BACON COUNTY HOSPITAL AND HEALTH SYSTEM

Policy Owner: Brenda Williamson

Effective Date: 4/8/2024

Last Reviewed: 11/26/2025

Purpose

Bacon County Hospital and Health System, Inc. (BCHSI) has established a Financial Assistance Policy (FAP) which provides eligible patients medical care at no charge or at a discounted charge. This policy covers emergency and other medically necessary care provided by the Hospital facility. In order for BCHSI to apply this Policy fairly and consistently, patients and their families have a duty to provide appropriate and timely information that will help BCHSI determine the appropriate level or type of financial assistance. This policy enables BCHSI to fulfill its mission to provide quality healthcare for those patients who have limited or no means to pay for these services.

Bacon County Hospital and Health System, Inc. does not discriminate on the basis of age, disability, national origin, pregnancy, race, color, religion, or sex.

Program Objectives

- To provide quality medical services to medically indigent patients without charge or at a reduced rate.
- To ensure that medically indigent patients receive care in the setting determined by current professional standards to be the most appropriate and cost effective for the treatment of the individual's medical condition.
- To ensure that medically indigent patients are not denied medical care or subjected to the under-utilization of medical services,
- To provide services that supports the need of the local community.

Definitions

- Medically Indigent - refers to patients who are unable to pay for some or all medically necessary treatment as determined by the Georgia Indigent Care Trust Fund
- Reasonable Efforts - refers to the efforts the Hospital makes to determine whether an individual is eligible for financial assistance in accordance with Federal and State guidelines
- Extraordinary Collection Efforts (ECAs) - refers to legal and credit related actions taken by the Hospital against guarantors in order to obtain payment of a hospital bill that Is defined as extraordinary by the Federal guidelines. These include negative credit bureau reporting, liens, judgments, lawsuits, and wage garnishments.
- Notification Period - refers to the period during which the Hospital Facility must notify an individual about the FAP beginning on the date of care and ending on the 120th day after the Hospital provides the individual with the first billing statement for the care.
- Application Period - refers to the period during which the Hospital must allow a patient to apply for financial assistance beginning on the date of care provided to the individual and ending on the 240th day after the Hospital provides the individual with the first billing statement for the care,
- Amounts Generally Billed to Insured Patients - refers to a limitation placed on charges for patients who qualify under the FAP to amounts not more than the amounts generally billed to individuals who have insurance covering such care.

- Co-Payments. Coinsurance and Deductibles - The amount determined by the patient's insurance policy as being due from the patient and/or any Guarantor. This amount is normally a required payment due from the patient or Guarantor by contract
- Emergency Medical Conditions - Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)
- Eligible Services - Services eligible under this Policy include emergency medical services provided In an emergency room setting, non-elective services provided in response to life-threatening circumstances in a non-emergency room setting and other medically necessary services. Eligible services do not include elective, cosmetic, or non-medically necessary services.
- Family Unit - The family unit consists of the applicant, spouse and all legal dependents as allowed by the Internal Revenue Service. If the applicant is a minor or legal dependent for income tax purposes, the family unit will include parent(s), legal guardian(s), and /or the taxpayer claiming the patients as a dependent for income tax purposes.
- Federal Poverty Guidelines (FPG) - The poverty guidelines Issued by the U.S. Department of Health and Human Services at the beginning of each calendar year that are used to determine eligibility for certain assistance programs.
- Financial Assistance - Free or discounted health services provided to individuals who meet TRH's criteria for financial assistance and are unable to pay for all or a portion of the medically necessary services provided by the Hospital.
- Free Care - Free Care is available when the household Income of a patient and/or Guarantor is either equal to or less than 125 percent of the current Federal Poverty Guidelines,
- Discounted Financial Assistance - Financial Assistance discounts are available when the household income of a patient and/or Guarantor is in excess of 125 percent and equal to or less than 200 percent of the current Federal Poverty Guidelines.
- Medically Necessary - Health care services that a Physician, exercising prudent clinical judgment would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or Its symptoms.
- Patient Liability - Patient Liability is the amount owed by the individual patient and/or Guarantor after first applying any insurance benefits and then applying any financial assistance discounts.

Scope

The financial assistance plan covers emergency and medically necessary hospital services only. Patients may receive services from certain third parties during their course of treatment that may or may not fully participate in the hospital's financial assistance plan.

Procedure

1. Admissions personnel will ask every patient potentially eligible for financial assistance if they require assistance with their Hospital bill. If the patient does not wish to complete the application upon registration, the Registrars will ask them to complete it and return it to the Financial Counselor within 30 days of the date of service. A new indigent application should be submitted every six months unless changes have occurred.

2. Free copies of the Financial Assistance Policy will be made available in the Emergency Department, Financial Counselor Office, and Admissions areas to all patients who request it

Application Process

A. **Eligibility Criteria**
The hospital will apply standard eligibility criteria for each person requesting free and reduced-charge care according the following standards:

1. A patient or guarantor must complete a Hospital FAP application.

2. Applicant must be a resident of the State of Georgia.

3. Applicant cannot be covered by Medicare, Medicaid or any other assistance program that may be available and applicant must not meet the basic qualifications to apply for these programs. If eligible, the Financial Counselor/Government Programs Coordinator will assist the patient or guarantor in making application for these programs.

