RAPIDES REGIONAL MEDICAL CENTER

POLICY: FINANCIAL ASSISTANCE POLICY FOR PATIENTS	**POLICY #25 PAGES 1 - 9**
Department Affected: Hospital-Wide and HPL clinic locations	**Effective: 01/01/19**
Review: Annually	**Reviewed/Revised: 3/9; 3/11; 3/12; 1/14; 3/13; 3/15; 10/15; 11/18; 5/19; 10/20; 06/25**
Policy Owner: Administration	

I. INTRODUCTION

Rapides Healthcare System (RHS) is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services, RHS strives to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. RHS will provide, without discrimination, medically necessary care for individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written financial assistance policy (FAP):

- Describes what services are eligible for assistance and what providers participate in the FAP,
- Includes patient eligibility criteria for financial assistance,
- Describes the method by which patients may apply for financial assistance, and
- Describes the basis for calculating amounts charged to patients.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with RHS's procedures for obtaining assistance or other forms of payment and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow RHS to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors of Rapides Healthcare System LLC establishes the following guidelines for the provisions of financial assistance.

II. POLICY

This policy is intended to comply with the financial assistance and emergency care policies required by Internal Revenue Section 501(r)-4 (**501(r)**) and shall be interpreted to so comply. This policy applies to all medically necessary care and emergency care provided by the Hospital and any substantially related entity of the Hospital. This policy supports the charitable purpose and mission of the RHS.

In order to ensure that all patients are adequately informed about this policy, Rapides Healthcare System ("RHS") has undertaken the following:

- This policy as well as the applications and instructions for completion and the plain language summary of this plan are available on the **RRMC website** under **Financial Assistance Policy and Application**. Both English and Spanish versions of these documents are posted to the website.
- At registration, patients are provided with paper copies of this policy, the Financial Assistance Application, and the plain language summary of this plan.
- The Financial Assistance Applications are available at all the hospital patient admission and patient accounting service areas, by mail at:
    - Rapides Regional Medical Center
      211 4th Street
      Alexandria, LA 71301
- Signs that prominently present information about the charity mission and guidelines are present at all points of admission.
- Paper copies of this policy, the Financial Assistance Application, and the plain language summary of this policy will be made available on request and without charge, both by mail at Rapides Regional Medical Center, 211 4th Street, Alexandria, LA 71301 and in the emergency rooms and admission areas.
- Conspicuous written notice shall be included on all patient bills of this policy, telephone number of the office or department that provides information about this policy and the application process and the RRMC website where this policy, the Financial Assistance Application, and the plain language summary of this policy
- Conspicuous notices and displays about this policy shall be displayed throughout the Hospital including the emergency rooms and admissions areas.

III. PROCEDURES

This policy is applied to charges for care provided by the hospital, HP Long Clinics and other medical providers with which RHS has contracted to provide care under this FAP. Those providers include the companies that provide radiology, laboratory, emergency and hospitalist services, as well as other independent physicians. The current listing of FAP Providers is available from RHS's

business office: First floor, main hospital, Phone 318-769-3225; email: rapidesregional@hcahealthcare.com, or 211 4th St. Alexandria, LA 71301. The office is open from 8:00 am to 5:00 pm, central time, Monday through Friday. The list is also available on RHS's website at: http://rapidesregional.com/patients-and-visitors.

Financial assistance may only be provided to patients receiving non-elective, or medically necessary care. This includes care received in the hospital, emergency room, and HP Long clinics.

Patients eligible for the RHS financial assistance may receive bills for services provided by medical professionals who are not on the FAP Providers list.

The eligibility determination for financial assistance shall be based on an Individualized determination of financial need and shall not consider age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

CHARITY CARE ELIGIBILITY SYSTEM

1. ***Application*** In order to qualify for financial assistance, the Hospital requires the completion of the Financial Assistance Application, a copy of which is attached as Exhibit B. The application allows for the collection of information in accordance with state law, the income and documentation requirements set forth below, and 501(r). Approved applications are valid for 9 months for all services provided. If the patient span of illness has continued beyond the initial 9 month eligibility period the Hospitals should re-verify financial assistance status. RHS may use electronic validation from a third-party vendor (i.e. credit scoring methodology) to provide Financial Assistance to patients who have not met the requirement of completing a Financial Assistance Application.

