

## Financial Assistance Policy

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### 1. Purpose

Piedmont Healthcare Corporation (PHC) seeks to treat patients equitably, with dignity, respect, and compassion. To this end, and in understanding that some patients may be unable to pay their hospital bills due to financial considerations, PHC will assist those who cannot pay for their care by extending financial assistance to qualifying patients, in keeping with the policy described below. In order for PHC to apply this policy fairly and consistently, patients and their families have a duty to provide appropriate and timely information. This program is referred to hereafter as the PHC Financial Assistance Program (FAP).

In accordance with the Affordable Care Act (ACA), any patient eligible for financial assistance under PHC's financial assistance policy will not be charged more for emergency or medically necessary care than the amount generally billed (AGB) to insured patients. All patients who qualify for financial assistance through Piedmont Healthcare, and under this policy, will not incur charges for medically necessary care during the timeframe for which their assistance is granted.

As further described below, this financial assistance policy:

- Includes eligibility criteria for financial assistance.
- Describes the method by which patients may apply for financial assistance.
- Describes the process used to determine financial assistance, the appeal process and presumptive eligibility.
- Describes how PHC will widely publicize the policy within the communities served by each PHC facility.
- Lists providers practicing within PHC who do and do not adhere to our financial assistance policy, in Addendums A and B.

- As required by law, PHC hospitals and employed physicians remain committed to serving the emergency needs of all patients, regardless of ability to pay.
- PHC will comply with federal and state laws and regulations relating to emergency medical services, patient financial assistance, and charity care, including but not limited to Section 1867 of the Social Security Act and Section 501(r) of the Internal Revenue Code.

## 2. Scope

This policy covers all Piedmont Healthcare hospitals and employed physicians.

## 3. Definitions

**Amounts generally billed (AGB)** – The average reimbursement percentage received from Medicare and Commercial/Managed Care companies for billable services provided by PHC.

**Community Care Clinic** – A clinic open to anyone, but primarily serves the uninsured and underinsured population. Clinic staff members are devoted to meeting the community's needs with creative, thought-provoking programming. Health screens and educational programs are offered as well as workplace wellness and safety programs. The clinic address is: 1270 Prince Avenue, Suite 200, Athens, GA 30606. The phone number is 706-275-7055.

**Denial** – A charge or service where a payer has sent back a remark code denying the claim. Denials are typically grouped by type:

- Technical (non-covered charge, eligibility issue)

**Eligible services** – Services eligible under this policy include (1) emergency medical services provided in an emergency room setting, (2) non-elective services provided in response to life-threatening circumstances in a non-emergency room setting, and (3) other medically necessary services (See definition below.).

**Emergency care** – Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

**Extraordinary collection actions** – A list of collection activities, as defined by the IRS and Department of Treasury, that healthcare organizations may employ to obtain payment for care, after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. These actions are further defined in Section 4.7 of this policy and include actions such as reporting adverse information to credit bureaus/reporting agencies, along with legal/judicial actions such as garnishing wages.

**Federal Poverty Level (FPL)** – The applicable household income thresholds established periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C.~9902(2).

**Financial assistance** – Healthcare services provided to uninsured persons who meet PHC's criteria for

financial assistance and are unable to pay for medically necessary services provided by PHC and its employed physicians.

**Gross charges** – The total charges at the organization's full established rates for the provision of patient care services before contractual adjustments and/or discounts are applied.

**Gross Income** – An individual or company's income before taxes and deductions.

**Guarantor** – Individual responsible for payment of the patient's bill; this may be the patient or another individual.

**Household** – Household size includes all persons who occupy a housing unit as their usual place of residence and can legally be claimed as a dependent on federal taxes. *Household* is used to determine a patient's Federal Poverty Level (FPL). Members of the household must consider the home their permanent residence.

**Medically necessary services** – Services provided to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity, and there is no other more conservative or substantially less costly course of treatment available or suitable for the person requesting the service.

