provided, and the stipulated deadline in the written notice has passed, AdventHealth may initiate an extraordinary collection activity. AdventHealth may still elect to provide financial assistance in absence of an application form submitted if third party sources based on the Independent Eligibility Assessment, indicate credible evidence that the patient is eligible.

- ***Incomplete Financial Assistance Application Form Submitted:***

If an individual submits an incomplete Financial Assistance Application within 240 days after the date the first post-discharge billing statement for the care is provided (the application period), AdventHealth must take the following actions:

- Suspend any Extraordinary Collection Activities (ECA)
- Provide the individual with a written notice that describes the additional information and/or documentation required under the Financial Assistance Policy or Financial Assistance Application Form that the individual must submit within a reasonable time and that contains contact information including the telephone number and physical location of the AdventHealth entity or department that can provide information about the financial assistance policy, as well as contact information that can provide assistance with the financial assistance application process or, alternatively, a non-profit organization or governmental agency that can provide assistance with the financial assistance application process.
- If the Financial Assistance Application Form is not completed by the deadline discussed above, the hospital may initiate or resume ECA's. Liens attached to insurance (auto, liability, life, and health) that represent potential proceeds owed because of an individual's claim for which AdventHealth provided care are permitted in connection with the collection process. No other personal judgments or liens will be filed against financial assistance policy eligible individuals.
- AdventHealth will make a minimum of two contact attempts to facilitate completion of an incomplete application before the normal collection cycle resumes.

- ***Complete Financial Assistance Application Submitted:***

If an individual submits a complete Financial Assistance Application during the

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application period two hundred forty (240) days after the date the first post-discharge billing statement for the care is provided, AdventHealth must take the following actions:

- Make and document the determination as to an individual's eligibility for financial assistance.
- Notify the individual in writing in a timely manner, generally within sixty (60) days after receiving a completed Financial Assistance Application Form of the eligibility determination and the basis for the determination.
- Provide the individual with a billing statement (not required for a \$0 balance billing statement) that indicates the amount owed as a financial assistance policy-eligible individual and describes how the individual can get information regarding the AGB for care and how the AdventHealth determined the amount the individual owes.
- Refund any excess payments to the individual provided no other balances are due that are ineligible for financial assistance.
- Take all available measures to reverse any ECA's that have been taken against the individual.
- Provide a written notification of denial to any individual determined ineligible for financial assistance and include both a reason for denial and a process and contact information for filing an appeal. If an individual disagrees with the denial, the individual may request an appeal in writing within 45 days of the denial. The appeal must include any additional relevant information that may assist in the appeal evaluation. A request for an appeal to overturn a denial will be reviewed monthly by the Financial Assistance Committee. Decisions reached by the Financial Assistance Committee will be communicated to the individual within sixty (60) days of the Committee's review and will reflect the Committee's final decision.
- Upon receipt of a complete financial assistance application, the AdventHealth hospital facility may postpone its determination of an individual's eligibility under its financial assistance policy if the individual has submitted an application for Medicaid assistance until such time as Medicaid eligibility has been determined.

D. Patient Financial Services Responsibilities

- Finance Review Committee: Patient applications for financial assistance are reviewed by one or more members of the Finance Review Committee, which consists of financial Coordinator, Supervisor or Manager of Financial Assistance, a Director, and a Vice President or higher. The Financial Assistance Committee reviews borderline and non-routine financial assistance recommendations that require case-by-case review.
- Financial assistance that exceeds \$25,000 per account must be approved by the Finance Review Committee.
- Following review and approval by the Financial Assistance Committee, the approved financial assistance will be applied to the individual's account by Patient Financial Services.