2. ***Calculation of Immediate Family Members*** The Hospital will request that patients requesting financial assistance verify the number of family members in their household.
    - *Adults* In calculating the number of family members in an adult patient's household include the patient, the patient's spouse and any dependents.
    - *Minors* In calculating the number of family members in a minor patient's household, include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependents of the patient's father.

3. ***Income Calculation*** Patients must provide their household's yearly income.
    - *Adults* For Adults, the term **yearly income** for purposes of classification as Financially indigent or Medically indigent in accordance with the Policy means the sum of the total yearly gross income of the patient and the patient's spouse.
    - *Minors* If the patient is a minor, the term **yearly income** means total yearly gross income from the patient, the patient's mother and the patient's father.

Financial assistance is available depending on a patient's annual income compared to the Federal Poverty Levels (FPL) updated annually in the Federal Register by the U.S. Department of Health and Human Services.

- Financially Indigent means an uninsured or underinsured person who is accepted for care with no obligation or with a discounted obligation to pay for the services rendered, based on the Charity Care Eligibility System. Patients will be classified as Financially Indigent if their household income falls below 200% of the FPL. Financially Indigent patients will be given a 100% Charity Discount.

- Medically Indigent means a patient whose medical or hospital bills, after payment by third-party payers, exceed a specified percentage of the person's Yearly Income, and who is unable to pay the remaining bill. Patients will be classified as Medically Indigent if the balance due is greater than 10% of the patient's income. The Uninsured Discount will be applied to the remaining balance after other payment/discounts and is granted using the following sliding scale:

Annual Income (% of FPL)	**Discount**
201% to 250%	90% Discount
251% to 300%	80% Discount
301% to 350%	70% Discount
351% to 400%	60% Discount
401% to 450%	50% Discount
451% to 500%	40% Discount

- Patients will be classified as Catastrophically Medically Indigent when their remaining balance after other payments/discounts exceeds a specified percentage of their income, as defined below. In such cases, the amount of discount may be calculated as the amount necessary to reduce the remaining balance to a reasonable percentage of the patient's household income:

Income Range	**Remaining Balance After Discount**
(Based upon FPL guidelines)	
201% to 500%	10% of patient's household income
501% to 1000%	25% of patient's household income
over 1000%	40% of patient's household income

- ***Charges Billed for Medical Services Provided*** **501(r) requires hospitals to limit the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to no more than amounts generally billed to insured individuals.** The charges billed the patient for medical care will not exceed the amounts generally billed to Medicare fee for service patients together with all private health insurers paying claims to the Hospitals during the prior 12-month period. ended November 30 of each calendar year, updated on an annual basis. This method of determined charge billed for care is an allowable method to determine charges under 501(r).

DOCUMENTATION REQUIREMENTS

- ***DOCUMENTATION AVAILABLE*** The income reported on the Financial Assistance Application may be verified through any of the following mechanisms:
    a. **Income Indicators** By providing any of the following items including IRS Form W-2, Wage and Tax Statement; Pay Check Remittance; Individual Tax Returns; telephone verification by employer; bank statements; Social Security payment remittances, unemployment insurance payment notices, Unemployment Compensation Determination Letters, electronic validation of income from a third party vendor (i.e. credit scoring methodology); or other appropriate indicators of yearly, monthly, weekly or hourly income.
    b. **Participation in a Public Benefit Program** By the provision of documentation showing current participation in a public benefit program such as Medicaid, Food Stamps, WIC, other similar indigency related programs. Proof of participation in any of the above programs indicates that the patient has been deemed Financially Indigent and therefore, is not required to provide his or her income on the Financial Assistance Application.
    c. **Documentation acceptable for Medicare patients:**
    For Medicare beneficiaries, in addition to thorough completion of the Medicare FAP Application, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:
        - State Income Tax Return for the most current year
        - Supporting W-2
        - Supporting 1099's
        - Most recent bank and broker statements listed in the Federal Tax Return
        - Current credit report
        - Qualified Medicare Benefits (QMB for inpatients only)
    d. **Documentation acceptable for Non-Medicare patients:**
        - Signed, witnessed FAP Application
        - W-2 withholding forms
        - Most Recent Employer Pay Stubs
        - Copies of all bank statements for last 3 months
        - Written documentation from income sources such as verification of wages from employer, verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the last twelve (12) months.
        - Income tax returns
        - Forms providing or denying unemployment compensation or worker's compensation

