POLICY

It is the policy of Community Rehabilitation Hospital, ["Community"] and its affiliates that anyone who identifies themselves as unable to pay all or part of their medical care maintains the right to apply for financial assistance. A **financial clearance process** will be followed by associates of Community to determine if a patient meets the network's definition of a medically indigent patient or may qualify for other forms of financial assistance. Charity is not considered a substitute for personal responsibility.

Patients are expected to cooperate with Community's procedures and fulfill documentation requirements necessary for qualification for the assistance program. In addition, patients will be expected to contribute to the cost of their care based on their ability to pay. Individuals with the financial capacity to afford insurance will be encouraged to do so in order to ensure access to future healthcare services, protect their overall health, protect their assets and lower the costs of care for the citizens of Community.

PURPOSE

To ensure policy and procedures exist for identifying those patients for whom service is to be rendered at a discount, based solely on ability to pay, financial condition and availability of third party funding. To clearly differentiate those patients eligible for Financial Assistance based on established guidelines, from those patients with financial resources who are unwilling to pay.

PHILOSOPHY

Community Rehabilitation Hospital, in keeping with its mission, serves the medical needs of the community regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. Medically necessary health care services will be provided to these patients at a reduced level of reimbursement, based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the process. We expect all responsible parties with the ability to pay, to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies.

DEFINITIONS

Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care as calculated by reviewing the prior 12 month closed claim reimbursement rate for Medicare and Commercial Insurance. AGB is updated annually.

Applicant: Patient or Guarantor requesting screening for the Financial Assistance Program. This may include an individual or a family (multiple wage earners within the same home) that fulfill the definition of "Family" below.

Assets: Personal property and items of value including saving accounts. Retirement funds will not be deemed Assets, however, distributions and payments from pension or retirement plans will be included in income.

Application Period: Is the period during which applications will be accepted and processed for Financial Assistance. The Application Period begins the date of the first patient statement and ends 240 days after.

Extraordinary Assets: Assets where items over and above the basic needs of housing and transportation required for self-sufficiency. Example of extraordinary asset would be saving accounts with a value in excess of an estimated three (3) months of the applicant's monthly budget expenses. Extraordinary Assets in excess of the current statement balance will be considered the applicants' ability to pay amount.

Catastrophic Income: Annualized income minus outstanding medical bills, including dental and vision and the initial statement balances are within 240 days immediately preceding the application date.

Catastrophic Consideration: If the amount of outstanding medical expenses exceeds 25% of annualized income (where outstanding medical expenses include medical, dental and vision with patient statement dates within 240 days immediately preceding the application date) then Catastrophic Income is compared to FAP guideline to determine eligibility and discount based on FPL. Catastrophic Consideration is only valid for each application and any subsequent charges or statements the applicant must reapply.

Charity Care: Medically necessary services that are delivered, but are never expected to be fully reimbursed. These services represent the facility's policy to provide free or discounted care to qualifying members.

Effective Date: Is the date the Financial Assistance Application was signed and dated**.**

Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service, if the patient claims someone else as a dependent on their income tax return, they may be considered as a dependent for the purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing Federal Poverty Guidelines: earnings, unemployment compensation, workers' compensation, social security, supplemental security income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources; Noncash benefits (such as food stamps and housing subsidies) do not count; Determined on a **before** tax basis; Excludes capital gains and losses; If a person lives with family, includes the income of all family members (non-relatives, such as housemates, do not count).

Gross Charges: The full amount charged by Community for items and services before any discounts, contractual allowances or deductions are applied.

Medically Indigent: A medically indigent patient is defined as one whose income is sufficient to cover basic living expenses, but cannot pay for medical services. The term may also be applied to persons with adequate incomes who are faced with unexpected, catastrophically high medical bills.

Medically Necessary: Hospital services or care rendered, both outpatient and inpatient, to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness of infirmity.

Presumptive Eligibility: The process by which Community may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

Qualification Period: Patients have the opportunity to apply for Financial Assistance within 240 days of the initial statement.

Uninsured: The patient has no level of insurance or other third party assistance to assist with meeting payment obligations for healthcare services.

Underinsured: The patient has some level of health insurance, but the out-of-pocket expenses still exceed his/her financial capability.

