Policy Title: CHSPSC, LLC Financial Assistance Policy (FAP)

Audience: All Employees

References and Citations:

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I. **Purpose**: To establish a framework and guidelines for providing financial assistance to qualifying patients with an effective and consistent method for identifying eligible patients and for administration and allocation.

II. **Scope:** This applies to CHSPSC, LLC and all CHSPSC, LLC affiliated facilities, including but not necessarily limited to Facilities and healthcare clinics, (each, a "Facility") that are not tax-exempt and, therefore, not subject to Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder (collectively, "501(r)").

III. **Responsibility:** Shared Services Center (SSC) VP, SSC Directors, Patient Access Director, and Facility Chief Financial Officer will be responsible for implementing this Policy. Each Facility will need to adapt applicable appendices to fall in line with this framework.

IV. **Policy:** CHSPSC, LLC Facilities are committed to treating all patients regardless of their ability to pay and 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 their medical care based on their individual financial situation. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), emergency and Medically Necessary Care will not be delayed or withheld based on a patient's ability to pay. As a service to our community, CHSPSC, LLC Facilities participate in state and/or county indigent programs where applicable and offer financial assistance to our patients care received at our Facilities subject to meeting eligibility criteria established herein and in accordance with the Facility's specific policy and state requirements. No patient will be denied financial assistance due to his or her race, religion, national origin or any other basis prohibited by law.

If the state, county or hospital district where the Facility is located has specific guidelines for Financial Assistance, including Charity Care, the Facility should incorporate the state, county or district guidelines and use this policy to supplement any indigent care or other such patient program. The Facility should modify its Financial Assistance Policy to comply with these specific requirements or guidelines.

This Policy is intended to be the minimum standard requirement for CHSPSC, LLC, Facilities, and Affiliates.

V. **Definitions:**

A. Assets or Liquid Assets – Assets, outside of a patient's primary residence, that are capable of being converted to cash within one year. These include checking accounts, savings accounts (including flexible spending and health savings accounts), trust funds, certificates of deposit, bonds, marketable securities and other investments (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)). Additionally, Assets include the liquidated value of luxury items, equity in recreational vehicles, boats, a second home, etc.

B. Asset Test – A substantive assessment of a patient's ability to pay based on eligible liquid or cash Assets in the categories included in the FAP Application.

C. Catastrophic Claim – An account with a patient responsibility balance of at least $50,000.00 after applying the Uninsured Discount or a partial Charity Care Discount.

D. Charity Care Discount – For Uninsured, a full or partial discount off gross charges for medical services available for eligible patients or patient guarantors with annualized individual or family incomes up to specified percentage of the Federal Poverty Level. For Insured, a full or partial discount off net charges for medical services available for eligible patients or patient guarantors with annualized individual or family incomes up to specified percentage of the Federal Poverty Level.

E. Emergency Services - Emergency Medical Conditions, as defined by Section 1867 of the Social Security Act (42 U.S.C. 1395dd), provided in an emergency room setting.

F. Federal Poverty Level – The Federal Poverty Level ("FPL") Guidelines 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 States Department of Health and Human Services under authority of United States Code, Title 42, Section 9902(2). Current FPL Guidelines can be found at http://aspe.hhs.gov/poverty-guidelines, and attached as **Appendix A**. Each Facility must update the FPL Guidelines for its Financial Assistance Program on an annual basis.

G. Financial Assistance – A reduction in the amount that the patient owes for medical services based on the patient's financial need determined by the provisions of this Policy. This reduction is generally determined as a percentage of gross or net charges.

H. Financial Assistance Program or "FAP" – As detailed herein, a program developed to identify and measure a patient's eligibility for either free or discounted Financial Assistance based on financial need and to outline the practice for allocating Financial Assistance in a consistent and efficient manner. Discounts offered under the Facility's Financial Assistance Program may include the Charity Care Discount, the Uninsured Discount, and the Catastrophic Care Discount. Discounts above and beyond the protocol outlined in this Policy are not part of the Facility's Financial Assistance Program and are governed by the CHSPSC, LLC policies titled "Special Insurance and Patient Settlements" and "Financial Counseling."

I. Financial Assistance Program or "FAP" Application – The application a patient must complete in order to identify whether the patient is eligible for the maximum level of assistance under the Charity Care Discount available under the Facility's Financial Assistance Program. The FAP Application, which includes an Asset Test, requests certain information and documentation from a patient to allow the Facility to evaluate and validate a patient's individual or

family income for purposes of determining whether the patient may be eligible for a Charity Care Discount under the Facility's Financial Assistance Program.