Elective, preventive and/or routine services and procedures are not considered Eligible Services. Other medical services not included in Eligible Services are cosmetic procedures, fertility services, global and executive health, occupational health and retail-type services, and other services that already have a specific global/package pricing arrangement. This is not an exhaustive list and modifications may be made at any time by PHC.

Should there be a question as to medical necessity, the final determination of whether medical care is considered urgent and/or medically necessary shall be made by the facility's Chief Medical Officer. PHC will follow all standards as established by the Emergency Medical Treatment and Active Labor Act (EMTALA).

**Presumptive Eligibility** – The process by which PHC may use analytics from public record sources other than the individual to determine eligibility for financial assistance, and/or the use of previous eligibility determinations.

**Uninsured** – Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers. Third-party assistance includes, but is not limited to, auto insurance, worker's compensation coverage, or other third-party liability coverage.

## 4. Policy

PHC will assist those who cannot pay for their care by extending financial assistance to qualifying patients based on the criteria in this policy.

## 4.1. Eligibility Criteria for Financial Assistance

Uninsured patients who are current residents of the state of Georgia and who have a gross household income at or below 300% of the Federal Poverty Level Guidelines (FPL) as shown in the table below may be awarded financial assistance (a 100% discount). The table below reflects the current Federal Poverty Level at 100%.

When determining a patient's eligibility, PHC does not take into account race, gender, age, sexual orientation, religious affiliation or immigrant status.

### 2023 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty guidelines
1	\$14,580
2	\$19,720
3	\$24,860
4	\$30,000
5	\$35,140
6	\$40,280
7	
8	\$50,560

For families/households with more than 8 persons, add \$5,140 for each additional person.

PHC will assist patients, through the use of outside vendors, in pursuing State of Georgia Medicaid or Social Security Administration benefits. It is imperative that patients, or patients' guarantors, comply with the application process for Georgia Medicaid and/or SSI. Those who do not cooperate will be denied PHC financial assistance.

Outside vendors may also assist in completing and submitting the financial assistance application. A final determination on the availability of Georgia Medicaid and/or SSI benefits must be determined prior to PHC's final decision on granting financial assistance. Note that a Medicaid Family Planning denial is eligible for financial assistance under the terms of this policy

## 4.2. Applying for Financial Assistance

It is PHC's policy to process financial assistance applications on an exception basis. Patients with registration addresses in the state of Georgia will be screened through an electronic verification of demographic and credit records to determine family income, household size, and propensity to pay. These criteria will be used to determine patient eligibility for financial assistance. A paper application and all supporting documentation may be submitted if a patient is not approved through the electronic screening process.

Paper applications may be obtained:

1. Online at [www.piedmont.org/patient-tools/piedmont-financial-assistance](http://www.piedmont.org/patient-tools/piedmont-financial-assistance)
2. Onsite in the admissions/registration area in all Piedmont Hospitals
3. By calling the Customer Solutions Center at 855-788-1212
4. By requesting a copy via U.S.P.S. mail, at the following address:  
Customer Solutions Center  
Piedmont Healthcare  
2727 Paces Ferry Road  
Building 2, Tenth Floor  
Atlanta, GA 30339

All applicants must provide proof of household income by including the information below with the application. In order to process a financial assistance application through to completion (i.e., rendering a determination), the application and all associated documents must be completed and submitted in their entirety.

For financial assistance applications, please bring the original or certified copies of the following documents. If mailing your financial assistance application, please include only certified copies and not original documents.

Acceptable forms of Photo ID (government IDs only): All documents must be valid and up to date.

- Valid state-issued driver's license
- State ID card
- Passport
- Military ID
- Consular or school picture ID.
- Visa or Residence Alien Card (if applicable)

Not acceptable: Costco card, selfie or holiday picture

Proof of Georgia Residency: Documents must be in the patient's name and no more than 30 days old.