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- Patient Financial Services has the responsibility to determine if AdventHealth has made reasonable efforts to evaluate whether an individual is financial assistance policy – eligible and whether the hospital may take action to engage in any ECA's.
- Billing agencies that contract with AdventHealth for collection services will follow this financial assistance policy with respect to all billing and collection matters.
- Selling an individual's debt to another party (other than a non-Extraordinary Collection Activity (ECA) sale as described below) is considered an Extraordinary Collection Activity (ECA) and should not be initiated until the required steps outlined above in Section C have been completed. Any proposed sale of debt, the master service agreement must be approved by the AdventHealth Senior Finance group and submitted to the AdventHealth Contract Review Process before execution.

Certain sales of debt are not considered Extraordinary Collection Activities. Non-ECA debt sales require that AdventHealth enter into a legally binding written agreement with the purchaser of the debt that stipulates the following:

- The purchaser may not engage in any Extraordinary Collection Activities (ECA's).
- The purchaser is prohibited from charging interest on the debt in excess of an IRS established rate.
- The debt is returnable or recallable by the AdventHealth hospital facility upon a determination that the individual is financial assistance policy eligible; and
- If the debt is not recalled or returned, the purchaser must ensure that the individual does not pay more than he or she is personally responsible for as an eligible individual under the financial assistance policy.

E. Individual Payment Plans

- Payment plans for self-pay patients will be offered to all patients. All collection activities will be conducted in conformance with the federal and state laws governing debt collection practices. No interest will accrue to account balances while payments are being made unless the individual has voluntarily chosen to participate in a payment arrangement that bears interest applied by a third party consumer financing lender.
- If an individual complies with the terms of his or her individually developed payment plan, no collection action will be taken.

F. Record-Keeping

- A record, paper or electronic, will be maintained reflecting authorization of financial assistance along with copies of all application and worksheet forms.
- Summary information regarding applications processed and financial assistance provided will be maintained in accordance with the records retention policy. Summary information includes the number of patients who applied for financial assistance at AdventHealth, how many patients received financial assistance, the amount of financial assistance

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provided to each patient, and the total bill for each patient.

- The cost of financial assistance will be reported annually in the Community Benefit Report. Financial Assistance (Charity Care) will be reported as the cost of care provided (not charges) using the most recently available operating costs and the associated cost to charge ratio.

G. Subordinate to Law: The provision of financial assistance may now or in the future be subject to federal, state, or local law. Such law governs to the extent it imposes more stringent requirements than this policy.

IV. DEFINITION(S): Patient types covered by this policy include, but are not necessarily limited to:

- Emergent Outpatients (OP)
- Emergent Admissions (inpatient (IP) or observation (OBS))
- IP/OP follow-up related to previous emergent visit

See addendum to this policy for a listing of all physician providers that deliver emergent related care at AdventHealth hospital facilities, and specifies which providers are covered by this financial assistance policy and which are not. The listing of providers contained in addendum to the policy can be accessed on-line at the AdventHealth website. A paper copy can be obtained free of charge from the AdventHealth hospital facility's Patient Financial Services Department.

The provider listing is updated quarterly to add new or missing information, correct erroneous information, and delete obsolete information. The date of the most recent update is included on the provider listing.

AdventHealth may list names of individual doctors, practice groups, or any other entities that provide emergency or medically necessary care by the name used either to contract with the hospital or to bill patients for care provided.

V. EXCEPTION(S): **The AdventHealth hospitals located in Colorado and Illinois have separate but similar policies due to state-specific and joint-ownership considerations. These hospitals are exceptions to this policy.**

VI. REFERENCE(S):

VII. RELATED DOCUMENT(S) / ATTACHMENT(S):

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Attachment 1 – 2023 Self Pay discount – Retrospective lookback including Medicare

