Policy Title/Number: Financial Assistance Policy (FAP) / FIN.10	
Department: Finance	
Title of Policy Owner: Vice President, Finance	
Effective Date: 3/1/2003	**Review Date: 9/17/2026**

I. PURPOSE

It is the policy of Good Shepherd Rehabilitation and GSPP Rehabilitation (GSR/GSPP) to provide healthcare services to all medically appropriate patients who seek care regardless of their ability to pay for services. This Financial Assistance Policy (FAP) includes both uninsured and under-insured patients.

II. SCOPE/ACCOUNTABILITY

Good Shepherd Rehabilitation and GSPP Rehabilitation

III. DEFINITIONS

Amount Generally Billed (AGB): AGB is the average amount paid by all private health insurers and Medicare for medically necessary patient services. GSR/GSPP use the "look back method" as defined in section 501(r) (5) (b) (1) of the Internal Revenue Code. GSR/GSPP will limit amounts charged for medically necessary care provided to individuals eligible for assistance under this policy to not more than AGB. The AGB will be updated annually upon approval of the most recent audited completed fiscal year's financial statements.

Coinsurance: A patient payment required by the patient's benefit plan in order for the patient to share financial responsibility. For example, the insurer will pay 80% of an approved amount, and the coinsurance will be 20%. Coinsurance formulas vary from plan to plan

Co-payment: The flat fee a patient pays each time they receive medical care. For example, $20 each time a patient visits the doctor.

Countable Assets: Liquid assets that are considered available for payment of healthcare liabilities. As defined in the PA Medicaid Bulletin, Hospital Uncompensated Care Program and Charity Care Plans countable assets do not include non-liquid assets such as homes, vehicles, household goods, IRAs and 401(k) accounts.

Deductible: The amount a patient must pay each year before their insurance plan is responsible.

Eligibility Period: An applicant's eligibility period for GSR/GSPP's financial assistance is 6 months. Open accounts in previous years will be eligible for financial assistance. Any patient who was approved for financial assistance and receives inpatient or outpatient services within the 6-month eligibility period will need to be screened for Medical Assistance eligibility prior to any financial assistance forgiveness being applied to the balance due. If a patient's household income changes during the eligibility period their financial assistance determination may change.

Financial Assistance: A reduction in the patient responsibility amount decreasing the patient responsibility amount to either charity care or the AGB. Financial assistance is available to uninsured patients who participate in the process to evaluate their ability to pay for services and have household income less than 200% of the Federal Poverty Guidelines. Financial Assistance is available to insured

patients with deductibles, copayments, coinsurance and non-covered liabilities and has household income less than 200% of the Federal Poverty Guideline. For purposes of this policy, the terms "financial assistance" and "charity care" are used interchangeably.

Financial Hardship or Extreme Hardship: A patient, including individuals in public/private insurance programs, whose deductibles, co-payments, Medical Assistance spend down, medical, or GSR/GSPP bills after payment is received from third-party payers exceeds their ability to pay. This would include patients whose family income exceeds 200% of the Federal Poverty Guidelines and are medically indigent.

GSR: Includes all entities of Good Shepherd Rehabilitation

GSPP: Includes all entities of GSPP Rehabilitation

Non-covered services: Services not reimbursed by health insurances such as not medically necessary; provided however, that medically necessary non-covered services are eligible for financial assistance.

Underinsured: A patient, including individuals in public/private insurance programs, whose deductibles, co-payments, Medical Assistance spend down, medical, or GSR/GSPP bills after payment by a third-party payer, including a tortfeasor and his/her insurer, constitutes a financial or extreme hardship. Individual receiving services that are not medically necessary are not considered underinsured.

Uninsured: A patient who does not have health insurance is not currently covered by any third-party payer program including auto and/or worker compensation and has no expectation of recovering damages from third parties on account of GSR/GSPP charges. This includes persons whose coverage is terminated while receiving services at GSR/GSPP and who are individually liable for their bill. Individuals receiving services that are not medically necessary are not considered uninsured. Individuals that have a Health Savings Account or a Flexible Spending Account are not considered uninsured.

IV. POLICY

GSR/GSPP provides healthcare to each person, regardless of religious belief, age, race, sex, sexual orientation, physical and intellectual capacity and economic status.

It is therefore the policy of GSR/GSPP to provide uncompensated medical services (i.e., charity) for individuals who have demonstrated need in excess of insurance, personal resources and funds available through Federal, State and Local medical funding programs.

