



FINANCIAL ASSISTANCE PROGRAM (FAP)			
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Category	Standard	Previous Review/Revision	March 31, 2020
Sub-Category	Leadership	Designated Responsible Individual	Chief Financial Officer & VP Revenue Cycle Management

POLICY STATEMENT:

It is Wellstar Health System’s policy to provide medically necessary hospital care at no cost to qualified patients of Wellstar, and to significantly discount medical care costs to others who cannot afford the full cost of hospital care, including but not limited to, those Wellstar patients faced with financial hardship due to medical misfortune.

Wellstar is committed to providing financial assistance to patients who have sought medically necessary care at Wellstar hospitals but have limited or no means to pay for that care. Our Financial Assistance Program (FAP) refers to what is commonly known as Charity Care. Wellstar follows the generally accepted accounting principles for the accounting of our charity care provided. Wellstar will provide emergency hospital medical care to all individuals, regardless of their insurance coverage, their ability to pay for these services or their eligibility under this FAP.

It is also the policy and practice of Wellstar to adhere to any and all applicable Federal, State, and Local laws and any contractual obligations which may be associated with the contents and subject matter contained in this document.

PURPOSE:

The purpose of this FAP is to set forth a fair and equitable process for providing financial assistance for emergency and medically necessary Hospital care provided at Wellstar to patients who are uninsured or have limited or no means to pay for their care. This FAP is not a substitute for personal responsibility. Patients are expected to cooperate with Wellstar and are required to cooperate in determining their eligibility for various programs (such as the State of Georgia Indigent Care Trust Fund [ICTF] and Medicaid program) in order to qualify for financial assistance under this FAP, and to pay for their care to the extent required under this FAP.

DEFINITION(S):

Allowable Medical Expenses: The total of family medical bills that if paid, would qualify as deductible medical expenses for Federal income tax purposes without regard to whether the expenses exceed the IRS-required threshold for taking the deduction. Paid and unpaid bills may be included.

Amounts Generally Billed (AGB): For Hospital(s) the amounts generally billed (AGB) is the amount charged for emergency and other medically necessary hospital care to individuals who have insurance covering such care. Wellstar uses the “look-back”, or retrospective method of allowed amounts for all claims with a primary coverage through Medicare and commercial insurers, to determine AGB, which is allowed for by the Federal Government. This calculation is further explained in the procedure LD-24-02.

Amounts Generally Billed Implementation Period: For Hospital(s) the final regulations define that a hospital may take up to 120 days after the end of the 12-month period used in calculating the AGB.

Amounts Generally Billed Percentage: For Hospital(s) means the percentage derived by dividing the AGB by the applicable gross charges that a hospital facility uses for any emergency or other medically necessary hospital care it provides to an individual who is eligible for assistance under the Wellstar FAP.

Application Period: A period of 240-days following the first post-discharge billing statement that was provided to an eligible FAP patient after individual care has been provided and the patient has left the service facility in which represents the regulatory time period for application submission.

Asset Statement: Is a summation net worth, excluding any possessions such as a car, house, or other valuables.

Award: The dollar amount, or discount off of charges which will be given, once it is determined that the patient/guarantor is deemed eligible for partial or full benefit. Please note that the award, if approved, will be granted only for remaining balances after any payments have been received from third parties. This “award” will, at a minimum, be sufficient such that the hospital will not charge any patient eligible for assistance, more than the AGB. This is otherwise known as the Minimum Charitable Allowance.

Billed Charges: Charges for services by Wellstar as published in the Charge Description Master (CDM).

Business Office: Department which is part of Wellstar and is responsible for billing, collection and payment processing.

Charges: Total charges for any hospital inpatient stay or outpatient service, procedure, or group of services.

Charity Care - Patients or guarantors who qualify for free or discounted care based on the Wellstar FAP and has income greater than 125% of the Federal Poverty Guideline (FPG).

Community: Community is defined geographically, by Wellstar hospitals’ intersecting 90 percent catchment areas irrespective of county lines, and statistically, by the demographics and determinants of health reported in the Wellstar Health System CHNA.

Community Health Needs Assessment (CHNA): Refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

- The current CHNA for Atlanta Medical Center/Atlanta Medical Center South, Cobb, Douglas, Kennestone, Paulding and Windy Hill, North Fulton, Spalding/Sylvan Grove and West Georgia Hospitals’ can be located at <https://www.Wellstar.org/about-us/pages/community-health-needs-assessment.aspx>

Discount: A discount off of total charges for individuals above and beyond those reductions covered by this FAP. These discounts may include prompt payment, packaged or bundled payment, selected services as defined and approved by Wellstar which conclude with a patient responsibility amount of less than total billed charges.

Discounted Care: Medical bills which are sent by Wellstar which receive a discount from the full, billed charges.

