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Owner Doris Schumacher: Manager, Claims
Policy Area Revenue Cycle
Applicability St Elizabeth
Reference Policy
Tags

Financial Assistance

Document Configuration

Section

Revenue Cycle

Subsection

Patient Accounts

Category

Corporate

References

- GL- 3001, *EMTALA: Collection of Financial Information*
- Self- Pay Billing & Collection Policy
- Federal Poverty Guidelines, US Department of Health and Human Services
- IRS Notice 2015-46 and 29 CFR 1.501(r) (4)- (6)
- 26 CFR 250 (31 Dec 2014) P 78954-79016
- GL-3034 Reporting Medicare Bad Debt
- Appendix 1- Financial Assistance Application Form
- Appendix 2- Discount chart based on income and asset thresholds, and the uninsured discount rate
- Appendix 3- Covered providers and departments

Appendix 4- Amounts Generally Billed(AGB) percentage and Most Favored Insurer percentage

Appendix 5- Public Access to documents

Applicable To

This policy applies to all patients of Gundersen St. Elizabeth's Hospital and Clinics (hereinafter, collectively referred to as GSEHC) receiving healthcare services at Gundersen St. Elizabeth's Hospital and Clinics, including Hospital, Wabasha Clinic, Alma Clinic, Senior Living, Home Care, Care Center-Grant Boulevard and Care Center-Shields Avenue.

Purpose Statement

GSEHC's mission is to distinguish ourselves through excellence in patient care, education, research and through improved health in the communities we serve. It is in our vision to enhance the health and well-being of our communities while enriching every life we touch including patients, families, and staff.

In service to this mission, GSEHC is committed to providing emergency and medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for care received from qualifying GSEHC providers.

Financial assistance provided under this policy is done so with expectation that patients will cooperate with the policy's application procedure and those of public benefit or coverage programs that may be available to cover cost of care. GSEHC will not discriminate on the basis of age, sex, race, creed, color, disability, religion, sexual orientation, national origin, or immigration status when making financial assistance determinations.

Definitions

The following definitions are applicable to all sections of this policy.

Amount Generally Billed (AGB): The amount generally billed is the expected payment for emergency or medically necessary services from patients, and/or a patients' guarantor. For qualifying patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method described in 1.501 (r)- 5 (b) (3) of the Internal Revenue Code. The Look Back Method will be based on actual past claims paid to GSEHC by Medicare Fee-for-Service together with all private health insurers paying claims. The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts of co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-for-Services together with all allowed claims from private health insurers. The gross charges for said claims will be included in the denominator. The AGB will be calculated annually by the 45th day following the close of the prior calendar year, and

implemented by the 120th day following the close of the calendar year.

Amount Generally Billed Percentage: The AGB percentage will be calculated each year by the 45th day of the year, and is described in Appendix 4 of this policy.

Application Period: The period during which applications will be accepted and processed for financial assistance. The application period begins on the date the care is provided and ends on the 240th day after the date that the first post-service billing statement is provided.

Catastrophic Care Assistance: Financial assistance provided to eligible patients with annualized family income in excess of 400% of the federal Poverty Level, and assets of less than the equivalent of 600% of the Federal Poverty Level, and financial obligations resulting from medical services provided by GSEHC in excess of 25% of the family income.

Discounted Care: Financial assistance that provides a discount, for eligible medical services provided by GSEHC, based on a sliding scale, for eligible patients, of patient guarantors, with annualized family income between 200- 400% of the Federal Poverty Level and assets at or below six times the Federal Poverty Level.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment of bodily functions, or
3. Serious dysfunction of any bodily organ or part; or
4. With respect to a pregnant woman who is having contractions:
 - a. That there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent of their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Income: An applicant’s family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parent or parent and/or step-parents, or caretaker relatives. Family income is determined using the Census Bureau definition, which include the following income when computing federal poverty guidelines:

1. Includes earning, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational stipends, alimony, child support,
2. Noncash benefits (such as food stamps and housing subsidies) do not count'
3. Determined on a before-tax basis;
4. Excludes capital gains or losses

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United State Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

Financial Assistance: Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for emergency or medically necessary care provided by GSEHC.

Free Care: a 100% waiver of patient financial obligation for eligible medical services provided by GSEHC for eligible patients, of their guarantors, with annualized family income at or below 200% of the FPL with assets below the equivalent of 600% of the FPL.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bills.

Gross Charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Homeless: As defined by the Federal government, and published in the Federal Register on December 5, 2011 by HUD: An individual of family who lacks a fixed, regular and adequate night time residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

Medically Necessary: As defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Medicare Fee-For-Service (FFS): Health insurance available under Medicare Part A and Part B of Title XVII of the Social Security Act (42 USC 1395c- 1395w-5).

