HAMPTON REGIONAL
& COASTAL PLAINS PHYSICIAN OFFICES
in affiliation with MUSC Health

Status: Active
Effective Date: 09-01-2007
Latest Revision Date: 2-27-2025
Admin Approval: Julie Allen, CFO

TITLE: *Financial Assistance Policy*

Scope: Hampton Regional Medical Center and Coastal Plains Physician Practices

Policy:

Hampton Regional Medical Center's mission statement "Compassion, Commitment, & Excellence, Every person, Every time" reflects our commitment to the community we serve. Hampton Regional Medical Center (HRMC) is dedicated to providing quality healthcare to all patients presenting for care regardless of their ability to pay.

The purpose of this policy is to aid HRMC and its affiliates in identifying and determining the financial responsibility for patients who are low income, uninsured, underinsured, and/or medically indigent. HRMC will always provide emergency medically necessary care regardless of the patient's ability to pay. Similarly, patients who can pay have an obligation to pay and providers have a duty to seek payment from these individuals.

Financial Assistance Guidelines:

Eligibility
Hampton Regional Medical Center will provide medically necessary care to Uninsured Patients with household income levels at or below 200% of the federal poverty level (FPL) at no cost to the patient.

HRMC will never bill any Financial Assistance eligible individual more than the "average amount generally billed" (AGB) to someone who is insured. This is calculated annually using the look-back method and would include Medicare fee-for-service together with all private health insurers paying claims divided by the sum of the associated gross charges for those claims. See additional information concerning the AGB below in "definitions".

Presumptive Eligibility
Patients who qualify and are receiving benefits from the following programs may be presumed eligible for 100% Financial Assistance:

- DSS guidelines are the same for individuals receiving Family Planning only, patients qualifying for Family Planning with unrelated diagnosis have already been qualified as meeting Medicaid eligibility. Therefore, patients presenting with Family Planning for unrelated diagnosis can automatically be qualified as meeting our internal 100% charity guidelines. Patients presenting with Family Planning cards as well as Medicaid rejections for "FP only" should be verified via the Medicaid Eligibility Inquiry.
- Food Stamps
- County and State relief programs
- Homelessness
- Deceased Patients. Unpaid balances of patients who are deceased with no estate or surviving responsible party would also qualify for assistance.

Patients who meet the presumptive eligibility criteria may be granted Financial Assistance without completing the Financial Assistance application.

Eligible Population & Service Area

This policy is applicable to all uninsured and underinsured patients in the service area. Patients of the hospital and patients of hospital-owned physician practices must reside within the HRMC service area. Patients living outside the service area may apply for Financial Assistance and will be reviewed and approved on a case-by-case basis.

Determination of Eligibility

In evaluating a patient's need for Financial Assistance, HRMC personnel may verify proof of total household income, liabilities, and assets. Examples of verifiable proof include, but are not limited to:

- Pay stubs,
- W-2 forms,
- Federal Income Tax Return
- 1099 Form,
- Written verification of wages from his/her Employer and written verification from a public welfare agency or other Governmental agency attesting to the patient's income status.
- 3 Consecutive months of banking statements, 3 months from the date of the application was received.

Upon request, an Uninsured Patient shall supply documentation necessary in order verify their income. If the Uninsured patient does not provide the information needed to reliably determine eligibility, external sources such as a Medicaid denial may be used.

Patients without an income source should supply a letter of support stating their need for Financial Assistance consideration based on their current financial situation
Household income is the primary criteria for determining eligibility. HRMC reserves the right, however, to deny participation in the Financial Assistance Program for uninsured

patients who, in the judgment of HRMC, have sufficient net assets to pay for hospital services provided.

All other payment options must be exhausted prior to granting Financial Assistance.

Information from the Financial Assistance Application will be used to determine eligibility for assistance. Household size and income level will be used to determine the amount of Financial Assistance based on the Federal Poverty Level. (See Exhibit A)

All self-pay patients are given a 20% discount off total charges. If a patient is screened and approved for Financial Assistance, the self-pay discount no longer applies.

All uninsured self-pay inpatient accounts, uninsured accounts with charges of $5,000 or above, and uninsured scheduled patients will be screened by the internal Financial Counselor for potential funding sources. Patients must comply with requests from the Financial Counselor in attempting to identify other coverage options or Financial Assistance will be denied.