Extraordinary Collection Actions (ECA): Actions taken by a Hospital against an individual related to obtaining payment of a bill for care that engage in a legal or judicial process unrelated to actions specifically excluded by the regulations, involve selling an individual’s debt to another party, the deferral or denial of (or the requirement of a payment before providing) medically necessary hospital care because of the individual’s non - payment of one or more bills for previously provided care, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, “credit agencies”). Wellstar does not use ECA for those individuals qualifying under this FAP, unless any residual patient pay responsibility remain unpaid in compliance with Wellstar’s Billing and Collection policy.

Family Unit: The Family Unit consists of individuals living alone; and spouses, parents and their children under age 21 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.

Federal Income Tax Return: The form or reporting method which is submitted to the Internal Revenue Service (IRS) for purposes of reporting taxable income. The form must be a copy of the actual, signed and dated form submitted to the IRS.

Federal Poverty Guideline (FPG): Guidelines set by the Federal Government which establishes income levels for households living above or below defined poverty or subsistence annual incomes.

Financial Assistance Program (FAP): Commonly known as, Charity Care, a program which may prospectively and /or retroactively establish the qualification for reductions issued to the amount owed by a patient for the bills sent by Wellstar Health under the authority of this FAP.

Financial Class: A technology term used for the purposes of associating specific payor categorization within a patient accounting system generally associated to a specific type or product of coverage used in the management and /or facilitation of account management.

Guarantor: A Guarantor is an individual whom signed the financial guarantee and/or individual who is financially responsible under the Laws of the State of Georgia or appropriate legal governing body.

Hospital: a facility that is required by a state to be licensed, registered or similarly recognized as a hospital as described in the Department of the Treasury; Internal Revenue Service; Section 501(c)(3) that operates one or more hospital facilities in accordance with Section 501(r)(2)(A)(i) and is also subject to the IRS regulations 501(r)5 and 501(r)6.

Household Income (HI): Income of all family members who reside in the same household as the patient, or in the household which the patient claims on their tax returns or other government documents as their home address.

ICTF Qualified Care: ICTF Qualified hospitals serve a “disproportionate number of low-income patients with special needs,” or serve “Medically Indigent” persons “with an income no greater than 125% of the FPG. Qualified hospitals are required by law to operate a program under which Patients may receive “care without charge”, otherwise referred to as ICTF Qualified Care or Indigent Care.

Indigent Care: – Medically necessary hospital care provided to a family whose household income is below 125% of FPG, or, medically necessary hospital care provided at no charge or a sliding fee scale to a family whose household income is between 125% and at a minimum, 200% FPG.

Intelligent Software: Software applications which provide “presumptive eligibility for Charity” for hospital provided services.

IRS 501 (r) (5): Is a Federal statute that requires a Hospital to limit the amounts charged for emergency and other medically necessary hospital care that is provided to individuals eligible for assistance under the organization’s financial assistance policy to not more than the AGB to individuals who have insurance.

IRS 501 (r) (6): Is a Federal statute that requires a Hospital to forego ECA against an individual before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the Hospital organization’s financial assistance policy.

Medically Necessary Care: Are Hospital services or supplies that the treating physician determines are needed for the diagnosis or treatment of a medical condition and meet the standards of good medical practice. Examples of hospital services not considered to be medically necessary hospital services include: hyperbaric services, cosmetic services*, dental surgery, tubal ligation*, vasectomy* and vaso-vasectomy*, retail pharmacy, laboratory outreach services and services deemed out of network by an individual’s insurance company*.

Further, Medically Necessary Care under this FAP does not include the professional fees charged by physicians and other providers for their services, even if those services were rendered at a Wellstar Hospital. In accordance with Georgia Health and Safety Code, emergency physicians who provide emergency hospital medical care and physicians not employed by Wellstar, are required by law to provide discounts to uninsured patients or patients with high hospital medical costs who are at or below 300 percent of the FPG. Detailed policies for emergency physician discounts and physicians not employed by Wellstar will be maintained by the individual physicians or their representative networks. A list of covered and non-covered providers is provided in Appendix A. Any additional questions related to covered and non-covered providers and services can be directed to the Wellstar Business Office at 805 Sandy Plains Road, Marietta, GA 30066, Attention: Single Billing Office (SBO) FAP Department.

[*If these services are rendered at a Wellstar hospital due to emergent patient care or classified as medically necessary as deemed by a physician and in accordance with the definition provided previously in this FAP, then these services may qualify under this FAP, but will be determined on a case by case basis by the Wellstar Business Office. Wellstar operates in compliance with the Emergency Medical Treatment Active Labor Act (EMTALA) as outlined in the policies: PAS-01-800-01, EMTALA/COBRA Guidelines AMC-RI.280 Medical Treatment and Labor Act EMTALA, Patient Access Services - Financial Clearance Policy 8220-1(WGMC) and Emergency Department – Plan of Care Policy 6231-001 (WGMC).]