Most Favored Insurer (MFI): As defined by the Minnesota Attorney General, MFI is the nongovernmental third party payor that provided the most revenue to the provider during

the previous calendar year.

Most Favored Insurer Percentage (MFIP): The MFIP will be calculated each year by the 45th day of the year, and is described in Appendix 4 of this policy.

Payment Plan: A payment plan that is agreed to by both GSEHC and a patient or patients' guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

Presumptive Eligibility: Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need.

Private Health Insurer: Any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.

Qualification Period: Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to all eligible accounts incurred for services received six months prior to application date.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured discount for eligible services provided by GSEHC under this policy, at the time that the non-discounted charges are rendered. Certain services are excluded and the applicable discount is automatically applied to the patient's billing statement. This discount is removed if insurance coverage is subsequently identified.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance available to cover the cost of a patient's healthcare expenses.

Underinsured Patient: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by GSEHC.

Implementation

ELIGIBLE SERVICES

Services eligible for the uninsured discount under the GSEHC financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:

1. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a patient's condition.

2. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.
3. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/ or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as “covered items or services.”
4. Services of providers employed by GSEHC are covered under this policy. Please see Appendix three for a full listing of providers included.

Services not eligible for financial assistance include the following:

1. Elective procedures not medically necessary, as well as services typically not covered by Medicare or defined by Medicare or other health insurance coverage as not medically necessary.
2. Lasik Surgery, Chiropractic Care, Fertility Services, Contacts/Glasses, Cosmetic Surgery/Plastic Services, Hearing Aides, Orthodontics, Dental Services, Optometry, Unity House.
3. Services received from care providers not employed by GSEHC (e.g. private and/or non- GSEHC medical or physician professionals, ambulance transport, etc.) Patients are encouraged to contact these providers directly to inquire into any available assistance and to make payment arrangements. See Appendix 3 for full listing of providers not covered under this policy.
4. Deductible and coinsurance associated with medically necessary services provided to patient’s out-of-network as defined by their insurers.
5. Third-party requested exams (e.g. DOT physicals).

COORDINATION WITH COMMUNITY HEALTH NEEDS ASSESSMENT

A community health need assessment (CHNA) was conducted for the area served by GSEHC. Mental health and senior health were identified as significant health issues. Any services for mental health or senior health not covered in the definition of eligible services for either financial assistance or self-pay discount, will be eligible for financial assistance and subject to the Most Favored Insurer discount or the AGB discount, whichever is most favorable for the patient.

ELIGIBILITY CRITERIA

Financial assistance will be extended to uninsured and under insured patients, or a patient’s guarantor, who meet specified criteria, as defined below. These criteria will assure that this financial assistance policy is consistently applied across GSEHC. GSEHC reserves the right to revise, modify or change this policy as necessary or appropriate.

Payment resources (insurance available through employment, Medical Assistance, Indigent Funds, Victims of Violent Crimes, etc.) must be reviewed and evaluated before an account is considered for financial assistance to assure that GSEHC resources are prudently managed in providing financial assistance. If a patient appears to be eligible for other assistance, GSEHC will refer the patient to the appropriate agency for assistance with completing the necessary applications and forms. Applicants for assistance are required to exhaust all other payment options as a condition of their approval for financial assistance.

Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by GSEHC as possible sources of payment for care, may be denied financial assistance. Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

Patients, or patient's guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial that was received within the previous six (6) months of applying for GSEHC financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.

The criteria to be considered by GSEHC when evaluating a patient's eligibility for financial assistance include family income, assets, and medical obligations. GSEHC's financial assistance program is available to all patients meeting the eligibility requirements set forth in this policy, regardless of geographic location or residency status. Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws.

Financial assistance will be offered to eligible under insured patients, providing such assistance is in accordance with insurer's contractual agreement. Financial assistance is typically not available for patient co-payment or balances after insurance in the event that a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Generally, out-of-network balances may be reviewed on a case by case basis. Patients with tax-advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement or a Flexible Spending Account, will be expected to utilize account funds prior to being granted financial assistance.

GSEHC reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of GSEHC.

FINANCIAL ASSISTANCE

Based on an assessment of an applicant's family income, assets, and medical obligations, eligible applicants may receive the following assistance.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured

discount at the time that the undiscounted charges are rendered. This applies to patients with no coverage for payment from health care insurance and/or other third party payors.