Urgent Care: Medically necessary care to treat medical conditions that are not immediately life-

threatening, but could result in the onset of illness or injury, disability, death or serious impairment or dysfunction if not treated within 12-24 hours.

Cost of Care: In cases where discounts or the Financial Assistance Policy may apply, adjustments will be made to total gross charges unless otherwise specified.

1.0 Policy Terms

1.1. Provision of Financial Assistance: Annually, Community will establish a percentage of total consolidated operating expenses to be allotted for Financial Assistance as a component of the larger category of Community Benefits. Further, we will monitor our ratio of Community Benefit cost to total consolidated operating expense and benchmark against predetermined components of the applicable market with a goal of providing Community Benefits in total at a ratio better than average within the applicable market served.

1.2. Nondiscrimination**:** We will render services to our patients who are in need of Medically Necessary Services regardless of the ability of the Responsible Party to pay for such services. The determination of full or partial Financial Assistance will be based on the ability to pay and financial condition and will not be based on race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, or any other classification or characteristic. Further, and following a determination of Financial Assistance Program eligibility, and in accordance with the Affordable Care Act (ACA), the eligible individual will not be charged more for emergency or other medically necessary services than the amounts generally billed to individuals who have insurance covering such services.

1.3. . Available Services**:** All available medically necessary health care services, inpatient and outpatient, will be available to all individuals under this policy. Specifically**,** the following healthcare services fall within the scope of the Financial Assistance Program at Community:

- Emergency Medical Services provided in an Emergency department setting at any Community Health Network hospital (RC 450,451),

  Services delivered in any setting that if delayed would result in an adverse change in the health status of a patient, non-elective services provided in response to life-threatening circumstances in a non-emergency room setting, Medically necessary services, as rendered or referred by a physician and evaluated on a case by case basis. Such necessary services delivered in a non-emergency setting may be performed at the discretion of Community and its physicians at a predetermined site of service/level of care in order to be deemed eligible for financial assistance.
- Those applicants approved for financial assistance may be asked to participate in Community's Primary Care Navigation Team program. Should the applicant be asked to become a part of the program, ongoing participation will be a requirement for subsequent financial assistance.

1.4. Program Exclusions:

1.4.1. All services provided to a patient that are deemed elective or not medically necessary.

1.4.2. Charity Care is not considered a substitute for personal responsibility and patient or guarantor will be expected to contribute to the cost of care based upon the ability to pay. For this reason, the following will be excluded from provision of charity coverage:

1.4.2.1. Coverage under the Community program will only be provided to citizens of the United States or legally documented aliens and applicants may be asked to provide documentation related to their citizenship or legal status, including but not limited to: a visa, a green card, or a letter of refugee status.

1.4.2.2. Coverage will exclude applicants residing outside of the state of Indiana.

1.4.2.3. Coverage will exclude provision of Financial Assistance for any co- payment amount an applicant may be contractually obligated to pay to Community Health per the terms and conditions existing between the applicant and their insurance carrier, with a co-payment cap of $500 per hospital account. Further, it is the expectation that fifty-percent (50%) of any deductibles be paid, in advance, of scheduling medical treatment.

1.4.2.4 Coverage exceptions may be made in the case of financial hardships due to excessive medication costs, extensive hospitalizations or other extenuating circumstances. Determination of coverage of these special circumstances will be reviewed on a case by case basis and requests for such exceptions must be submitted, in writing to the Financial Assistance Committee.

2.0 Determination of Eligibility

2.1. Emergency Services**:** In keeping with the Emergency Medical Treatment and Labor Act (EMTALA), as amended from time to time, no determination of eligibility will be attempted until after an appropriate medical screening examination and necessary stabilizing treatment have been provided. If the patient requires Emergency Services, the determination of eligibility will be made after services have been rendered.

2.2. Non-Emergency Services**:** In non-emergency situations the determination of eligibility for Financial Assistance will be made *before* providing services. If complete information on the patient's insurance or the responsible party's financial situation is unavailable prior to rendering services or at the time of services, the determination of eligibility will be made after rendering services.

2.3. All efforts will be made to establish eligibility for Financial Assistance before the patient leaves the facility/first patient visit concludes.