Consistent with the mission and values of GSR/GSPP, it is our policy to provide medically necessary care to all individuals without regard to their ability to pay for services. This policy is intended to meet the charity care and financial assistance requirements of the Pennsylvania Tobacco Settlement Act, section 501(r) of the Internal Revenue Code, the Pennsylvania Health & Human Service Medicaid Bulletin 01-10-24 addressing Hospital Uncompensated Care Program and Charity Care Plans and the Hospital Association of Pennsylvania Charity Care and Financial Aid Guidelines for Pennsylvania Hospitals. This Financial Assistance Policy applies to all individuals who request to participate in the process to evaluate their ability to pay for GSR/GSPP's services. The policy incorporates the following principles:

-Uninsured individuals are never expected to pay more than the Amount Generally Billed (AGB) for medically necessary care. AGB is determined based on the average payment of private insurers plus Medicare and the Commonwealth of Pennsylvania's Medicaid Program. Individuals must cooperate with Good Shepherd in the process to apply for insurance, government assistance or other source of payment.

-Uninsured individuals with family annual income less than 200% of the Federal Poverty Guideline will be considered for charity care. Good Shepherd will employ the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services.

Every attempt will be made by the service line to verify all potential insurance coverage for services. In the case when a patient has no coverage or limited coverage for care, the service line will prospectively identify eligibility for the provisions of charity care.

The factors used to determine eligibility include sources of income, demographic information, living expenses, ongoing healthcare needs and other personal assets/liabilities.

Generally, a patient will automatically qualify if their household income is less than 200% of the current federally established poverty level.

All patients indicating an inability to pay AGB will be assisted in applying for insurance, government assistance or other sources of payment and will be evaluated for eligibility for financial assistance under this policy. All applicants will be screened without prejudice and without discrimination.

Both eligibility for financial assistance and the amount of financial assistance is based on an individual's household income. In situations where the patient is unable to participate in the process to evaluate their ability to pay for services other factors will be considered as evidence of the patient's eligibility for Financial Assistance. Other factors include 1) notification that a deceased patient's estate is insufficient to pay for services, 2) the patient has completed a Medicaid application indicating income and countable assets qualifying for Medical Assistance, 3) GSR/GSPP has evidence the patient has no income due to being incarcerated or 4) the GSR/GSPP medical record indicates the patient is unable to pay for services. For example, the medical record indicates the patient is homeless.

All sources of patient and qualifying patient family income will be included when determining if the patient qualifies for financial assistance. Income includes all components of the patient and spouse's adjusted gross income as stated on the IRS 1040 form.

Payment will be pursued using standard GSR/GSPP collection practices. GSR/GSPP collection practices meet the requirements of Section 501(r) of the Internal Revenue Code and the Fair Debt Collection Practices Act.

In cases of documented extreme hardship where the patient had or has income in excess of 200% of the federal poverty guideline and upon approval of the Vice President of Finance/Chief Financial Officer and Sr. Manager, Revenue Cycle and Operations, an amount less than AGB may be accepted to satisfy an individual's obligation. In this special situation the patient's financial assets and liabilities information will be requested and considered.

V. PROCEDURE

Action	Responsibility
A. Notification: All patients shall be notified of GSR/GSPP's Financial Assistance Policy availability prior to the start of their care.	Inpatient Admissions/Outpatient
B. Description of Eligibility Criteria: As responsible stewards of our community's healthcare resources, we are committed to identify financial resources available to the patient, including: 1. Group or individual medical plans 2. Worker's Compensation 3. Medicare & Medicaid 4. Auto and other third-party coverage	Care Management Patient Access Nurse Liaisons Patient Accounts
C. In those situations where a primary coverage is not available, the patient shall be considered for charity/free care. The following criteria will be used: 1. Patient charges will be considered as charity/free care for any patient whose gross	Sr. Manager, Revenue Cycle and Operations

family income is at or below 200% of the current federally established poverty guidelines.

2. The sliding fee schedule derived from the Federal Poverty Guidelines and family size will be used to determine charity/free care eligibility.
3. GSR/GSPP care for catastrophic cases: Under unique circumstances where a significant financial hardship or personal financial loss will result to the patient/resident regardless of the income, charity care requests will be reviewed by Administration.

D. Approval Guidelines: Each case and proposed charity/free care write-off shall be reviewed and approved as follows:

Charge Range	
1. $0-$20,000	Sr. Manager, Revenue Cycle and Operations
2. $20,000 and over	VP/CFO

E. Process for Eligibility Determination/Identification of Charity Care Patients:

1. During the pre-registration and/or registration process, Patient Access Areas will verify insurance and conclude whether there is proper coverage for the potential for charity care. — Inpatient Admissions, Outpatient Registration, Care Managers
2. A charity care application will be issued to determine the personal financial status of each patient (see attached Financial Assistance Application). — Patient Access Areas, Care Managers
3. Final Determination-Charity/free care may be considered based on the initial review of the personal financial situation of the patient. This can be authorized by the Sr. Manager Revenue Cycle and Operations — Patient Accounts, Sr. Manager, Revenue Cycle and Operations