J. Gross Charges – The full, undiscounted price of medical services consistently and uniformly charged to patients before applying any contractual allowances, discounts or deductions.

K. Insured – Patients with any type of insurance coverage and/or third-party payor program, which reimburses for, compensates or discounts medical expenses. For purposes of this Policy, patients are considered to be insured even if their benefits are out-of-network.

L. Medical Indigency or Medically Indigent – When a patient's "Balance Due" (defined as the patient's residual account balance after payment by all third party payors for Medically Necessary Care received from the Facility) exceeds a specified percentage of the patient's annual gross income, determined in accordance with the Facility's Charity Care Discount eligibility criteria.

M. Medically Necessary Care – As defined by Medicare, services or items reasonable and necessary for the diagnosis or treatment of illness or injury. For purposes of this Policy, Medically Necessary Care includes Emergency Services (as defined below).

N. Policy – This Financial Assistance Policy.

O. Uninsured – Patients for whom there is not a third party responsible for all or any portion of their medical expenses.

P. Uninsured Discount – The flat-rate discount applied to eligible Gross Charges for Uninsured patients. This discount rate is set by the Facility.

VI. Corporate Financial Assistance Policy and Procedures

A. Financial Assistance: Charity Care Discount

i. **Policy.** Each Facility should have a Charity Care Discount approved and signed by the Facility Chief Financial Officer, the Vice-President of Revenue Cycle and the Regional Vice-President that establishes the Charity Care Discount available at the Facility, attached as **Appendix B**. If the Facility changes the Charity Care Discount they offer, a revised **Appendix B** should be issued and signed by the Facility's Chief Financial Officer, the Vice President of Revenue Cycle and Regional Vice-President. The Facility should retain a copy of the signed Facility Charity Care Discount policy. The Facility Charity Care Discount will be reviewed annually.

ii. **Eligible Services.** Emergency Services and Medically Necessary Care may be eligible for a Charity Care Discount, depending on other eligibility criteria set forth below. Services that are elective, non-medically necessary and/or cosmetic services are not generally eligible for the Charity Care Discount at the Facility; however, the Facility CFO or Shared Services Center ("SSC") may approve application of the Charity Care Discount for such services on a case-by-case basis.

iii. **Charity Care Discount**. The Facility offers a Charity Care Discount off the entire bill or on a sliding scale basis, as described in **Appendix B**, if the patient meets the applicable eligibility criteria identified below. More information on the Facility's Charity Care Discount is found in **Appendix B**.

iv. **Charity Care Discount Program Eligibility and Administration.**

1. A patient may be eligible for a Charity Care Discount after Facility evaluation of the FAP Application or through the Facility's presumptive eligibility screening process described below, if applicable, to determine whether the patient has an adjusted individual or household gross income[1] that falls within a specified percentage of the current Federal Poverty Level (FPL) Guidelines established by the Department of Health and Human Services, attached as **Appendix A**, which must be updated annually by the Facility, as described by each Facility in **Appendix B.** However, a patient must cooperate with the Facility in providing the information and documentation necessary to determine eligibility.

2. Presumptive Eligibility Screening.[2][3] Facilities may provide presumptive eligibility screening services for Uninsured patients screened for potential Medicaid eligibility as well as coverage by other sources, including other governmental programs, who do not appear to qualify for coverage under any program to evaluate the patient's eligibility to receive a Charity Care Discount under the Facility's Financial Assistance Program ("Presumptive Eligibility"). For Facilities that offer Presumptive Eligibility, the Facility should screen eligible patients using a health care industry-recognized predictive model based on public record databases to evaluate a patient's adjusted family gross income under current FPL Guidelines, attached as **Appendix A**. Information from the predictive model is used to satisfy the documentation requirements required in the FAP Application process for a Charity Care Discount.

    a. A patient is deemed eligible for a Charity Care Discount through the Facility's Presumptive Eligibility screening process if the patient,
        (1) Is Uninsured;
        (2) Received or is scheduled to receive Medically Necessary Care;
        (3) Is not eligible for Medicare/ Medicaid, or is not pending Medicare/Medicaid approval; or is not presumed to qualify for Medicare/Medicaid;
        (4) Has financial criteria that falls within a specified percentage of the FPL Guidelines established by the Department of Health and Human Services for the patient's applicable family size, as described by each Facility in **Appendix B**; and
        (5) Did not agree prior to rendering of healthcare services to pay a specific dollar amount for the services provided as a special arrangement.