3.0 Confidentiality and Participation

3.1. The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this policy and procedure will be guided by these values. No information obtained in the Financial Assistance application may be released unless the patient/responsible party gives express written permission for such release.

3.2. Staff Information**:** All employees will understand the fundamentals of the Financial Assistance Policy and be able to direct questions to the appropriate staff member(s). Staff with public and patient contact will be able to provide responsible parties with printed material explaining the Financial Assistance Program.

3.3. Financial Assistance Appeals**:** The Network will maintain a Financial Assistance Appeals process to review appeals from those whose applications have been denied or which do not provide for a level of Financial Assistance to which the responsible parties believe they are eligible. Any exception to the policy would need approval from the Financial Assistance Committee.

3.4. . Physician Participation**:** We will encourage and support physicians not employed by Community who possess admitting privileges and others who provide services to our patients to establish and implement a Financial Assistance Program for the patients they see in connection with services rendered by Community. We will provide qualification status for individual patients, upon request, to physicians who are making efforts to financially clear their patient. Such communication will reveal minimum necessary information.

4.0 Collection Efforts

4.1. Notwithstanding any other provision of any other policy at Community regarding billing and collection matters, Community will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill from Community is eligible for financial assistance under this policy.

4.1.1. For the purposes of this policy “Extraordinary efforts” include lawsuits, liens, garnishments, or other collection efforts that are deemed extraordinary by the U.S. Department of Treasury or the Internal Revenue Service.

5.0 Notification/Duty to Inform

Community will undertake the following efforts to widely publicize its Financial Assistance Policy:

5.1. Written Notification - A Plain Language Summary will be posted in each patient registration and waiting area and available online at ecommunity.com. In the case of services rendered in the home, the Financial Assistance Summary will be provided to the responsible party during the first in-home visit. All publications and informational materials related to the Financial Assistance Program will be translated into languages appropriate to the population in the service area.
5.2. Oral Notification: All points of access will make every effort to inform each responsible party about the existence of Community's Financial Assistance Program in the appropriate language during any pre-admission, registration, admission or discharge process. Additionally, the post-service collection process will integrate notification of the availability of assistance into the standard process when collection efforts fail.
5.3. Statement Notification: Statements will provide information about the Financial Assistance Program.
5.4. Community will make reasonable efforts to inform and notify residents of the community served about the Financial Assistance Policy in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. Modes of delivery of this information may include newsletters, brochures and/or the provision of online access.

6.0 Uniformity Across Network

6.1. This Policy applies to all Community Health Network corporations that provide healthcare items and services to patients as adopted by the applicable Boards of Directors and in accordance with the guidance provided by 501r requirements. The only exclusions to this are certain business units operating separate Financial Assistance Program due to regulations or statutory requirements. Such entities listed in Table 1.3.
6.2. Reporting: Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations including Indiana Code 16-21-9-7, as amended and recodified from time to time. Such report will be made available to the public upon request.
6.3. Corporate Responsibility**:** Each corporation's principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, will certify in each annual report, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statements of a material fact or omits to state a material fact.
6.4. . Accounting: Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.
6.5. Internal Record Keeping**:** Application for Financial Assistance: When required, *completed*

applications will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained and available in the network's imaging system. All debt discharged shall be recorded in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.
6.6. . Automatic Discounts for the Uninsured: All automatic discounts for the Uninsured will be coded specifically as an "automatic discount for the Uninsured" in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes. Applicants who are determined to qualify for the applicable charity discount will not be provided the automatic discount for the uninsured.
6.7. Prohibition on Medical Record Documentation: No records will be placed in or notations made in a patient's health (medical) record regarding financial matters, including whether the patient paid all or part of any medical bills.

7.0 Extenuating Circumstances for Presumptive Eligibility

7.1. The financial clearance process may include investigation and collection of relevant documentation to verify available income from all qualifying sources (current and past), family size, and other factors that may affect the network's decision to extend charity care or assistance to an individual. Any individual that follows the financial clearance process and ultimately meets the network's financial guidelines will receive discounted services according to the applicant's financial resources.
7.2. Generalized Patient Situation: The following are examples that can serve as guidelines for Charity Care consideration:

- Uninsured patients who lack the ability to pay,
- Insured patients who lack the ability to pay for services not covered by their insurer, excluding applicable insurer co-payments,
- Deceased patient without an estate,
- Unsupported disabled patient with little or no income,
- Patients involved in a medical catastrophe resulting in financial hardship.