Health-Share Plan: Health sharing is not insurance, but it is recognized by the Department of Health and Human Services as part of an exemption authorized by the Affordable Care Act (ACA) related to the individual mandate requirement of insurance coverage. Wellstar views health share plan participants as uninsured for the purposes of limiting personal financial responsibility following any plan payment to that of AGB.

Minimum Charitable Allowance: For uninsured patients, this amount is that charity care discount that is arrived by taking 100% of charges and subtracting the specified AGB equivalent charges, which are calculated by multiplying the AGB percentage by total charges

Notification Period: A period of 120-days following the first post-discharge billing statement that was provided to an eligible FAP patient after individual care has been provided and the patient has left the service facility.

Out-of-Network: Hospital services are out-of-network if Wellstar is not contracted with an individual’s insurance benefit plan.

Out-of-Pocket Costs: Costs which the patient pays for out of personal funds and/or income.

Patient: All hospital inpatients and outpatients.

Payment Plan: Plan which sets a series of equal payments over an extended period of time to satisfy the patient-owed amounts of bills sent by Wellstar.

Qualifying Assets: Monetary assets which are counted toward the patient's income in determining if the patient will meet the income eligibility for the program. For purposes of this Policy, "Qualifying Assets" will mean the patient's monetary assets, including cash, stocks, bonds, commodities, cash investment equivalents, savings accounts or other bank accounts, but excluding IRS qualified retirement plans and deferred-compensation plans. Certain real property or tangible assets (primary residences, principle automobiles, etc.) will not be included in "Qualifying Assets;" however, additional residences in excess of a single primary residence, automobiles in excess of the principle automobile and recreational vehicles will be included. "Qualifying Assets" will not include the principal amounts of funds contained within an IRS recognized retirement account, such as an Individual Retirement Account (IRA), 401K or 403B retirement accounts.

Qualifying Patient: Patient who meets the financial qualifications for the Community Financial Assistance program as defined in the Wellstar Community Financial Assistance Policy and related Job Aides inclusive of Table I and / or Table II and has not been otherwise excluded through policy.

Third Party Insurance: An entity (corporation, company health plan trust, automobile med pay benefit, etc.) other than the patient which will pay all or a portion of the patient's medical bills. Including any settlement or proceeds received from an entity although paid directly by the patient, the patient's representative or third-party administrator.

Under-Insured: Persons who have some level of insurance, but coverage is inadequate to resolve an average healthcare claim. Coverage may include but not be limited to auto accident, supplemental only, cancer only, and some personal indemnity policies. Under-insured classification does not apply to high deductible health plans as those plans relate to prompt payment or payment plan discounts.

Uninsured: Persons who do not have insurance of any kind, who have been verified as not being able to qualify for alternative payment sources such as crime victims, disability, Medicaid, other third-party liability such as third-party injury cases where a hospital lien is / may be filed, or liability financing program. Note that patients must divulge all sources of primary, secondary, auto, liability, supplemental, and all alternative sources of insurance and means of payment before being considered for financial assistance under this FAP. Wellstar will try to assist all uninsured patients in determining if previously unknown sources of insurance or assistance are available, prior to approving FAP applications.

Wellstar Medical Group (WMG): The total functional, organizational and structural operations of preadmission, registration, insurance verification, precertification, financial counseling and other "front-desk" registration related activities in a Wellstar physician office.

Wellstar Medical Group Uninsured Discount (WMGUD): For uninsured WMG patients, this amount is arrived by taking 100% of charges and subtracting twenty (20%) percent of charges.

Wellstar Medical Group Graduate Medical Education (GME) Locations: GME Internal Medicine (IM) Marietta, GME Family Medicine (FM) Smyrna, and GME Obstetrics/Gynecology (OB/GYN) Marietta.

Wellstar Providers Not Subject to this FAP:

Certain services provided at a Wellstar hospital by a physician, physician assistant, nurse anesthetist or other professionals employed by Wellstar or otherwise part of a Wellstar Hospital medical staff, are not covered under this Wellstar FAP. Specifically, services provided in the departments/providers listed in Job Aid 5, Appendix A, are not covered by this FAP.