Patients, or patients' guarantors, granted the uninsured discount, are not precluded from applying and qualifying for additional financial assistance provided herein.

Full Free Care: The full amount of GSEHC charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 200% of the current federal poverty level with assets below the equivalent of 600% of the FPL threshold.

Discounted Care: A sliding scale discount will be provided for GSEHC charges for services covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is greater than 200% but less than or equal to 400% of the current federal poverty level with assets below the equivalent of 600% of the FPL. Discounts will be provided, according to the following schedule, based on the family income of the patient, or the patient's guarantor:

1. Family income above 200% FPL but equal to or less than 225% FPL are eligible to receive a 80% discount on the patient balance due.
2. Family income above 225% FPL but equal to or less than 250% FPL are eligible to receive a 60% discount on the patient balance due.
3. Family income above 250% FPL but equal to or less than 275% FPL are eligible to receive a 40% discount on the patient balance due.
4. Family income above 275% FPL but equal to or less than 400% FPL are eligible to receive a 20% discount on the patient balance due.

Catastrophic Care: GSEHC patients not meeting financial assistance eligibility thresholds may be eligible for assistance under circumstances when GSEHC medical bills would result in severe financial hardship. Patients, or their guarantors, may be eligible for catastrophic care assistance if they have incurred out-of-pocket obligations resulting from medical services provided by GSEHC that exceed 25% of family income and have assets below the equivalent of 600% of the FPL threshold.

Patients, or patients' guarantors, meeting eligibility criteria for catastrophic care will have their GSEHC charges discounted to an amount not to exceed 25% of family income.

Payment Plans: Payment in full is expected, for balances due, within 21 days of the initial patient statement. If unfeasible for a patient, or guarantor, to pay in full within this time frame, a payment plan may be extended for up to 36 months or 3 years for any balance remaining after discounts have been granted to applicants eligible for financial assistance. A reasonable payment plan will be established between GSEHC and the patient. The term of the payment plan will be based on the applicant's outstanding medical bills, family income and any extenuating circumstances. If approved, the plan will be interest-free.

Patients are responsible for communicating with GSEHC anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

PRESUMPTIVE ELIGIBILITY

GSEHC understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by GSEHC to determine whether a patient's account is uncollectible and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

1. Patients or guarantors who have declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off.
2. Patients or guarantors who are deceased with no estate in probate.
3. Patients or guarantors determined to be homeless.
4. Accounts returned by the collection agency as uncollectible due to any of the above reasons.
5. Patients or guarantors who qualify for State Medicaid programs, will be eligible for assistance for any cost-sharing obligations associated with the program or uncovered services.

GSEHC understands that certain patients may be non-responsive to GSEHC's application process. Under these circumstances, GSEHC may utilize other sources of information to make an individual assessment of financial need. This information will enable GSEHC to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

GSEHC may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity.

The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for GSEHC financial assistance under the traditional application process.

The electronic technology, when utilized, will be deployed prior to bad debt assignment after

all other eligibility and payment sources have been exhausted. This allows GSEHC to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection and will not be included in the hospital's bad debt expense.

EMERGENCY MEDICAL SERVICES

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations. GSEHC may request that patient cost-sharing payments (i.e. co-payments) be made at the time of service, provided such requests do not cause a delay in a medical screening examination or necessary stabilizing care for an identified emergency medical condition (See Policy GL-3001).

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

The amount generally billed or the Most Favored Insurer percentage, whichever is most favorable for the patient, is the expected payment from patients, or a patient's guarantor, eligible for financial assistance. For qualifying uninsured patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method.

The Look Back Method will be based on amounts allowed under Medicare Fee-For-Services together with all private health insurers paying claims to GSEHC or based on the discount provided to the Most Favored Insurer for GSEHC, whichever is most beneficial to the patient. The claims to be included in both calculations will be claims allowed during the prior calendar year. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-For-Service together with all private health insurers paying claims for AGB. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the insurance payments received from the Most Favored Insurer. The gross charges for said claims will be included in the denominator. The AGB and Most Favored Insurer discount percentage will be calculated annually. The most favorable percentages will be applied by the 120th day after the end of the calendar year used by GSEHC to calculate those percentage(s).

If you have any questions regarding the AGB percentage or Most Favored Insurer percentage, please contact the Patient Accounts department at 651-565-5697 or

800-581-4531, ext. 24204. Information on the percentages will be provided free of charge.

Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under GSEHC financial assistance policy.

APPLYING FOR FINANCIAL ASSISTANCE

Eligibility for financial assistance will be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, GSEHC may seek additional information.

Reliable evidence to support the need for financial assistance is required.