    b. If the patient is determined to be eligible for a Charity Care Discount through Presumptive Eligibility, the patient's account should be flagged and the applicable Charity Care Discount should be administered based on the discount percentages described in **Appendix B**. For accounts flagged, the Facility must notify the patient of the determination in states where it is required. Notification will include the option to decline the Charity Care Discount.

    c. Where state regulations require the submission of an application, facilities located in those states will not be able to determine patient eligibility on the basis of Presumptive Eligibility. Rather, a FAP

[1] Household consists of the patient, spouse and all legal dependents. If the patient is a minor or legal dependent, the family gross income will include parent(s), legal guardian(s) and/or the taxpayer claiming the patient as a dependent for income tax purposes.
[2] Charity Care based on Presumptive Eligibility is not available at every Facility and is not available for Facilities located in Florida based on state law. Whether the Facility offers Presumptive Eligibility will be identified on **Appendix B.**
[3] Presumptive Eligibility Screening is not available for patients between the ages of 19-23 as they may be eligible to qualify as a dependent for tax purposes. However, such individuals will still be eligible to apply for Charity Care through the FAP Application process and may be eligible for other discounts offered under this Policy.

Application must be provided to the patient or responsible party and returned completed prior to any write-off transaction being applied to the account.

d. Accounts flagged as presumptive Charity Care may be subject to a verification review if a payment of $200 or more was made on the patient's account prior to receipt of the Charity Care Discount. The purpose of the review is to verify the presumptive charity status through additional documentation. Patients whose accounts are subject to a charity care verification review must complete Facility's FAP application to be eligible for a Charity Care Discount.

e. If a patient does not meet the Presumptive Eligibility criteria, or if the patient presumptively qualifies for a partial discount, the patient will still have an opportunity to qualify for a Charity Care Discount through the FAP Application process or if the patient meets the definition of Medical Indigency.

f. Patients eligible for Medicare <u>must</u> complete and submit a Financial Assistance Application and an Asset Test in order to qualify for a Charity Care Discount for benefits not covered by Medicare.

3. <u>FAP Application Process</u>. A patient may have an opportunity to qualify for a Charity Care Discount through the FAP Application process set forth below. Generally, patients may apply for a Charity Care Discount at the time of service or any time after care is provided during their billing cycle. The FAP Application and Asset Test request information from the patient that allows the Facility to evaluate a patient's adjusted family gross income under current FPL Guidelines, attached as **<u>Appendix A</u>**.

   a. All patients who wish to apply for a Charity Care Discount or are identified as a possible candidate for a Charity Care Discount will have a FAP Application made available to them. A Facility may also post the FAP Application on its website to make it available to the community.

   b. A patient who wishes to apply for a Charity Care Discount must provide adequate documentation, as outlined below, supporting their financial income and expenses to be considered for charity care.

   c. For Uninsured patients, a patient is deemed eligible for a Charity Care Discount after Facility evaluation of the FAP Application if the patient,
      (1) Received or is scheduled to receive Medically Necessary Care;
      (2) Has financial criteria that falls within a specified percentage of the FPL Guidelines, as described in Facility's **<u>Appendix B</u>**; *<u>and</u>*
      (3) Financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to the Facility's patient Asset Test.

   d. For Insured patients, a patient is deemed eligible for a Charity Care Discount applied to the Balance Due that exceeds $1,500 after Facility evaluation of the FAP Application if the patient,
      (1) Received Emergency Services;
      (2) Has financial criteria that falls within a specified percentage of the FPL Guidelines, as described in Facility's **<u>Appendix B</u>**; *<u>and</u>*
      (3) Financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to the Facility's patient Asset Test.

e. Medical Indigency. Patients who are not deemed eligible for a Charity Discount based on the above criteria may still be eligible to receive a Charity Care Discount if the patient meets the definition of Medical Indigency with a Balance Due that exceeds a specified percentage of the patient's annual gross income determined through the application process, as described in Facility's **Appendix B**.

f. The FAP Application must be provided to the patient or responsible party, completed and returned prior to any write-off transaction being applied to the account.

g. In states where it is required, the Facility must notify the patient of the determination of whether the patient qualified for the Charity Care Discount. Notification will include the option to decline the Charity Care Discount.