CARE SETTING: [Mark all that apply]

- Wellstar Cobb Hospital
- Wellstar Douglas Hospital
- Wellstar Kennestone Hospital
- Wellstar Paulding Medical Center
- Wellstar Windy Hill Hospital
- Wellstar Atlanta Medical Center

- Wellstar Atlanta Medical Center- South Campus
- Wellstar North Fulton Hospital
- Wellstar Spalding Regional Hospital
- Wellstar Sylvan Grove Hospital
- Wellstar West Georgia Medical Center
- Wellstar Medical Group (WMG GME Only)
- Wellstar Home Hospice Marietta
- Wellstar Community Hospice Cobb & Kennesaw
- Wellstar West Georgia Hospice
- Wellstar Home Health Marietta
- Wellstar West Georgia Home Health

Services Eligible Under This FAP:

Financial Assistance eligibility will be extended to Qualifying Patients who receive emergency and Medically Necessary Care. Other medical services rendered by and at Wellstar may be reviewed on a case-by-case basis after the appropriate approval process.

Community Benefit:

The Wellstar Financial Assistance Program is intended to assist patients in paying for necessary healthcare services. Wellstar establishes Indigent, Charity, and Discount programs which meet State Health Planning Agency requirements. Annually, Wellstar completes the State Health Planning Survey, which reports all Wellstar Indigent/Charity activity to the State. The Department of Community Health (DCH) requires that Wellstar and Wellstar complies with the following:

- Provide Medically Necessary Care for no charge to persons with incomes at or below 125% of the FPG; and
- Provide Medically Necessary Care for no charge or a sliding fee scale for persons with incomes between 126% and, at a minimum, 200% of FPG; and
- Provides that at no time will individuals eligible for the Wellstar Hospital Financial Assistance Policy, be personally responsible for paying more than the specified AGB.

The Department of Community Health (DCH) Medical Assistance program allows hospitals to “coordinate” their ICTF program with an existing program of care for the Medically Indigent provided that no patients are rendered ineligible for services without charge or at a reduced charge who would have been eligible if the variance had not been granted.

To determine indigent or financial assistance (charity care) status, Wellstar may use a full and complete FAP application, review credit reports, other publicly available information to evaluate patient/guarantor income and assets, use an automated system or technology, executive administrative evaluation, or internally available information to determine eligibility. If a patient/guarantor does not apply for Financial Assistance under this FAP, or we are not otherwise informed of one’s eligibility, normal collection activities will ensue which may include up to the use of ECAs. Wellstar may, at its sole discretion, elect to utilize automation or technology to determine probable eligibility, prior to any account going to bad debt or during the Application and /or Notification periods as defined above. The level of automation logic currently in use at Wellstar varies based on the specific configurations for each hospital patient accounting system and is subject to change. In general, the use of technology and proprietary information available allows for the determination of a modeled assessment to reasonably determine financial capability, financial need or paymentability and is evaluated through the use of a consistently applied algorithm that is proprietary in nature by the service provider. The output of the evaluation for these types of services is provided as a gradient measure such as an alpha, numeric or color score with a defined scale providing a low, medium, high and unable to determine assessment outcome. This evaluation is commonly referred to throughout the healthcare industry as Propensity to Pay (P2P) scoring. Wellstar Health has determined that a low ability and low propensity to pay, with a medical credit score of less than 600 (indicated in the system as a color (red), represents probable evidence that the patient qualifies for Indigent Care. Wellstar may seek further information to qualify the patient, however, further qualification or proof is not required under

the FAP.

Other special circumstances may qualify a Patient for full Indigent or sliding scale discounts at the discretion of the Wellstar Health System. Special circumstances may include but are not limited to:

- Patient deceased, with verification that there is no estate
- Catastrophic Medical event or incident
- Verified Homelessness
- Bankruptcy
- Health Share Plans i.e., Medi-Share, Samaritan Ministries, Christian Healthcare Ministries (Christian Care), and Liberty Healthshare are examples.
 - Wellstar views health share plan participants as uninsured for the purposes of limiting personal financial responsibility following any plan payment to that of AGB.

LOCATION OF VARIATION:

PROCEDURE:

	Required Action Steps	Performed By	Supplemental Guidance
COMMUNICATION OF FINANCIAL ASSISTANCE PROGRAM OPTIONS			
STEP ONE	1.1 Provide notice of the availability of Financial Assistance Program.	Wellstar	<p>Wellstar provides notice of the availability of Financial Assistance Program via:</p> <ul style="list-style-type: none"> ◆ Conspicuous Signage in Emergency Departments and main registration areas ◆ Patient brochure(available in certain locations) ◆ Verbal Notice ◆ Billing statements ◆ Plain Language Summary [Job Aids 3.1A through 3Q] offered at registration and/or discharge ◆ Online at Wellstar’s website (www.Wellstar.org) <p>In addition, Wellstar will provide notice of the FAP, and FAP Application to community stakeholders who participated in the CHNA.</p>
	1.2 Language translation of FAP Plain Language Summary and FAP Application notifications.	Wellstar	Language translations of the FAP Plain Language Summary and FAP Application notifications, at a minimum will be provided for those languages which have been determined to meet the 5- percent/1000 person threshold under the HHS Safe Harbor as reasonably determined by Wellstar.