- Lease contract (may be used if still valid and all other documents show the same address)
- Food stamps letter
- Utility bills (must show physical address and be dated within 30 days)
- Other business documents that verify place of residency, such as: credit card statements, IRS or Medicaid letters, student letters from school, bank statements, mortgage statements

Note: A P.O. Box does not demonstrate residency.

Proof of Income – One or more of the following:

- If Employed (required): Three most recent paycheck stubs (patient and spouse/partner) OR
- If Unemployed (required): Unemployment Claim or unemployment award letter; and copies of three most recent monthly bank statements (all accounts) OR
- If Self-Employed (required): Copies of three most recent monthly bank statements from both personal and business checking/savings accounts (all accounts, both patient and spouse/partner) OR
- If Retired (required): SSN letter (if applicable) and copies of three most recently monthly bank statements from both personal and business checking/savings accounts (all accounts, both patient and spouse/partner)

Additional documents to verify information (these are not a replacement for requirements of the above lists)

- Any decision letters indicating that the patient is receiving unemployment compensation, Medicaid, Social Security disability, General Assistance, etc.
  - Food Stamps letter
  - Verification of homelessness or a letter from a shelter on company letterhead
  - Other business documents showing how the patient is being supported.
  - Proof of number of dependents: one or more of the following:
    - Previous year's signed income tax return (most recent) if claiming dependents
    - Any decision letters indicating that the patient has legal responsibility for the child, such as court ordered guardianship or custody papers
1. If patients do not have the needed information to complete the application, provide supporting documentation, or are unsure of where to obtain it, they can contact our financial counselors who can provide guidance. Please call our Financial Assistance Team at 855-788-1212.

Applications must be received within 245 days from receipt of the first PHC statement for Eligible Services. Failure to meet the above criteria provides grounds for denial of financial assistance. If an application is incomplete, and/or required supporting documentation is not submitted, needed information must be provided within thirty (30) calendar days from the date of notification, or the application will be denied.

### **4.3. Determining Financial Assistance Eligibility**

Eligibility for financial assistance will be determined based on an individual's gross household income to assess financial need and residency requirements. This procedure includes an application process, in which the patient or the patient's guarantor is required to supply personal, financial and other documentation necessary to make a determination of financial need. Approval for financial assistance by an affiliated clinic can serve as approval for PHC financial assistance.

If an uninsured patient, or their associated guarantor, appears to possess insufficient income or resources to pay outstanding bills for Eligible Services, the patient or such guarantor may request financial assistance. The availability of financial assistance is based upon the eligibility criteria in this

policy.

If approved for PHC financial assistance, PHC will contact the patient via phone and/or letter identifying the effective dates of eligibility. The individual requesting financial assistance will be notified of missing or incomplete information. A letter will be sent to the applicant identifying incomplete applications or missing required supporting documentation.

Patients who are denied financial assistance will be sent a letter detailing the reason for the denial. The patient then has thirty (30) calendar days to appeal the decision, and provide any supporting information to supplement his or her application to gain approval for financial assistance.

## 4.4. Appealing Denied Financial Assistance

Patients denied financial assistance are able to appeal that determination by contacting the Customer Solutions Center, via any of the methods below.

1. Email to: [assistance@piedmont.org](mailto:assistance@piedmont.org)
2. By calling the Customer Solutions Center at 855-788-1212
3. By U.S.P.S. mail, at the following address:

Customer Solutions Center  
Piedmont Healthcare  
2727 Paces Ferry Road  
Building 2, 10 Floor  
Atlanta, GA 30339

All appeals will be considered within ten (10) business days of receipt, and a phone call will be made to the applicant outlining the final determination within the following five (5) business days. A letter to the applicant also will be sent within the following five (5) business days.

Financial counselors are available to provide assistance with the financial assistance application process, or to help with a denied application. PHC financial counselors are available on site at all hospitals, or patients may call the Customer Solutions Center at 855-788-1212.

