



Origination 04/2025

Last Approved N/A

Effective 04/2025

Last Revised 05/2026

Next Review 3 years after approval

Area REVENUE CYCLE

Applicability USA Health

Patient Financial Assistance Policy

POLICY STATEMENT:

- A. **General Policy Statement:** The purpose of this policy is to provide a fair and consistent method for uninsured and/or under-insured patients to apply and be considered for financial assistance for the personally responsible portion of their bill (after all sources of funding have been exhausted including insurance/entitlement payments) related to emergency and other medically necessary care received while being treated at USA Health Hospitals and Clinics. Elective procedures are disqualified from being considered under this policy. While not all services of USA Health are eligible under this Financial Assistance Policy (FAP), this policy is compliant with applicable federal, state, and local laws. All USA Health employees, faculty & staff are responsible for complying with this policy. It applies to all patients without regard to race, creed, age, sex, or ability to pay.
- B. **Notification to Public:** USA Health's Hospitals will post a sign in conspicuous places in admission and registration areas (including in the Emergency Department) stating: "You may be eligible for financial assistance, under the terms and conditions of the USA Health's Financial Assistance Policy, offered to qualified patients. For additional information, contact the financial counselors by calling (251) 434-3505, Monday – Friday, 8 am – 4:30 pm. All inquiries, as well as all applications and supporting documents are confidential."
1. USA Health will provide a notice of the FAP, a plain language summary of the FAP, and an application along with instructions on applying in a prominent place on its website via link & in Access/ED Registration areas in paper form
 2. USA Health will include a statement on each patient bill that patients meeting certain income criteria may qualify for the financial assistance under the FAP. A telephone number and website with additional information will be included.
- C. **Amounts Generally Billed (AGB):** All patients of USA Health are charged equally for the services provided. Once it is determined that a patient qualifies for financial assistance under

this policy, the charges will be reduced by an amount appropriate to the award.

1. If the award is 100%, the patient will be advised, and the amount charged for those services will be reduced to zero and no longer billed.
2. Where there is an award of financial assistance that does not cover 100% of the charges for the service, the amounts charged to patients eligible for discounted care will not be more than the amounts generally billed (AGB) to patients under the Internal Revenue Service's "look-back method," which is the percentage of charges that USA Hospitals would have received from a combination of Medicare and all private insurers' patients.
 - a. The look-back percentage will be calculated separately for each hospital, but considered as an average across the covered entities to determine an Inpatient AGB and an Outpatient AGB respectively, to be reviewed in conjunction with this policy.

D. Definitions: 501(r): Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

1. **Amount Generally Billed (AGB):** An amount that is not more than the amounts generally billed to individuals who have insurance covering such care as defined by IRS Section 501(r)(5)(A)
2. **Applicant:** Patient or other individual responsible for payment of the patient's care who seeks financial assistance.
3. **Application Period:** Begins on the date medical care is provided and ends 240 days after the first post-discharge billing statement or 30 days after the hospital or authorized third party provides written notice of extraordinary collection actions the hospital plans to initiate, whichever is later.
4. **Bad Debt:** The unpaid charges for care to patients who are able but unwilling to pay all or some portion of the medical bills for which they are responsible.
5. **Charity Committee:** A committee appointed by the USA Health's CFO to review the applications for financial assistance, review recommendations for assistance, patient attestations and affidavits, Retrospective Charity and/or Indigent Care Approvals. This committee will consider appeals in the event a patient or their representative wishes a reconsideration of a denial of full or partial assistance. The Charity Committee will have final authority for Financial Assistant Policies and/or Indigent Care Approvals as well as all appeals to assure that reasonable efforts have been made to determine an individual's eligibility.
6. **Covered Providers:** All emergency and other medically necessary hospital care services provided in USA Health University Hospital and USA Health Children's & Women's and Providence in Mobile, Alabama as well as in hospital departments/clinics located in Mobile and Baldwin Counties.
7. **USA Health Collection Policy:** The USA Health Collection Policy is also known as the "Self-Pay Balance Follow-up and Collection" Policy details the actions that the facility may take in the event of nonpayment and maybe found on the USA Health's website along with the FAP and Addendums.
8. **Emergency Care:** The care or treatment for an Emergency Medical Condition, as

defined by EMTALA.