	Required Action Steps	Performed By	Supplemental Guidance
STEP ONE CONT.	1.3 Alternate Programs.	Wellstar, Wellstar contracted 3 rd party, Wellstar affiliate	In certain situations, Wellstar may utilize third-party assistance to help identify and/or assist patients that qualify for financial assistance based on publicly or privately available programs. Examples of such programs include but are not limited to: Wellstar Community Health Collaborative, Wellstar 4-1 Care Network, Wellstar Medical Group GME office(s), Medicaid eligibility, Cancer-Care, state and private funded prescription programs, participation in the Women, Infants and Children (WIC) program, participation in the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), US Dept of Housing & Urban development (HUD) – Housing Choice Voucher program (Section 8), Community care programs such as Good Samaritan, MUST Ministries, etc., or eligibility for other federal, state, county or local assistance programs.
	FINANCIAL ASSISTANCE PROGRAM– PATIENT (FAP) APPLICATION		
STEP TWO	NOTE: A patient may qualify for financial assistance under this FAP if they meet one of the following guidelines based on income or expenses and they are not eligible for other private or public health coverage so long as the patient has complied with the requirements of the policy governing Wellstar financial assistance, this FAP.		
	2.1 Qualifying Income for Minimum Charitable Allowance under this Financial Assistance Program.	Patient	A patient is eligible to receive a Minimum Charitable Allowance under this FAP.
	2.2 Additional charitable discount opportunity: household income and qualifying assets tests and medical indigency tests.	Patient	<p>In addition to the Minimum Charitable Allowance, patients may be eligible for additional charitable allowances, under this FAP, based upon household income and in certain situations, if Qualifying Assets do not exceed an amount equal to 200% of his or her billed charges for services rendered. For purposes of this Policy, “Qualifying Assets” will:</p> <ul style="list-style-type: none"> ◆ Include the patient’s monetary assets, including cash, stocks, bonds, cash, commodities, investment equivalents, savings accounts or other bank accounts ◆ Exclude IRS qualified retirement plans, such as IRAs, 401K or 403B retirement accounts, or deferred- compensation plans ◆ Exclude certain real property or tangible assets (primary residences, principle automobile, etc.); however, additional residences in excess of a single primary residence, vehicles in excess of the principle automobile and recreational vehicles may be included <p>Patients not eligible for additional charitable allowances, based on assets may be eligible for financial assistance through an exception-based review if their allowable medical expenses have depleted the family’s resources so that they are unable to pay for eligible services (Medical Indigency).</p>

	Required Action Steps	Performed By	Supplemental Guidance
STEP TWO CONT.	2.2 cont.	Patient	<p>Exception-based discounts may be issued on a sliding scale from 0- 100% at the discretion of Wellstar. The following two qualifications must both apply:</p> <ul style="list-style-type: none"> ◆ Expenses – The patient’s allowable medical expenses must be greater than 20% of the household income. (Allowable medical expenses are the total of family medical bills that if paid, would qualify as deductible medical expenses for Federal income tax purposes without regard to whether the expenses exceed the IRS-required threshold for taking the deduction. Paid and unpaid bills may be included.) ◆ Resources – The patient’s excess medical expenses (the amount by which allowable medical expenses exceed 20% of the household income) must be greater than available Qualifying Assets.
PATIENT RESPONSIBILITY FOR FINANCIAL ASSISTANCE PROGRAM			
STEP THREE	<p>NOTE: If the patient has third party insurance which would have covered the qualifying services, the patient is responsible for complying with the conditions of coverage for their third-party insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of eligibility under this Financial Assistance Program.</p> <p>Patient cooperation with Wellstar is necessary in identifying and determining alternative sources of payment or coverage from public and private payment programs. As such, a patient (or his or her guardian or family member) must provide any or all of the following that are applicable, when requested:</p>		
	3.1 Provide required information.	Patient	<p>Required information:</p> <ul style="list-style-type: none"> ◆ Submit a true, accurate, signed and completed application for financial assistance; and ◆ Provide a copy of the prior year Federal Income Tax Return and W2/1099 (including all schedules) ◆ Provide any additional items specifically requested as part of the application or application verification process
	3.2 Provide two additional financial documentations.	Patient	<p>Provide two of the following if unable to provide a copy of the most recent Federal Income Tax Return or as further requested by Wellstar in the course of the application or application verification process:</p> <ul style="list-style-type: none"> ◆ Provide 3 months of the most recent pay stubs (or certification of unemployment); or ◆ Separation Notice or unemployment claim if unemployed; or ◆ Provide two (2) current bank statements for all checking and savings accounts; or ◆ Provide award letter from Social Security Office; or ◆ Provide Current Profit and Loss report for all self-employed applicants; or ◆ Current saving accounts and certificate of deposits, and other investment statements; or ◆ Provide Asset Statement, with equity adjustments (Rental property, land, second houses)