- A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted.

e. **Undocumented Residents or Homeless**: Patients who are identified as undocumented or homeless may be considered for financial assistance if an attempt to complete the FAP application was documented, and a manager has reviewed and approved a policy exception. Identification as undocumented or homeless is determined through:
   - Medicaid eligibility screening
   - Registration process
   - Discharge to a shelter
   - Clinical or case management documentation
   - Attempt to run a credit report

- ***DOCUMENTATION UNAVAILABLE*** In cases where the patient is unable to provide the documentation verifying yearly income, the Hospital may verify the patient's income **by providing an explanation of why the patient is unable to provide documentation verifying income and:**
  a. ***Obtaining the Patients Written Attestation***. The patient or responsible party sign the Financial Assistance Application attesting to the accuracy of the income information provided: **or**
  b. ***Obtaining the Patient's Verbal Attestation***. Through the written attestation of RHS Personnel completing the Financial Assistance Application that patient verbally verified the Hospital's calculation of the income reported on the Financial Assistance Application.
  c. ***De Minimis Accounts.*** If the patient's account of de minimis value, not to exceed $500, the Hospital may verify the income reported by the patient on the Financial Assistance Application by:
     - Obtaining the Patient's Written Attestation. Obtaining a Financial Assistance Application signed by the patient attesting to the veracity of the income information provided; and
     - Documenting Efforts to Obtain Documentation. Under this de minimis account section there is no requirement to provide an explanation of why the patient is unable to provide documentation verifying income. However, there must be two different documented attempts by the Hospital to obtain documentation from the patient verifying income.
  d. ***Expired Patients.*** Patients that expire and research documented through family contact and/or courthouse records indicate that an estate does not exist may be considered for a charity discount, and income verification is not required.

VERIFICATION PROCEDURES

In determining a patient's total income, the Hospital may consider other financial assets of liabilities of the patient as well as the patient's family income and the patient's family's

ability to pay. If a determination is made that a patient has the ability to pay the remainder of the bill, such determination does not preclude a re-assessment of the patient's ability to pay upon presentation of additional documentation.

- ***Classification Pending Income Verification***. The Hospital may consider a request for financial assistance at any time before, during or after the dates of service. During the verification process, while the Hospital is collecting the information necessary to determine a patient's income, the patient may be treated as a private pay patient in accordance with the Hospital policies.
- ***Inconsistent or Incomplete Information.*** This policy in no way limits the Hospital's ability to conduct additional due diligence concerning a patient's ability to pay if information provided by the patient during the application process appears to be inconsistent or incomplete. For example, RHS may choose to inquire why little or no assets were reported if a patient's income is high.
- ***Information Falsification***. Falsification of information may result in denial of the Financial Assistance Application. If after a patient is granted financial assistance, the Hospital finds material provision(s) of the Financial Assistance to be untrue, charity care status may be revoked, and the financial assistance may be withdrawn.

4. **Approval Procedures:** RHS will work with all uninsured patients to determine eligibility for Medicaid or charity assistance, as outlined in the "Uninsured Patient Information Document" attached as Exhibit 1. Patients will be notified by mail of eligibility for financial assistance once the application has been reviewed and processed. In reviewing an application for approval, Shared Service Center (SSC) Management will make the determination of eligibility, including a determination that reasonable efforts were undertaken to determine eligibility. Such manager may also make further inquiry into available information such as assets, etc. to determine a patient's ability to pay or make further inquiry regarding qualifying the patient for governmental or other funding.