## 4.5. Presumptive Eligibility

Separate from the eligibility assessment of a formal application for financial assistance described in Section 4.3 above, Georgia residents may also be presumed to be eligible ("presumptive eligibility") for financial assistance based on evidence provided through the use of a third-party screening tool, regardless of insurance status. To qualify for financial assistance under presumptive eligibility, the patient must have a Federal Poverty Level no higher than 300%. Information obtained from the third-party screening tool will help verify the patient's financial status through public record data and may be utilized as the sole documentation source to make a financial assistance determination.

Patients qualified for financial assistance through presumptive eligibility are covered for services based on an individual account basis. Those who are ineligible for financial assistance through the presumptive eligibility process may apply through the standard application process, as detailed in Section **4.2**.

## **4.6. Amounts Billed to Patients**

In no event are gross charges billed to a patient approved for financial assistance. For patients who are uninsured, the financial assistance discount of 100% is applied to gross charges for Eligible Services. PHC uses the "look back" method in calculating the amounts generally billed (AGB). Additional detail regarding AGB calculations will be furnished upon request by contacting the Financial Assistance Team at 855-788-1212.

## **4.7. Collection Practices and Policies**

Applicants approved for financial assistance will be exempt from all collection efforts related to outstanding accounts that fall within the eight (8) month approval time frame. PHC will not turn over any account approved for financial assistance to a collection agency or report it to a credit bureau. Normal collection efforts will be applied to account balances that fall outside of the eight (8) month approval time frame, as outlined by the PHC Billing and Collections policy. Please refer to that policy for further details.

PHC will not impose extraordinary collection efforts such as wage garnishment, liens on primary residence or other legal actions for any patient/guarantor, without first making reasonable efforts to determine whether that patient is eligible for financial assistance under this policy.

## **4.8. Communication of the Financial Assistance Program to Patients and within the Community**

Notification of the PHC financial assistance program will be disseminated by each Piedmont Healthcare facility including, but not limited to the publication of notices in emergency rooms, in admitting and registration areas, by Patient Financial Care personnel located on facility campuses, and other public places as chosen by PHC. Additionally, information about the financial assistance program appears on all patient billing statements issued after the self-pay balance has been determined. We also provide a plain language summary with admissions documents.

PHC publishes the full financial assistance policy on Piedmont.org, and a summary version in brochures available in registration and admission areas, as well as at other places within the communities served by PHC.

The Financial Assistance Policy, Financial Assistance Application and Plain Language Summary are available in the primary language of any populations with limited English proficiency that constitute more than ten (10) percent of the residents in the communities served by PHC.



## 4.9. Regulatory Requirements

In implementing this policy, PHC shall comply with all federal, state, and local laws, rules and regulations that apply to activities conducted pursuant to this policy.

## 4.10. Enforcement and Exceptions

Failure to comply with this policy may result in disciplinary action up to and including termination of employment for employees, or termination of contract or services for third-party personnel, students or volunteers.

## 5. Responsibilities

Not applicable

## 6. Procedure

Not applicable

## 7. References

[EMTALA Policy](#)

Billing and Collections Policy

Financial Assistance Application

Financial Assistance Worksheet

## 8. Appendix A

A directory of physician practices that are included or honor PHC's Financial Assistance Policy is available by contacting the Manager of Financial Assistance at the information below. This directory will be updated bi-annually and is also available online via the link below.

Matthew Fisher, Director  
Customer Solutions Center  
Piedmont Healthcare  
2727 Paces Ferry Road Suite 2-1000  
Atlanta, GA 30339  
P: 855-788-1212  
E: [assistance@piedmont.org](mailto:assistance@piedmont.org)

[Provider List](#)

## 9. Addendum

### Addendum A

Care delivered at Athens Community Care Clinic will be eligible for financial assistance, to include

medically necessary services as well as any routine or screening service.