	Required Action Steps	Performed By	Supplemental Guidance
STEP THREE CONT.	3.2 cont.	Patient	<p>Written statements for the most recent two (2) months for all other income (e.g., unemployment compensation, disability, retirement, student loans, award letter from Social Security Office, current Profit and Loss report for all self-employed applicants, alimony documentation, child support documentation, etc.).</p> <ul style="list-style-type: none"> ◆ Contribution statements from individuals who contribute income or in-kind assistance to the patient.
FINANCIAL ASSISTANCE PROGRAM			
STEP FOUR	<p>NOTE: The patient/guarantor is expected to pay any amount of their account that is not eligible for write-off under this FAP. Failure to do so may result in a reversal of any Financial Assistance Program discounts. Those who fail to pay the remaining balance after adjusting the bill for Financial Assistance will become delinquent and be subject to normal collection procedures.</p> <p>However, in no event will the charges for a FAP eligible patient exceed the specific AGB as defined by Wellstar FAP and related procedures.</p> <p>Please refer to Wellstar's <i>SBO Collections and Bad Debt Procedure</i> for an explanation of expectations regarding payment of out-of-pocket responsibility. Please refer to Wellstar's <i>Charity Care Eligibility and Financial Assistance Table I & II</i>.</p>		
	4.1 Refer to Wellstar's <i>Charity Care Eligibility and Financial Assistance Table I & II</i>	Wellstar and/or Patient	May also refer to Wellstar's <i>SBO Collections and Bad Debt Procedure</i> for explanation of expectations regarding payment of out of pocket responsibility.
	4.2 Wellstar Charity Care Eligibility Categories and Patient Responsibility for FAP Eligible patients	Wellstar and/or Patient	<p>All uninsured patients are entitled to the Minimum Charitable Allowance (MCA), as defined in this policy.</p> <p>Further charitable allowances are provided to individuals who meet the following Household Income (HI) guidelines.</p> <p><u>FAP Categories</u> Category 1 (HI below 125% of FPG) Category 2 (HI 126%-200% of FPG)</p> <p><u>Patient Payment Responsibility</u> Category 1 - 0% of AGB Category 2 - 3% of AGB</p> <p>Still, further charitable allowances are again provided to individuals who meet the Qualifying Assets test noted above and the following Household Income (HI) guidelines.</p> <p><u>FAP Categories</u> Category 3 (HI 201%-250% of FPG) Category 4 (HI 251%-300% of FPG)</p> <p><u>Patient Payment Responsibility*</u> Category 3 - 10% of AGB Category 4 - 20% of AGB</p> <p>*For patients with insurance coverage, the patient pay responsibility will be the insurance co-pay, co-insurance and deductible, capped in all cases at a percentage of gross charges, up to AGB.</p>

	Required Action Steps	Performed By	Supplemental Guidance
STEP FOUR CONT.	4.3 Follow FAP procedures in accordance with federal and state programs.	Wellstar and/or Patient	<p>Federal and State Programs Any federal government or state government programs where a discount is given due to patient care via Medicare, Medicaid, pending Medicaid application vendors, DFCS, county health programs, city programs or ordinances, or any other government program, provided at Wellstar will be considered by the FAP department for the remaining self-pay balance. Patients must still follow all FAP procedures, must fill out a FAP application when requested, must qualify under the FAP guidelines, and provide all necessary documentation as requested by Wellstar under this Financial Assistance Policy.</p> <p>Self-Pay Discounting All patient self-pay balances after any other non FAP discounts are eligible to apply for Financial Assistance under this FAP. However, any patients who choose to utilize Wellstar's Cash-Pay Rate i.e. SP3 program or "Pay in Full Option" options are not eligible for the Wellstar FAP.</p> <p>Eligibility Period If a patient qualifies for Financial Assistance under this FAP for a specific service or hospital stay, an applicable retroactive Financial Assistance Program write-off will be applied to all patient balances for any services up to six (6) months prior to the application approval date. Other balances may be considered at the discretion of Business Office staff/management. FAP approval is valid for six (6) months from application approval date for future qualified services.</p> <p>Refund of Amounts Previously Paid In the event a patient or any member of the patient's immediate family pays all or part of his or her bill for services rendered, and that payment is specifically identified for the service which is subsequently determined to qualify for free or discounted care under this Policy, Wellstar will provide refunds to the individual who issued the payment that resulted in a patient payment amount made in excess of the amount the individual is personally responsible for paying based upon AGB.</p>