Eligibility Period and Notification

The patient or his/her representative may request Financial Assistance before services are rendered, at the time of service, or after services are rendered. Patients who have met the Financial Assistance criteria and are deemed eligible for Financial Assistance will be notified of eligibility within 30 days of receipt of a complete application and all required documentation.

The Financial Assistance application and documentation must be updated every six (6) months, or at any time during that six-month period the patient's financial circumstances change to the extent the patient becomes ineligible. Each visit within the six-month period will be reviewed for potential access to other Entitlement Programs.

The Hospital will accept Financial Assistance applications up to 240 days after the first post discharge statement date. Documentation must be provided if the request is more than 90 days after the service date. Failure to return the requested documents within 30 days of application or within 240 days from the date of the first statement may be considered incomplete and may result in denial of the Financial Assistance.

Covered Services

Covered services include emergency and medically necessary services received at Hampton Regional Medical Center or its physician owned practices. Covered services are determined by physician evaluation. Covered services do not include cosmetic, elective, non-urgent test, services or procedures, and prescription medications.

Non-Covered Financial Assistance Services

Patients are not eligible for Financial Assistance if:

- Procedures are cosmetic services, elective, non-urgent test, services or procedures, and prescription medications
- Patients who do not comply with request made by the Financial Counselor or Patient Accounting team.
- Accounts indicating third party involvement (i.e. worker's compensation, auto

accident coverage, third party liability, etc.) will be reviewed in detail and will require proof of no third-party liability. Financial Assistance will be considered for patients only after all third-party liability payments have been received.

- Patients that abuse the Financial Assistance Program, either by requesting unnecessary procedures, inappropriate actions toward staff, or by utilizing an unnecessary treatment location, may be denied Financial Assistance.
- Patients without a valid physician order and scheduled procedure, excluding Emergency Room visits and some ancillary services, will not be considered for Financial Assistance.

Record Keeping

The application and documentation are retained electronically in the Financial Assistance folder. Files are retained for a minimum of 7 years.

Financial Assistance Budget

The availability of Financial Assistance may be limited based upon HRMC's budget or other financial constraints, which would impact the ability of HRMC to remain viable.

Communication

Hampton Regional communicates the availability of Financial Assistance to all patients through means which include, but are not limited to:

- At registration, you may be directed to a Financial Counselor if you do not have coverage, or if coverage is determined to be insufficient.
- This policy, the application, and a plain language summary shall be available on HRMC's website, www.hamptonregional.org
- Financial Assistance brochures, which inform the reader about Financial Assistance available under this policy, how to obtain more information about this policy and the application process, are available both by mail and in public locations throughout Hampton Regional Medical Center, including at a minimum the ER and admissions areas, and hospital owned physician practices.
- Included on all billing statements, along with contact information for the Financial Counselor.
- Paper copies of this policy, the application, and plain language summary are available upon request and without charge to the patient. A request can be submitted to:

  Hampton Regional Medical Center
  Financial Assistance Counselor
  PO Box 338
  Varnville, SC 29944

Patient Responsibilities

If applicable, prior to being considered for Financial Assistance, the patient/family must cooperate with HRMC to furnish information and documentation to apply for other

existing financial resources that may be available to pay for the patients' health care, such as Medicaid, Medicare, third-party liability, etc.

HRMC reserves the right to reverse a Financial Assistance determination if subsequent findings indicate the information relied upon was in error or if compensation for services is obtained from any other source.

Patients who qualify for partial discounts must cooperate with HRMC to establish a reasonable payment plan and make a good faith effort to honor the payment plans for their discounted healthcare bills. Any change in the patient's financial situation that could impact their ability to pay should be communicated to HRMC.

Patients who have an outstanding balance after they are evaluated for Financial Assistance, or who do not comply with the Financial Assistance requirements will be billed following our Patient Billing and Collections Policy. To obtain a copy of this policy at no cost, patients can contact our financial counselor at (803) 943-1213.

Exclusions

This policy only applies to services rendered at Hampton Regional Medical Center and its hospital owned physician practices. This policy does not apply to services provided within or outside the facility by physicians or other healthcare providers who are not employed by Hampton Regional Medical Center. For a complete list of providers who honor the Hampton Regional Medical Center Financial Assistance policy, please see the list located on our website, www.hamptonregional.org, request a hard copy from any registration location, or contact us at (803) 943-1213.