7.3. Interested Party Requests: Requests for consideration of discharge of debt may be proposed by sources other than the responsible party, such as the patient's physician(s), family members, community or religious groups, social services organizations, or Community personnel. We will inform the responsible party of such a request and it will be processed as any other such request.
7.4. Conversion from Uninsured: When an uninsured patient has been given a discount on an account(s) and the patient subsequently qualifies for discounted care for those accounts, total gross charges will be applied to the traditional Charity Care component of Community Benefit.
7.5. Presumptive Eligibility for Financial Assistance**:** There may be instances when a patient is unable to complete the financial assistance application and/or supply the necessary supporting documentation. In such cases, the financial counselor shall complete the enrollment form on behalf of a patient and search for evidence of financial need. For non-Medicare Traditional enrolled applicants, Community staff will use all available resources to verify such information including public databases, credit reports, or other directories. Such examples include:

- Current enrollment in State assistance program (food stamps, welfare, certain pharmaceutical assistance programs, etc.)- AUTOMATIC Eligibility.
- Natural Disaster victim as designated by federally published zip codes- AUTOMATIC Eligibility.
- Low-income housing resident, supported by a county appraisal district record- AUTOMATIC Eligibility.
- Patient is eligible for other unfunded state or local assistance programs
- Patient receives discounted care from a community clinic and is referred to Community for further treatment
- Unfavorable credit history (delinquent accounts; charge-offs; bankruptcy filing within past year; no credit).
- Lack of family support for incapacitated patient.
- Mental incompetence as declared by a licensed medical professional.
- A deceased patient with no estate and with no other responsible party for payment has met the criteria necessary for us to write-off the discharged debt to Charity Care.

7.6. We will assume a homeless patient, with no evidence of assets through communication with the patient, credit reports and other appropriate means and with, to the best of our knowledge, no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

7.7. When a Medicaid patient is admitted for inpatient or outpatient services and has unpaid accounts for dates of service within thirty (30) days prior to the patient's Medicaid effective date; and to the best of our knowledge, there is no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write-off the discharged debt to Charity Care.

7.8. Upon verbal confirmation of family size and income by the applicant, outside financial information such as "propensity to pay" scoring information provided by an outside vendor may be used as a screening tool for the manual verification of eligibility for the Community Financial Assistance Program.

8.0 Program Administration and Process

8.1. Financial Assistance Application: Upon request from Community the Financial Assistance Application must be completed by the patient or the financial counselor on their behalf and submitted to the network for review before financial assistance will be considered (See ***Attachment B Financial Assistance Program Application)***. The following items may be requested to substantiate financial need of an individual patient:

- Recent W-2s, recent payment stub to verify income level, previous year's tax forms, bank or credit union statements for checking and savings accounts and other statements from financial or legal institutions to verify additional sources of qualifying income.
- External data that provides information on a patient's or guarantor's ability to pay. Proof of non-qualification for any other State/Government Financial Assistance Programs (i.e. Medicaid or other grant-based county or city programs).

8.2. Substantial effort will be made by Community and its business associates to identify alternative

sources of payment via patient qualification from other programs before financial assistance will be granted. This effort will require cooperation from the patient/guarantor. Lack of cooperation with this phase of the determination process will disqualify the patient from the Community Health Network Financial Assistance Program.

8.3. Collection of Family Size and Income Data are the key drivers of the calculation to determine qualification for financial assistance. Community's definitions of family size and income are located in the "Definitions" section of this policy. For purposes of determining the scope of documentation required with the application:

8.3.1. When the patient is a non-emancipated minor: Biological mother and father and/or step parent(s) if child is adopted and all persons on the tax return(s), filer(s) and dependents of same; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

8.3.2. When the patient is not a minor or is an emancipated minor: The patient, the spouse and the dependents of same on the tax return(s) of the patient and/or spouse; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

8.4. Family income, family size, FPL%, and other data may be obtained and used to corroborate provided details leading to eligibility for Community's Financial Assistance Program.