	Required Action Steps	Performed By	Supplemental Guidance
STEP FOUR CONT	4.3 cont.	Wellstar and/or Patient	<p>Appeal Regarding Application of FAP In the event any patient believes his or her application for Financial Assistance Program was not properly considered in accordance with this FAP, or he or she otherwise disagrees with the application of this FAP in his or her case, a patient may submit a written request for reconsideration to the Vice-President, Revenue Cycle, and then to the Chief Financial Officer of Wellstar, who will be the final level of appeal.</p> <p style="text-align: center;">Wellstar Single Business Office Attn: Vice President, Revenue Cycle 805 Sandy Plains Road Marietta, GA 30066</p> <p>Non-Discriminatory Application of FAP Any decisions made under this Policy, including the decision to grant or deny financial assistance under this FAP, will be based on an individualized determination of financial need, and will not take into account race, color, national origin, citizenship, religion, creed, gender, sexual preference, age, or disability.</p> <p>Application by the Patient Financial Counselors, upon discovery of the patient's financial circumstances during the patient interview, will advise the patient of the Financial Assistance Program and the availability of financial assistance under this Policy. Patients will be informed of available assistance through a standard message placed on the patient's bill, as well as through a handout available at the Hospitals', through the Business Office and/or through the Wellstar Internet site.</p> <p>The Financial Assistance Program's availability and referral numbers will be placed within any notification on Wellstar's internet site, the patient's bill, or the available handout.</p> <p>Notice of availability Notice of availability of financial assistance and instructions for patient screening will be posted in the emergency rooms, and the main registration departments of the Wellstar hospitals, as well as in the offsite business office and other outpatient sites, as appropriate.</p> <p>Patient, or a patient's guardian or legal conservator, may apply under this FAP by calling the Wellstar Single Billing Office and requesting an application at the Wellstar Financial Assistance Program website or from a Wellstar financial representative.</p>

	Required Action Steps	Performed By	Supplemental Guidance
STEP FOUR CONT	4.3 cont.	Wellstar and/or Patient	<p>website: http://www.Wellstar.org</p> <p>If assistance is needed, with the application, please contact:</p> <p>Wellstar Single Business Office 805 Sandy Plains Road Marietta, GA 30066 470-245-9998</p> <p>A patient may apply for multiple outstanding balances on the same application. Financial Assistance Program applications may be submitted within 240 days following the patient's post- discharge first statement.</p> <p>Wellstar will review Financial Assistance Program applications bi-weekly upon receipt for approval. Balances approved will be submitted for write-off to a transaction code assigned to Financial Assistance Program and will follow the signature authority of the Wellstar adjustment approval guidelines. In the event the application is lacking the required information, patient will be notified in writing and be given 30 days to provide the additional information.</p> <p>Any recoveries to an account which has qualified and was classified under an originating transaction other than Charity will have the amount of the recovery or adjustment reversed so that appropriate amounts are reconciled with the Financial Assistance Program. Recording of Financial Assistance Program adjustment codes will be used to ensure the diminished Charity Care is reflected properly in the accounting records.</p>
	4.4 Applying for Financial Assistance by Staff/Management of the WHS Business Office, or Presumptive Eligibility or alternate means of qualification.	Wellstar	<p>On an individual patient basis, the staff or management member of the Wellstar Business Office may complete an internal Financial Assistance Program Application to include a full explanation of:</p> <ul style="list-style-type: none"> • The reason(s) the patient or patient's parent/guardian cannot apply on his/her own behalf. • The patient's documented extenuating medical or socio-economic circumstances which preclude the patient from completing the application him/herself. • Patient notification of the eligibility determination will be provided if the eligibility is less than the most generous assistance available. • Wellstar may also assign accounts to presumptive eligibility, without a Financial Assistance Program application submitted by the patient, based on predetermined