9. **EMTALA:** The Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd).
10. **Federal Poverty Level (FPL):** The FPL is the set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities, (also known as Federal Poverty Guidelines) and are updated annually. The amount is adjusted for family size and may be regionally adjusted for eligibility in certain programs and benefits. Information on the FPL may be obtained at: <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/> (This website is maintained by the federal government and subject to change at their discretion.)
11. **Financial Assistance:** The cost of providing free or discounted care to individuals who cannot afford to pay all or a portion of their hospital medical bills based on the eligibility rules identified in this policy.
12. **Gross Charges:** The full established price for medical care provided to patients.
13. **Medically Necessary Care:** Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
 - a. In accordance with generally accepted standards of medical practice;
 - b. Clinically appropriate in terms of type, frequency, extent, site and duration; and
 - c. Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.
 - d. Qualifies for charity care as defined in this policy;
 - e. Does not qualify for charity care but does qualify for some discount of his/her charges for hospital services based on a substantive assessment of his/her ability to pay; or
 - f. Has some means to pay but qualifies for a discount based on this policy.
14. **Organization:** USA Health facility or clinic
15. **Patient:** An individual who receives care at a USA Health and the person who is financially responsible for the care of the patient.
16. **Self-pay Balance:** The amount due to a provider or hospital after services are rendered and all other payment options or reimbursement methods are exhausted.
17. **Self-Pay Balance Follow-Up and Collection Policy:** The Policy and Procedure used for collection of Self-Pay balances due after insurance or if there was no insurance at all. This is sometimes referred to as the USA Health Hospitals' Collection Policy.
18. **Uninsured Patient:** A person who is uninsured or does not otherwise qualify for any governmental or private program that provides coverage for any of the services rendered and either:
 - a. Qualifies for charity care as defined in this policy;

- b. Does not qualify for financial assistance but does qualify for some discount of his/her charges for hospital services based on a substantive assessment of his/her ability to pay; or
- c. Has some means to pay but qualifies for a discount based on this policy.

PROCEDURE:

- A. **Qualification Period:** In general, patients are eligible for financial assistance when they receive emergency or medically necessary care at a USA Health facility, and the patient's family income is at or less than 400% of the Federal Poverty Level (FPL)
 1. The amount of assistance is determined using a sliding scale and may be periodically subject to revision or change.
 2. Approval of financial assistance is made on a case by case and discharge by discharge basis & as circumstances change. Patients may be required to apply or re-apply for financial assistance. Each USA site reserves the right to require reapplication.

- B. **Eligibility Guidelines:** Patient applications can be submitted for consideration for up to 240 days past the post discharge patient statement.

Federal Poverty Level (FPL)/house hold consideration	Percentage of assistance granted
up to 200%	100% FAP adjustment applied
200-300%	85% FAP adjustment applied
300-400%	76% FAP adjustment applied

- C. **Approval Period:** Once approved for financial assistance the patient's approved application will continue in effect for Emergency and Medically Necessary Hospital Services for a period 180 days, unless notified otherwise by the Hospital's Business Office. For oncology patient approvals, this period will cover the full course of treatment regardless of length.
- D. **Contact Info:** To find out if you qualify for financial assistance, please complete the Application Form and attach the documents required to prove income, assets or other available resources. If you need assistance in completing the application, financial counselors are available by calling:
 1. **Phone:** (251) 434-3505, Monday - Friday, 8 am - 4:30 pm
 2. **Mail:** USA Health
Attention: Business Office - Financial Counselor
P.O. Box 40010
Mobile, AL 36640-0010
- E. **Application process:** A patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the USA Health's website, at any Registration Office, or the Business Office of USA Health. USA Health will require:
 1. The uninsured work with a financial counselor to apply for Medicaid or other public

assistance programs for which the patient is deemed to be potentially eligible to qualify for financial assistance (except where eligible and approved via presumptive scoring).

2. Patient provide accurate information on a FAP Application or in connection with the presumptive scoring eligibility process.

F. Verification Documentation Requirements: Along with the application, a patient will need to provide verification of his/her household's income and verification of all assets owned by any household member. Examples of proof of income and assets include:

1. Copies of 3 most recent paystubs from employer
2. Copies of most recently filed tax return (if self-employed, include all schedules)
3. Social Security and/or Pension Retirement Award Letter
4. Parent or guardian's most recently filed tax return, if applicant is a dependent listed on their tax form and under the age 25
5. Copy of receipt of unemployment benefits
6. Approval/denial of eligibility for Medicaid and/or state-funded medical assistance
7. Other income validation documents
8. If the patient receives assistance from or lives in a home with family or friends, please have them complete the attached form labeled "Letter of Support."