4. A patient who is deemed not eligible for a Charity Care Discount may be considered for other assistance under the Financial Assistance program, as set forth below, or may qualify for discounts available at the Facility that are not part of the Financial Assistance Program on a case-by-case basis, for example, as set forth in the Facility's Special Insurance and Patient Settlements Policy. Please consult the Facility CFO or SSC for additional information.

5. Criteria for Evaluating FAP Applications.

   a. The FAP Application will request for the following financial information related to the patient:
      (1) A copy of the last four pay checks stubs;
      (2) Prior year Federal 1040 tax return;
      (3) Unemployment benefits (check stubs);
      (4) Social Security benefits (copy of check or letter from Social Security);
      (5) Department of Social Services grants and/or amount of food stamps;
      (6) List of personal expenses, including but not limited to rent, house payment, utilities, car payment, insurance, food, etc.; and/or
      (7) Other documents needed to verify Assets to determine eligibility.

   b. However, there may be additional state-specific requirements that must be addressed in the Facility FAP Application. The Facility's FAP Application is found in **Appendix C.**

   c. **Tax Filings.** Where the patient/guarantor indicates they do not file federal tax returns, the Facility will request that the patient/guarantor complete IRS Form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the Facility has completed lines 6-9. The Facility will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, the Facility will enter prior year and prior 3 years. A copy of the IRS Form 4506-T is attached hereto as **Appendix D**.

   d. **Asset Test.** Applying the Asset Test, a patient with Assets that exceed 400% of the FPL or have $100,000 or more in eligible or liquid Assets (i.e. cash, bonds, certificates of deposit), for the guarantor or patient may not be eligible for the Charity Care Discount. The Facility Chief Financial Officer and Patient Access Director along with the Shared Service Center (SSC) will determine the amount due if the patient's liquid assets exceed $100,000.

e. Patients will initially be given thirty (30) days to complete and return the FAP Application and all necessary documentation to the Facility or the SSC. The FAP Application will be sent to the Facility financial counselor or SSC designated director for final determination.

6. Information Not Available.

   a. A patient who is unable to provide the above-mentioned documentation to support a non-presumptive charity care eligibility determination must contact the Facility or the SSC to discuss other available evidence that may demonstrate eligibility. Notarized letters from family members, neighbors, etc. stating or certifying the patient has no income or other financial resources are not considered adequate documentation.

   b. Accounts for which complete documentation is not received will be returned to the normal self-pay collections workflow.

   c. The patient's account predictive scoring may be an option for additional consideration at the discretion of the Facility Chief Financial Officer or SSC VP.

7. Incomplete Information.

   a. A patient should be notified in-person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within thirty (30) days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.

   b. Applications that remain incomplete after thirty (30) days from the date the notice was mailed may result in denial of application.

   c. The application may be reopened and reconsidered once the required information is received.

8. Denial.

   a. A patient or guarantor who applied for a Charity Care Discount but was denied may be informed in writing that their request for a Charity Care Discount was denied. A Facility must inform the patient or guarantor of the denial if required by state law.[4]

   b. The patient or guarantor may appeal the determination of eligibility for financial assistance by providing additional information or verification that you believe will impact this decision within thirty (30) days receipt of notification of denial. Following this evaluation, written notification of the determination from that reconsideration will be provided to the patient/ guarantor.

9. Processing Procedures:

   a. Once the eligibility determination is made, the results will be documented in the comments section on the patient's account and the completed and approved FAP Application will be filed attached to the adjustment sheet and maintained for audit purposes. Documentation of the approval and account

[4] Notification of the patient's eligibility for a Charity Care Discount under the Facility's Financial Assistance Program is required in New Mexico, Pennsylvania, and Texas.

adjustment will be determined by the Facility in accordance with the CHSPSC, LLC financial policy for approving adjustments.

b. Once approved for Financial Assistance, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self-pay.

10. Notification of Approval. Some states may require that a Facility notify patients who have been approved for a Charity Care Discount. A Facility must attempt to notify every patient who has been approved for a Charity Care Discount in writing, if required by state law where the Facility is located.

11. Length of Eligibility.

    a. The patient's account status will never be permanently designated as eligible for a Charity Care Discount; rather the patient's status will be reviewed every three (3) months. This means that a patient's eligibility determination remains effective for three (3) months, during which other accounts belonging to the same patient may be added to the previous approval, if requested by the patient. The Facility may require a new FAP Application or presumptive qualifications evaluation once the three (3) month period of eligibility expires, measured from the date of approval. The Facility may also require a new FAP Application or presumptive qualifications evaluation within the three (3) month period, if a patient's financial situation appears to or is suspected to have changed.

    b. A patient's Charity Care Discount may be revoked, rescinded or amended if,
        (1) A patient received the discount due to circumstances which undermines the Financial Assistance Program;
        (2) Other payment sources are identified after receiving the Charity Care Discount; or
        (3) A change in healthcare insurance coverage is identified after receiving the Charity Care Discount.