	Required Action Steps	Performed By	Supplemental Guidance												
STEP FOUR CONT.	4.4 cont.	Wellstar	<p>criteria collected from approved sources. These criteria include but are not limited to:</p> <ul style="list-style-type: none"> ◆ Logic for propensity to pay scoring as based off of vendor calculations. ◆ Technology and proprietary information available which allows for the determination of a modeled assessment to reasonably determine financial capability, financial need or payment ability and is evaluated through the use of a consistently applied algorithm that is proprietary in nature by the service provider. ◆ The patient qualifies for a government program with eligibility requirements that reasonably meet the qualifications for the Wellstar Financial Assistance Program within 240 days of the date the patient received services at Wellstar Health or the date of the first patient bill. ◆ After normal collection efforts have not produced any payment, and Wellstar has identified with reasonable effort and assurance that the patient's estimated income is at 300% or less of the FPG. <p>The enrollment, participation or referral from a program, provider or clinic which has substantially similar approval criteria to that of the Wellstar's FAP and has been approved by Wellstar.</p>												
	4.5 Offer Patient/Family Education.	Wellstar	<p>Provided through direct education from customer service representatives and vendor partners in response to patient phone calls. All patient contact is logged electronically.</p>												
Amounts Generally Billed (AGB)															
STEP FIVE	<p>NOTE: AGB Percentages:</p> <ul style="list-style-type: none"> • Retrospectively effective 01/15/2021, for dates of discharge effective 07/01/2020 the AGB percentage for all Wellstar facilities is 24%. • For dates of discharge prior to 07/01/2020 the AGB percentage for all Wellstar facilities is 25%. • As the result of the harmonization to the Epic Electronic Medical Record, for the Care Setting locations indicated above, patient discharges on or after 02/25/18 use the same AGB percentage. • For dates of discharge prior to 2/25/18 the AGB percentage is determined by the Facility Location, as indicated below: <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Wellstar Kennestone Hospital: (25%)</td> <td style="width: 50%;">Wellstar Atlanta Medical Center: (15%)</td> </tr> <tr> <td>Wellstar Cobb Hospital: (25%)</td> <td>Wellstar Atlanta Medical Center South: (15%)</td> </tr> <tr> <td>Wellstar Paulding Hospital: (25%)</td> <td>Wellstar North Fulton Hospital: (15%)</td> </tr> <tr> <td>Wellstar Paulding Hospital: (25%)</td> <td>Wellstar Sylvan Grove Hospital: (15%)</td> </tr> <tr> <td>Wellstar Douglas Hospital: (25%)</td> <td>Wellstar Spalding Regional Hospital: (15%)</td> </tr> <tr> <td>Wellstar Windy Hill Hospital: (25%)</td> <td>Wellstar West Georgia Medical Center: (40%)</td> </tr> </table>			Wellstar Kennestone Hospital: (25%)	Wellstar Atlanta Medical Center: (15%)	Wellstar Cobb Hospital: (25%)	Wellstar Atlanta Medical Center South: (15%)	Wellstar Paulding Hospital: (25%)	Wellstar North Fulton Hospital: (15%)	Wellstar Paulding Hospital: (25%)	Wellstar Sylvan Grove Hospital: (15%)	Wellstar Douglas Hospital: (25%)	Wellstar Spalding Regional Hospital: (15%)	Wellstar Windy Hill Hospital: (25%)	Wellstar West Georgia Medical Center: (40%)
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5.1 Determination of the AGB percentage.	Wellstar	<p>Details of the procedures used in the calculation of the AGB percentage are defined in the Wellstar procedure entitled, <i>Calculation of Amounts Generally Billed (AGB)</i> [LD-24-02] and is available by request to Wellstar Business Office between the hours of 8:00am and 4:30pm, Monday through Friday at (678) 838-5750.</p>													

RELATED DOCUMENTS	
Policy / Procedure	Emergency Medical Treatment and Active Labor Act (EMTLA) [LD-108] SBO Collections and Bad Debt Procedure [82280-01] Self-Pay Discount Program for Select Outpatient Services (SP3) [LD-102-01] Financial Assistance Program: Calculation of Amounts Generally Billed (AGB) [LD-24-02] Wellstar Medical Group (WMG) Graduate Medical Education (GME) - Financial Assistance Program (FAP) [LD-24-03]
Job Aids	Financial Assistance Program Tables [LD-24-01-JA1] Financial Assistance Program Eligibility Determination [LD-24-01-JA2] Financial Assistance Program Plain Language Summary [LD-24-01-JA3.1A-3Q] Financial Assistance Program Application [LD-24-01-JA4.1A-4Q] Wellstar Health System Excluded Providers [LD-24-01-JA5]
Related Medical Record Form(s)	
	Item #
Self-Pay Exam Order Form	WS1182 - 101119
Regulatory Requirements	O.C.G.A. Title 31 Chapter 8, Article 6; Appendix Q – Indigent Care Trust Fund Program; DCH Hospital Policy Manual; April 1, 2016 Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)) (the Affordable Care Act) Department of the Treasury; Internal Revenue Service; Section 1.501(r) 1 through 7; 26 CFR Parts 1, 53, and 602 Section 501(r)(3): Community Health Needs Assessment Requirements Section 501(r)(4): Financial Assistance Policy (FAP) & Emergency Care Section 501(r)(5): Amounts Generally Billed Section 501(r)(6): Reasonable Efforts for Assistance
Evidence Based Practice References	
<i>This replaces all previous [SPP LD-24-01] Financial Assistance Program (FAP) P&P and all previous [SPP LD-24-01] Financial Assistance Program (FAP) shall automatically terminate upon the published date set forth above.</i>	