   In the event that a patient does not qualify for charity assistance, or the patient is responsible for a portion of the balance after charity assistance has been applied, the uninsured discount or other applicable discounts will be applied to the account. The amount due will not exceed amounts generally billed to patients with insurance as determined by using the look-back method described in the Internal Revenue Service Regulations. Patients may request information on this calculation by submitting a request to the following:

   Patient Account Services
   211 4th Street
   Alexandria, LA 71301

5. Document Retention Procedures Hospital or Patient Account Services will maintain documentation in accordance with RHS retention policies sufficient to identify each patient granted status as Financially Indigent or Medically Indigent, the patient's income, the method used to verify the patient's income, the amount owed by the patient, and the person who approved granting the patient status as Financially Indigent or Medically

Indigent. (Government programs such as Medicaid may require such supporting documentation to be retained up to, and in some cases exceeding, seven years).

6. **Attached is a list of providers** who may deliver emergency or other medically necessary services in RHS hospitals. This list specifies which providers are covered by this Financial Assistance Policy. Providers of elective procedures or other care that is not emergency care or otherwise medically necessary are not covered by the Financial Assistance Policy. The attached list is updated yearly.

   Members of the public may obtain a copy of the list of providers by written request to the following address: RHS, 211 4th Street, Alexandria, LA 71301; or by calling the facility telephone number listed in Financial Assistance Policy. Patients can also download a copy of this list this website: https://rapidesregional.com/patients-and-visitors/financial-assistance-providers.dot.

7. **Notification of policy:** The Hospital will provide at admission (i) paper copies of this policy, the Financial Assistance Application, and a plain language summary of this policy and make these available in the Hospital's emergency rooms and (ii) make reasonable efforts to orally notify the patient about his policy and how the patient may obtain assistance with the application process.

8. **Application Period:** The Financial Assistance Application will be accepted and processed for a period of 240 days after the bill described above is provided.

9. **Incomplete Application:** If a patient timely submits an incomplete application, the Hospital will provide the patient written notice of the additional information and/or documentation required under this policy or the Financial Assistance Application and a telephone number and physical location of an office or department that can assist or provide information to the patient. The patient will have 30 days to provide the missing information or documentation.

10. **Notification of Financial Assistance:** Once completed application is made the Hospital will make eligibility determination under this policy. The hospital has final authority for making the eligibility determination. If eligibility determined, the Hospital will provide the patient a bill that shows the amount, if any, the patient owes the Hospital and how that amount was determined and states the amounts generally billed (ABG) for the care. The Hospital will refund to the patient any amount the patient paid in excess of the amount the patient owes under the determination.

11. RHS management has developed policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment) that consider whether the patient qualifies for FAP, a patient's good faith effort to apply for a governmental program or for charity from RHS, and a patient's good faith effort to comply with his or her payment agreements with RHS.

RHS will not impose extraordinary collections actions such as postponement of care, wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this policy. Reasonable efforts shall include:

- Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital.
- Documentation that RHS has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with RHS's application requirements.
- Documentation that the patient does not qualify for financial assistance under this policy.
- Patients will receive a written notice 30 days before extraordinary collections actions are initiated notifying them of RHS's intent to begin such action and of the availability of financial assistance, accompanied by a FAP Plain Language Summary. RHS will also make all reasonable efforts to notify patients verbally before any actions are taken.

No extraordinary collections actions will be taken prior to 120 days following the issuance of the first patient billing. Patients have a total of 240 days following the first billing to submit an application for a charity discount, and should any extraordinary collection action be in process at the time an application is submitted, such actions will be suspended while the application is processed.

The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. However, if a patient is qualified for FAP, any amount paid by the patient above that required by the FAP will be refunded.

Assistance with completing the FAP Application and answers to questions about the application process can be found by contacting the hospital's business office: First floor, main hospital, Phone 318-769-3225; email: rapidesregional@hcahealthcare.com or in person at the main hospital admitting office, 211 4th St. Alexandria, LA 71301. The office is open from 8:00 am to 5:00 pm, central time, Monday through Friday.

In implementing this policy, RHS management and staff shall comply with all federal, state, and local laws, rules and regulations that may apply to activities conducted pursuant to the Policy.

Revisions Approved by:
Bill Davis, Chief Financial Officer
RHS Audit & Compliance Committee (June 23, 2025)
RHS Executive Committee (June 24, 2025)