8.5. . Assistance Basis: The basis for Community's Financial Assistance Program is the Federal Poverty Level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services. The calculation of the financial assistance discount is a conversion of the patient's basic demographic information (monthly family income and family size) into a % of FPL.

8.6. . Assistance Levels: For uninsured and underinsured applicants, a sliding scale assistance protocol will be applied to each patient account as follows:

- Patients (applicants) with income levels less than or equal to 200% of the current year's Federal Poverty Level (FPL) will qualify for 100% financial assistance,
- Patients (applicants) with income levels ranging from 201% to 300% of the current year's federal poverty level (FPL) will qualify for partial assistance determined by a sliding scale detailed in table 1.1.,
- Patients (applicants) with income levels greater than 300% of Federal Poverty Level (FPL) will not be eligible for the Financial Assistance Program unless approved by the Financial Assistance Committee. These patients may be eligible to receive discounted rates on a case-by-case basis based on their specific situation, such as catastrophic illness, at the discretion of Community through an appeal process.
- Patients (applicants) who are uninsured and do not meet these income requirements will receive a discount of:
    - 65% on gross charges for facility services, based on Amount Generally Billable (AGB).
    - 25% on gross charges for professional services, except procedures which are 50%.
    - 40% on gross charges for Community Home Health Services.

8.7. Liability Limitation: Responsible parties who do not qualify for financial assistance (>300% of the FPL) will have medical, dental and/or vision debt per calendar year limited to twenty-five percent (25%) of their annual gross family income. In such cases the patient must present all outstanding medical bills with statement dates within 240 days immediately preceding the application date. At the point where

the 25% threshold has been met during the 240 days, Community may limit the liability for services provided within the network that are subject to the terms of the Financial Assistance policy. It is the responsibility of the patient or guarantor to declare financial hardship.

8.8. Patients qualifying for partial assistance will be asked to pay the determined balance in full. If patient cannot pay the discounted balance in full then patients can be set up on payment arrangements within the payment arrangement guidelines. All others follow the chart below, but no patient will receive charity care if >300% of FPL without approval. If a patient qualifies for <100% discount, he/she will be asked to pay a 50% deposit in advance of services and enter into an acceptable balance resolution plan. Based on the totality of a patient's circumstances, further allowances may be made at the discretion of Community.

8.9. Financial Assistance Coverage Date Span: It is preferred, but not required, that a request for Charity Care and a determination of financial need occur prior to the rendering of services. However, the determination may be completed at any point during the collection cycle. The following restrictions apply:

8.9.1. Financial Assistance applications must be received within 240 days (120 days Notification Period + 120 days Application Period) from the first patient statement to be considered for financial assistance. Upon receipt of a completed application within the notated Application Period, extraordinary collection actions will cease. Patient must cooperate with submitting supporting documentation upon request within a reasonable time frame.

8.9.2. Prospective Coverage through Financial Assistance Program:
Patients will be granted extended prospective financial assistance eligibility for a period of ninety (90) days from the date of qualification.

8.10. If the qualification for Financial Assistance cannot be determined through the use of external databases or other programs designed to establish financial need, the patient will also be provided a list of additional documentation that will be required to substantiate their financial situation. If required, the application and all required supplemental documentation must be received before a decision can be made regarding the provision of Financial Assistance.

8.11. The responsible party ("applicant") will have fifteen (15) days following the initial date of request on the application to complete and return the application. The applicant may request an extension of fifteen (15) days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days will result in denial of the application and no discharge of debt.

8.12. All patients submitting an application will have their respective accounts at issue logged in appropriate database for future use.

8.13. Using the documentation provided or results determined through the use of external databases or other programs designed to establish financial need, the Financial Counselor will use the current year's Financial Assistance Program criteria to determine the "scope of eligibility" as detailed throughout this policy.

8.14. Patient Approval/Denial Notification Requirements: Upon receipt of a complete application or analysis of information provided by external databases or other programs designed to establish financial need, it will be approved or denied within forty-five (45) days following the date of receipt.

The applicant will be given or mailed a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.

8.15 Exception process: Upon receipt of a denial notification for financial assistance, responsible party ("applicant") may request charges to be further reviewed through an appeals process.