Extraordinary Collection Actions

Balances will be the financial responsibility of the patient and/or guarantor unless the balance is deemed as covered under the Financial Assistance Policy. Statements are generated every 30 days after the date of the initial statement. If the account is not paid within 120 days from the date of the first post discharge statement, it may be placed with an outside collection agency. Patients are notified 30 days prior to bad debt placement. Statements include information on how to apply for Financial Assistance, payment plan options, and information on how to contact a Financial Counselor. If a patient qualifies and applies for Financial Assistance after placement with an outside collection agency, the process of collection action will be suspended. Patients may apply for Financial Assistance through day 240.

Other extraordinary collection actions may include reporting the debt to a credit bureau or garnishment of wages or taxes in the event of nonpayment. All reasonable efforts to determine a patient's eligibility for Financial Assistance will be made before any other action is taken. If a patient is approved for Financial Assistance after collection actions are initiated, all reasonable efforts will be made to reverse any negative effects of the action.

Definitions

The following definitions are applicable to all sections of this Policy:

Uninsured Patient- an individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitations Medicare, Medicaid, SCHIP, and Champus), Workers' Compensation, Medical Savings Account or other coverage for all or any part of his/her bill, including claims against third parties covered by insurance to which HRMC is subrogated, but only if payment is actually made by such insurance company.

Underinsured Patient- an individual having some form of health insurance that does not offer complete financial protection resulting in a residual balance that is beyond the patient's financial means.

Financial Assistance- a reduction in an Uninsured or Underinsured patient's billed charges for inpatient or outpatient hospital service in accordance with the HRMC's Uninsured Patient Financial Assistance Guidelines.

Medically Necessary Services- services for a condition which, if not promptly treated, would lead to an adverse change in the health status of a patient.

Plain Language Summary- A written statement that notifies an individual that Hampton Regional Medical Center offers Financial Assistance under this policy and provides information in language that is clear, concise, and easy to understand.

Hospital owned physician practices- includes Coastal Plains Primary Care and Coastal Plains Physician Associates.

Bad Debt- accounts that have been categorized as uncollectible because the patient has been unable to resolve the outstanding debt.

Elective- services that, in the opinion of a physician, are not needed or can be safely postponed.

Emergency Care- immediate care which is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy.

Service Area- the defined service area is Hampton County.

Amount Generally Billed (AGB)-
IRS regulation 501R requires the hospital to calculate the Amount Generally Billed to patients who have insurance and to assure patients who qualify for the Financial Assistance Program are not charged more than the average amount reimbursable by insurance.

HRMC uses the "look-back method" described by the IRS in the 501r regulations. This method compares the charges for claims processed by private insurance companies and Medicare fee-for-service with the "amounts allowed" for those services. The "amounts

allowed" means the portion that Medicare pays or allocates to the patient to pay, which can include co-insurance, co-payments, and deductibles.

The AGB is calculated by reviewing all past claims that have been paid in full to the hospital facility for medically necessary care by Medicare fee-for-service together with all private health insurers paying claims to the hospital in a prior 12-month period. The AGB for a Financial Assistance-eligible individual is determined by multiplying gross charges for that care (emergency or medically necessary) by the HRMC AGB billed to Medicare and other private insurers. The percentage is calculated at least annually by dividing the sum of certain claims paid to the hospital by the sum of the associated gross charges for those claims.

Exhibit A

2025 FEDERAL POVERTY GUIDELINES
January 2025

	100%	**200%**	**201% - 300%**	**301% - 400%**
FAMILY SIZE	POVERTY LEVEL	MAXIMUM INCOME FOR **100%** WRITE OFF	MAXIMUM INCOME FOR **75%** WRITE OFF	MAXIMUM INCOME FOR **50%** WRITE OFF
1	$15,650	$31,300	$46,950	$62,600
2	$21,150	$42,300	$63,450	$84,600
3	$26,650	$53,300	$79,950	$106,600
4	$32,150	$64,300	$96,450	$128,600
5	$37,650	$75,300	$112,950	$150,600
6	$43,150	$86,300	$129,450	$172,600
7	$48,650	$97,300	$145,950	$194,600
8	$54,150	$108,300	$162,450	$216,600

FAMILIES WITH MORE THAN 8 PERSONS ADD $5,500 FOR EACH ADDITIONAL MEMBER