2023 AdventHealth Self Pay Discount Calculations	2023 Requested Self Pay Discount % (501r)
Southeast Region	
Hendersonville	70%
Murray	87%
Manchester	80%
Gordon	87%
Redmond	87%
Great Lakes Region	
Hinsdale Hospital	75%
La Grange Memorial Hospital	75%
Bolingbrook Hospital	75%
GlenOaks Medical Center	75%
Southwest Region	
Texas Health Huguley	78%
Mansfield	78%
Central Texas	78%
Rollins Brook	78%
Mid America Region	
Shawnee Mission	82%
Durand	31%
South Overland Park***	82%
Ottawa	82%
Central Florida Division South	
Orlando	79%
West Florida Division	
Tampa/Pepin	86%
Zephyrhills	86%

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POLICY

Carrollwood	86%
Connerton	86%
Wesley Chapel	86%
North Pinellas	86%
Dade City	86%
Ocala	86%
Sebring	86%
Heart of Florida	86%
Lake Wales	86%

Central Florida Division North	
Deland	79%
Fish	79%
Palm Coast	79%
New Smyrna	79%
Daytona Beach	79%
Waterman	79%

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2023 AdventHealth Self Pay Discount Calculations	2023 Requested Self Pay Discount % (501r)	AGB calculation Method
Southeast Region		
Hendersonville	70%	12-Month Comm+Mcare Lookback Method
Murray	87%	12-Month Comm+Mcare Lookback Method
Manchester	80%	12-Month Comm+Mcare Lookback Method
Gordon	87%	12-Month Comm+Mcare Lookback Method
Redmond	87%	12-Month Comm+Mcare Lookback Method
Great Lakes Region		
Hinsdale Hospital	75%	12-Month Comm+Mcare Lookback Method
La Grange Memorial Hospital	75%	12-Month Comm+Mcare Lookback Method
Bolingbrook Hospital	75%	12-Month Comm+Mcare Lookback Method
GlenOaks Medical Center	75%	12-Month Comm+Mcare Lookback Method
Southwest Region		
Texas Health Huguley	78%	12-Month Comm+Mcare Lookback Method
Mansfield	78%	12-Month Comm+Mcare Lookback Method
Central Texas	78%	12-Month Comm+Mcare Lookback Method
Rollins Brook	78%	12-Month Comm+Mcare Lookback Method
Mid America Region		
Shawnee Mission	82%	12-Month Comm+Mcare Lookback Method
Durand	31%	12-Month Comm+Mcare Lookback Method
South Overland Park***	82%	12-Month Comm+Mcare Lookback Method
Ottawa	82%	12-Month Comm+Mcare Lookback Method
Central Florida Division South		
Orlando	79%	12-Month Medicare only Lookback Method
West Florida Division		
Tampa/Pepin	86%	12-Month Comm+Mcare Lookback Method
Zephyrhills	86%	12-Month Comm+Mcare Lookback Method
Carrollwood	86%	12-Month Comm+Mcare Lookback Method

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Connerton	86%	12-Month Comm+Mcare Lookback Method
Wesley Chapel	86%	12-Month Comm+Mcare Lookback Method
North Pinellas	86%	12-Month Comm+Mcare Lookback Method
Dade City	86%	12-Month Comm+Mcare Lookback Method
Ocala	86%	12-Month Comm+Mcare Lookback Method
Sebring	86%	12-Month Comm+Mcare Lookback Method
Heart of Florida	86%	12-Month Comm+Mcare Lookback Method
Lake Wales	86%	12-Month Comm+Mcare Lookback Method

Central Florida Division North		
Deland	79%	12-Month Comm+Mcare Lookback Method
Fish	79%	12-Month Comm+Mcare Lookback Method
Palm Coast	79%	12-Month Comm+Mcare Lookback Method
New Smyrna	79%	12-Month Comm+Mcare Lookback Method
Daytona Beach	79%	12-Month Comm+Mcare Lookback Method
Waterman	79%	12-Month Comm+Mcare Lookback Method

Attachment 2 – Asset Test

Note: the below limits are 2022 Medicare Shared Savings Program resource limits and may be updated annually at <https://www.medicare.gov/basics/costs/help/medicare-savings-programs>

Individual	
Individual	\$8,400
Married couple	\$12,600

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