4. Any balance due from patient after Medicare, Medicaid, Medicare HMO's, Medicaid CMO's or Medicare/Medical replacements pays, are not covered under the FAP.

5. Applicant cannot be covered by private insurance.

6. The combination of family income and total number of family members must fall within guidelines given in this policy.

7. Charges must be in conjunction with an inpatient stay or hospital-based outpatient services. Screening tests, elective or "Not Medically Necessary" procedures, Sleep Studies, EEG's, and non-hospital based Physician fees are not covered under the Hospital's FAP.

B. **Program Requirements**

1. Income Calculation, Verification, and Family Unit Size

a. Income Calculation:

1. Income is the family units gross income. The Hospital will use either the average monthly income for the previous three months or for the previous year, **whichever is more favorable to the applicant.**

2. For self-employed individuals, the amount of income to be counted is gross income minus work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

3. For money received that may be considered as a non-recurring lump sum (insurance settlements, accumulated back RSDI payments, etc.), consider the gross amount received as income in the month received.

4. Temporary Assistance Needy Families (TANF) or Social Security Insurance (SSI) income received by any family member should be excluded.

5. The Hospital will not count income from any person who is not financially responsible for the patient. For example, the Hospital will not count income from one sibling as available to another sibling for purposes of paying medical bills. Likewise, the Hospital will not count income from any child (minor or adult) in considering eligibility under the FAP for the child's parent.

b. Verification of income:

1. The FAP requires reasonable methods of income verification such as pay stubs, award letters, employer statements, income tax returns, etc.

2. The applicant's statement of zero income maybe accepted.

3. Should presumptive eligibility software indicate that the patient is likely to have financial means in excess of what is stated, the hospital reserves the right to insist on documentation of income through tax returns or other acceptable means.

c. Family unit: A family unit consists of individuals living alone; and spouses, parents and their children under age 18 living in the same household. A family unit may include minor children living with a legal guardian. The child, legal guardian, and the legal guardian's family unit living in the same household may comprise a family unit.

2. During the application process the Financial Counselor/Government Programs Coordinator will verify the income for the (3) months (prior to the months of service) or last year. This may be accomplished by asking for copies of payroll check stubs, bank deposit slips, W-2 Forms/Income Tax Return (Last Year) or by calling the employer for payroll records.

3. The application should be taken prior to admission/registration or if doing so is impossible, then before or at discharge. Applications for financial assistance will be accepted up to 240 days after the first statement date.

4. The Patient Account Rep will keep a neat and orderly file related to the Hospital's FAP to include applications for the program. Each file will be maintained and updated on a regular basis so as to have current records at all times. The Patient Account Rep will be responsible for providing each admission/registration area with updated forms and instruction. Telephone and walk-in logs will be maintained in order to follow up on potential candidates for this program. Follow up will be performed in a timely manner and written documentation will be kept on each interview in an organized manner.

C. **Denials / Appeals Process**

1. Free and Reduced-Charge Services. The Hospital will inform persons who have been denied free or reduced-charge services under the Hospital's FAP that they have an opportunity for reconsideration by the Hospital. The Hospital will maintain written evidence verifying that its reconsideration process has been utilized.

2. The Hospital will implement and maintain a process that includes the following mechanisms for tracking and documenting requests for reconsideration:

a. Keep an application on file for each person applying for free or reduced-charge services.

b. Make determinations of eligibility within five working days from the date application information is completed.

c. Issue written notice to the applicant that approves or denies free or reduced-charge services from the Hospital within five working days from the date application information is complete. If an applicant is determined ineligible, written notices must include the reasons and the information used to determine the results. Notices that deny free or reduced-charge services or that only approve reduced-charge services must include a provision informing the applicant that the request can be reconsidered.

d. Appeals will be reviewed by Hospital Administration including the Department Manager and/or Director. Notices will include specific contact information to these designated Hospital personnel.

3. The Hospital shall seek to resolve complaints in a timely manner regarding its compliance with the maintenance of the Hospital's FAP.

D. **Incomplete Applications and Reasonable Efforts**

1. The Hospital must make reasonable efforts to determine whether an Individual is FAP-eligible or provide required notices during a notification period ending 120 days after the date of the first billing statement. Reasonable Efforts to address incomplete applications include:

a. Suspend any Extraordinary Collection Efforts (ECAs) against an individual (meaning it does not initiate any new ECA's or take further action with respect to previously initiated ECAs);

b. Provide patients with a written notice describing the additional information and/or documentation the individual must submit to complete their FAP application including a plain language summary of the FAP with the written notice; and

c. Provide patients with at least one written notice informing them about the ECA's that the Hospital or other authorized party may initiate or resume if they do not complete the application or pay the amount due by a completion deadline,

2. Although a Hospital facility may undertake ECAs after the 120-day notification period if the Hospital has not determined whether an individual is FAP-eligible, they will still accept and process a FAP application from the individual for an additional 120 days.