USA Health may be able to consider outstanding medical bills to qualify a patient for financial assistance. Please provide documentation of any outstanding monthly medical and pharmacy/drug costs, such as current invoices or statements of account balances. To be considered, the following must be provided:

1. Completed application along with
2. Proof of income
3. Asset listing
4. Outstanding medical bills (if applicable)

G. Asset Qualifications: A patient may not be eligible for the financial assistance if the patient is deemed to have sufficient cash convertible assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a patient's ability to pay based on the categories of assets measured in the FAP Application. A patient with such assets that exceed 25% of such patient's household income amount may not be eligible for financial assistance. USA Health will only consider assets that household members have access to without penalty. Examples of proof of assets include:

1. Current bank statements (checking and savings accounts) from last 3 months
2. Investments, including stocks and bonds
3. Trust funds
4. Money market accounts
5. Mutual funds

H. **Presumptive Assistance:** Eligibility for financial assistance may be determined at any point in the revenue cycle via presumptive scoring for a patient with a sufficient unpaid balance & no FAP application. If patient is granted 100% financial assistance without submitting a completed FAP application and via presumptive scoring only, the amount of financial assistance for which patient is eligible is limited to patient's unpaid balance after considering any payments made on patient's account. A determination of eligibility based on presumptive scoring applies to the episode of care for which the presumptive scoring is conducted only. USA Health reserves the right to include out of state Medicaid in Presumptive Assistance. The FPL percentage for full adjustment under the Presumptive Assistance process that occurs after a reasonable collection effort and before extraneous collections measures is set at 100% of the FPL.

I. **Catastrophic Assistance:** A patient with income greater than 400 % of the FPL may be eligible for financial assistance under a "Means Test." A patient will be eligible for financial assistance pursuant to the Means Test if the patient has an excessive total medical debt, which includes medical debt to USA Health, for emergency and other medically necessary care, that is equal to or greater than such patient's household's gross income. Financial assistance provided via the Means Test is the same as is granted to a patient with income at 400% of the FPL, if such patient submits an Application on or prior to the 240th day after the patient's first discharge bill and the application is approved by the Organization. The amount of financial assistance available to a patient in this category is limited to patient's unpaid balance. A patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

Patients who are not eligible for financial assistance, as described above, may qualify for other types of assistance offered by USA Health.

1. Uninsured patients who are not eligible for financial assistance will be provided a discount based on at least the amount of the discount provided to the highest-paying payor for USA Health.
2. Uninsured and insured patients who are not eligible for financial assistance may receive other settlement offers in accordance with special programs extended by USA Health.

J. **Appeal Rights:** The patient may appeal any denial of eligibility for Financial Assistance by providing additional information to USA Health within 14 calendar days of receipt of notification of denial. All appeals will be reviewed by an appeals committee. The process for patients and families to appeal USA Health decisions regarding eligibility for financial assistance is as follows:

1. If the patient feels critical information was left out of the original financial statement, they may appeal in writing listing the additional information and supporting documentation and why it was not provided originally. The appeal should be sent to:

Attn: Business Office - Financial Counselor
P.O. Box 40010
Mobile, AL 36640-0010

If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to the patient.

- K. **Charges/Collection Activity:** USA Health will allow a reasonable amount of time for the patient or the patient's representative to provide reasonable evidence and information required to determine if the patient qualifies for financial assistance. The patient or the patient's representative should contact the Hospital Business Office or Patient Financial Counselor as soon as possible if they intend to apply for financial assistance.

The Hospital Business Office will not utilize outside collection efforts (ECA) during the first 120 days after the first bill.

During the period of 120 to 240 after the first patient bill, the Business Office will suspend outside collection efforts if an application for financial assistance is received.

If an application is received that needs additional information the applicant will be given 30 days to perfect their application, before collection activities resume.

If the collection agency identifies a patient as eligible, the patient's account may be still considered for financial assistance. The Collection Agency will notify the USA Business Office and upon approval from the Business Office, collection activity will be suspended on these accounts until USA Health Hospitals Financial Counselors have reviewed the patient's account. If the entire account balance is adjusted, the account will be returned to USA Hospitals. If a partial adjustment occurs, the patient fails to cooperate with the financial assistance process, or if the patient is not eligible for financial assistance, collection activity may resume.

L. **Exclusions:**

1. Please Note: The financial assistance offered under this program does not apply to physician or other professional fees outside of USA Health Physician Groups billed separately from the hospital fees and devoid of USA Health employment agreements.
2. For a patient that participates in certain insurance plans that deem USA Health to be "out-of-network," USA Health may reduce or deny the financial assistance that would otherwise be available to the patient based upon a review of patient's insurance information and other pertinent facts and circumstances.