The following income documentation is required from patients, or their guarantors, to determine eligibility:

1. Copy of the Federal tax return, and all attached Schedules, from the most recent tax year
2. Current Proof of Income (copy of most recent pay stubs or other documentation)
3. Proof of other income, including unemployment, workers' compensation, alimony, trust income, veteran's benefits
4. Current Bank Statements

The following asset documentation is required from patients, or their guarantors, to determine eligibility:

1. Checking accounts
2. Savings accounts
3. Money market accounts
4. Certificates of deposit
5. Annuities
6. Non-retirement investment accounts
7. Retirement accounts, including pensions
8. Real estate
9. Other assets

Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement.

If an application is incomplete, or there has been a request for additional information, the application will remain active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30 day

time frame, the application will be denied.

During the period in which the fully completed Financial Assistance Application (FAA) is being reviewed, there will be a stay of all collection proceedings. The FAA will be documented in the patient record or scanned and the account will be noted. The normal billing process is to continue while the FAA is reviewed and considered. If a complete, conforming FAA is approved by the appropriate GSEHC representative, this will be noted in the patient's file and the account balance will be written-off to the appropriate code. Financial assistance applications are to be submitted to the following office:

Gundersen St. Elizabeth's Hospital and Clinics
Attn: Financial Counselor
1200 Grant Boulevard West
Wabasha, MN 55981
651-565-5697

If denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

ELIGIBILITY DETERMINATIONS, APPEALS AND DISPUTE RESOLUTION

Patients must be notified of the decision in writing regarding their FAA within thirty (30) days of submitting a completed application. An applicant determined eligible for financial assistance will be refunded payments in excess of the amount determined owed by the patient or guarantor on the accounts for which they have been granted assistance under the GSEHC financial assistance policy. Refunds apply to excess payments of \$5 or more. In accordance with this policy, financial assistance is generally not extended for co-payments or balances after insurance when a patient fails to obtain proper referrals or authorizations, or if such assistance is not in accordance with insurer's contractual agreement, therefore such payments received will not be refunded.

Patients may appeal this decision in writing within 30 days of receiving notification to:

Gundersen St. Elizabeth's Hospital and Clinics
Attn: Financial Counselor
1200 Grant Boulevard West
Wabasha, MN 55981

Appeals must be filed within 30 days of the date of the original decision. The Customer Financial Services Manager will review the appeal for further consideration. Decisions of the Customer Financial Services Manager will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, GSEHC will grant financial assistance for a period of six months. Financial assistance will also be applied retroactively to all

unpaid bills for eligible accounts incurred for services received six months prior to application date. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on the GSEHC financial assistance policy and instructions on how to contact GSEHC for assistance and further information, as well as information on payment options, will be posted in hospital and clinic registration and admitting locations, and in the hospital emergency department. This information may also be obtained from financial counselors throughout the organization.

The GSEHC financial assistance policy, application and a plain language summary of the policy will be available on the system's website at www.gundersenhealth.org/FAA. This information is also available, free of charge, by contacting (651)-565-5697. If you need help in completing the financial assistance application, you may call (651)-565-5697 to talk with a financial counselor.

Information on the GSEHC financial assistance policy will be communicated to patients in culturally appropriate language. Information on financial assistance, and the notice posted in hospital and clinic locations will be translated and in any language that is the primary language spoken by the lessor 1,000 or 5% of the residents in the service area.

In addition, GSEHC includes reference to payment policies and financial assistance on all printed GSEHC monthly patient statements and collection letters. Information on the GSEHC financial assistance policy is available, at any time, upon patient request.

REGULATORY REQUIREMENTS

GSEHC will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that GSEHC track financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

RECORD KEEPING

GSEHC will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

POLICY APPROVAL

The GSEHC financial assistance policy has been provided to and approved by the GSEHC Board of Directors on February 15, 2023. This policy is subject to periodic review. Any substantive changes to the policy must be approved by the GSEHC Board of Directors.

Responsibilities

Leaders:

Responsible for ensuring that their staff are complying with policy.

Employee:

Acknowledge and agree to comply with these practices

Attachments

[Appendix 2: Discount Level](#)

[Appendix 3: Covered Providers and Departments](#)

[Appendix 4: Amounts Generally Billed \(AGB\) Percentage](#)

[Appendix 5: Public Access to Policy](#)

[Financial Assistance Application_2022.pdf](#)

Approval Signatures

Step Description

Approver

Date

Finance Administrator

John Wolfe: Finance
Administrator

3/31/2023

Doris Schumacher: Manager,
Claims

3/21/2023