F. Financial Assistance forms, instructions and written application shall be furnished to the patient when financial assistance is requested, when need is indicated or when financial screening indicates potential need. All applications, whether initiated by the patient or the hospital, should be accompanied by documentation to verify information indicated on the application form. The following type of documentation may be acceptable for verification purposes: — Care Management, Patient Access, Nurse Liaisons, Patient Accounts, All Staff

1. W-2 withholding statements for all employment during the relevant time period.
2. Pay stubs from all employment during the relevant time period.
3. An income tax return from the recently filed calendar year.
4. Forms approving or denying eligibility for Medical Assistance.
5. Forms approving or denying unemployment compensations,
6. Written statements from employers or welfare agencies.

G. Patient/Guarantor assets shall be evaluated to ensure that the applicant meets all required criteria for financial assistance.	Sr. Manager, Revenue Cycle and Operations
H. Those patients requesting financial assistance for catastrophic cases may be required to furnish additional documentation in accordance with individual circumstances. One or more of the following types of documentation may be required: 1. Proof of medical expenses 2. Pharmacy bills 3. Healthcare required outside hospital setting 4. Medical supplies	Sr. Manager, Revenue Cycle and Operations
I. Patients will be asked to provide verification of ineligibility for Medical Assistance. During the initial request period the hospital may pursue other sources of funding, including Medical Assistance.	Sr. Manager, Revenue Cycle and Operations
J. Income shall be annualized from the date of the application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration seasonal employment and temporary increase and/or decreases of income.	Inpatient Admissions/Outpatient
K. Time frames for Final Determination and Appeals: The hospital shall provide final determination within fourteen (14) days of receipt of all requested documents to make a determination.	Inpatient Admissions/Outpatient
L. Denials: Denials will be written and include instructions for appeal or reconsideration as follows: 1. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Sr. Manager, Revenue Cycle and Operations within fourteen (14) days of receipt of notification. 2. All appeals will be reviewed by the Sr. Manager, Revenue Cycle and Operations or Vice President of Finance/CFO. If this determination affirms the previous denials of charity care, written notification will be sent to the patient/guarantor.	Inpatient Admissions/Outpatient
M. Documentation and Records 1. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application forms. a. Documents pertaining to charity shall be retained for seven (7) years. 2. Public Notification: GSR/GSPP's financial assistance policy shall be publicly available on its website(s), through the use of signs, written documentation and verbal explanation at time of registration.	Inpatient Admissions/Outpatient Finance Marketing

N. Control and Reporting Mechanisms — Sr. Manager, Revenue Cycle and Operations

1. The Sr. Manager, Revenue Cycle and Operations and Vice President of Finance/CFO shall develop, publish and maintain the forms, instructions and procedures necessary for the financial planning budgeting and reporting required by this policy.
2. This statement of Hospital policy and the level of the minimum financial commitment to the poor shall be reviewed at least annually by the Chief Executive Officer. — VP President of Finance/CFO

O. Collections

1. All bills sent to patients registered as uninsured patients will receive a summary of the FAP with their bill. In addition, their statement will show the net amount billed for the services rendered as well as the expected payment or AGB. Payment of all outstanding patient balances will be pursued using standard GSR/GSPP collection practices, which include:

    - 30-day billing cycle with a total of four (4) bills being sent to the patient

    - Account balances not on a payment plan or not paid in full after the 120-day billing cycle will be sent to an attorney or collection agency

    - Balances not paid to the attorney or collection agency will be forwarded to the credit bureau for handling within 30 days of placement

    - FAP can be completed at any time during the collection process and will be considered for approval

It is the policy of GSR/GSPP to pursue collection of patient balances from patients who have the ability to pay for these services. Collection procedures will be applied consistently and fairly for all patients. All collection procedures will comply with applicable laws and with GSR/GSPP's mission. These collection procedures may include: letters requesting payment; phone calls requesting resolution of the balance; letters indicating the account may be placed with an attorney or collection agency. In certain cases, GSR/GSPP may authorize an attorney to pursue legal action against a patient and per Pennsylvania law, his/her spouse to collect an outstanding balance. Such legal action may result in a judgment being entered against the patient and in appropriate circumstances his/her spouse.

VI. **KEYWORDS:** financial assistance, FAP, charity care, finance, poverty, federal register, revenue cycle, AGB, financial hardship

VII. **REFERENCES**

The Hospital & Health System Association of Pennsylvania (HAP)
The Department of Health & Human Services Poverty Guidelines (published January 15, 2026 - Federal Register)

VIII. **ATTACHMENTS: N/A**