3. If an individual fails to complete the FAP application by the deadline, the Hospital will have made reasonable efforts to determine whether the individual is FAP-eligible and thus may initiate or resume ECAs against the individual.

E. **Limitation on Funds Available**
The hospital makes a certain amount of funds available for financial assistance in compliance with State and Federal requirements. When funds have been exhausted for a given month, applications for financial assistance may be denied for lack of funds even though an applicant may otherwise meet the approval criteria. Within the scope and allowable timeframes given in this policy and according to Federal Guidelines, the applicant may reapply during the next monthly funding cycle.

F. **Intersection With Other Programs (e.g. Mercy Clinic, Community Grants)**
The Hospital's FAP includes the Hospital Charity Care and the Georgia Indigent Care Trust Fund programs. In addition to the Hospital's FAP, patients might also qualify for separate, non-Hospital funded financial assistance programs to include free clinics and community grant programs and will not be considered ineligible for Hospital financial assistance due to eligibility for outside financial assistance programs.

Calculation and Application of Charges

A. The Hospital will provide services at no charge for patients with incomes below 125 percent of the federal poverty level who are determined eligible for Financial Assistance, provided charity care funds are available for the given fiscal period.

B. The Hospital will provide reduced charge services for patients who are determined eligible for Financial Assistance with incomes between 125 percent and 200 percent of the federal poverty level, provided funds are available for the given fiscal period. Charges will be reduced to the Medicare DRG (Diagnosis Related Group) allowable rate for Inpatient Admissions and to the effective Medicare discount rate for Outpatient Services (see Appendix B).

C. Any patient determined to be eligible for assistance under the FAP will not be charged in excess of the Amounts Generally Billed (AGB) to insured patients. The amount generally billed to insured patients is calculated by the "Medicare" method as outlined in Section 501(r) of the IRS Code.

Patient Billing

A. At any point during the billing process, a patient may apply for financial assistance by contacting Business Services or a Patient Financial Counselor (see *Appendix A).*

B. The Hospital provides a billing statement to all patients with a balance due. The statement also contains payment options.

C. Statements are printed on a 30-day cycle with payment due upon receipt. Patients are provided with two consecutive statements at day zero (or the statement date) and day 30.

During this period, patients may arrange to pay the Hospital in person at the Business Office, over the phone by calling a toll-free number provided on the statement, or over the Internet by following instructions provided on the statement. During this period the Hospital may choose to contact patients via telephone to encourage payment and to check for non-receipt of a statement.

D. At 60-90 days past due, the Hospital may attempt to contact patients with outstanding balances through various channels including phone calls and letters.

E. At 90-120 days past due, patients will receive notification from the Hospital that their account is at risk of going to collections if the balance due is not resolved.

F. At 150+ days past due, accounts may be referred to a third party collections vendor.

Collections

A. At any point during the collections process up to 240 days after the original statement date a patient may apply for financial assistance by contacting Business Services or a Patient Financial Counselor.

B. The Hospital employs various third party agencies to collect unpaid debts from patients. This process may start as soon as 120 days past the statement date for accounts with unresolved balances.

C. Third party agencies are charged with using strategic and legal means to seek to resolve unpaid balances. Strategic means include contacting the patient/guarantor through phone calls and letters in conformance to the Fair Debt Collections Practices Act in an attempt to resolve the unpaid balance through payment in full or agreement to a payment plan. Accounts with unpaid balances may be reported to the Credit Bureaus.

D. Legal means include judgments, liens, wage garnishments, and lawsuits.

E. The FAP defines Credit Bureau Reporting and Legal Means as ECAs. Patients who qualify for financial assistance under the FAP are exempt from ECAs.

F. Before any ECAs are pursued on qualifying accounts, the hospital and/or its third party agencies will make reasonable efforts to notify the patient.

Appendix A

Bacon County Hospital and Health System Contact Information

- **Business Office Manager**
  Bacon County Hospital and Health System

Attn: Business Office
P.O. Box 1987
Alma, GA 31610
(912) 632-8961

- **Financial Counselor**
  Bacon County Hospital and Health System
  Attn: Financial Counselor
  P.O. Box 1987
  Alma, GA 31510
  (912)632-8961

Appendix B

Discount to Charge Determination Methodology

Discounts to charges will be determined using the look back method as outlined in rule 501(r) for Outpatient Services. The look back method calculates the overall effective discount rate on an annual basis for the prior fiscal year. This rate is based on the effective Medicare allowable reimbursement rate over a period of 12 months for BCHSI for Outpatient Services. Using this data, the average contractual rate including both Payer and Patient payments will be calculated. This formula will yield what the rule refers to as the Amount Generally Billed to Insured patients. This discount rate will be applied to gross charges for an uninsured patient who qualifies under the FAP.

Finalize

Origination:	03/2016
Last approved:	06/2025
Last revised:	03/2016
Next Review:	06/2026
Owner:	Brenda Williamson, Director of Financial Services
References:	
Approved By:	QM (00/00) Medical Staff (00/00) Board (00/00)