12. Out-of-State Medicaid Recipient.

    a. Patients covered by out-of-state Medicaid where the Facility and/or the ordering/providing physician are not authorized providers will be eligible for charity care upon verification of Medicaid coverage for the service dates since they will be considered uninsured. No other documents will be required in order to approve the FAP Application. The patient will not be required to make a formal FAP Application. The Facility may submit the application and verification of Medicaid coverage as proof of qualification.

13. Medicaid Eligibility with Limited Coverage

    Patients who are eligible for Medicaid coverage but have medically necessary services that are excluded from coverage due to "spell of illness" or other Medicaid benefit limitations will be eligible for charity upon verification of Medicaid coverage for the service dates. No other documents will be required in order to approve the FAP Application. The patient will not be required to make a formal FAP Application. The Facility may submit the application and verification of Medicaid coverage as proof of qualification.
    If it is determined that a patients' Medicaid coverage has more generous eligibility limits than the Facility financial assistance policy, then additional verification of the patient's income may be performed before

making a charity care eligibility determination.

v. **Collection Efforts.**

1. All collection efforts should be suspended if the patient has submitted a complete FAP Application and all accompanying documentation. Collection efforts should be suspended until a final eligibility determination is made. However, if the FAP and / or accompanying documentation are incomplete, collection efforts and statement processing will continue until all the required documentation is received.

2. If a patient is awarded a 100% balance adjustment under the Policy, collections efforts will cease. However, if the patient is awarded a sliding scale adjustment that is less than 100%, collections efforts and statement processing may resume for the remaining balance not adjusted under the Policy.

3. If a patient is awarded a Charity Care Discount, any deposits or payments received from the patient for that care must be refunded if the payments exceed any balance remaining after application of the all Financial Assistance discounts.

vi. **Publicity of Charity Care.**

1. At the time of service, all patients should be notified of the possibility of a Charity Care Discount under the Facility Financial Assistance Program.

2. An opportunity to complete a FAP Application should be given to all patients who wish to apply for a Charity Care Discount or have been recommended by practice staff, a physician or a financial counselor for a Charity Care Discount.

3. A patient may request a FAP Application in-person, by phone, by mail, or by accessing the electronic version via the Facility's website, if available. Copies of the policy, application forms, and instructions should be made available free of charge.

4. Patients should be provided a written notice with their bill that contains information regarding the Charity Care Discount including information about applying for charity care and contact information for the Business Office where the patient may obtain further information about this and other Financial Assistance available under this policy.

5. Information about the Charity Care Discount should be posted in languages representative of the Facility's patient demographics and in conspicuous places, including but not limited to posting notices in the emergency rooms, urgent care centers, admitting and registration departments, business offices and patient financial services offices that are located at the Facility. Facilities must consult state law to determine additional notice and publication requirements.

6. Any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with EMTALA and all applicable state and federal regulations.

B. Financial Assistance: Uninsured Discount

i. **Policy.** Each Facility should have an Uninsured Discount policy that is approved and signed by the Facility's Chief Financial Officer, the Vice-President of Revenue Cycle and the Regional Vice-President that establishes the Uninsured Discount available at the Facility, attached here as **Appendix E**. If the Facility changes the percentage of Uninsured Discount they offer, a revised **Appendix E** should be issued and signed by the Facility's Chief Financial Officer, Vice President of Revenue Cycle and Regional Vice-President. The Facility should retain a copy of the signed Facility Uninsured Discount policy. The Facility Uninsured Discount will be reviewed annually.

ii. The Uninsured Discount rate will be determined at the Facility level and identified on **Appendix E**. If the state where the Facility is located has specific guidelines for Uninsured discounts, the Facility should follow the state guidelines.

iii. **Eligibility.** The Uninsured Discount applies to Uninsured patients.

1. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:

    a. The patient's insurance does not cover a portion or all of the services and treatment rendered during a patient visit; or

    b. The patient's applicable benefits have been exhausted.

iv. **Patient Account System.**

1. The Uninsured Discount is set up in all Facilities to apply prior to the time of the final bill. The Uninsured Discount will be applied at the time when the Facility is able to identify and classify a patient as Self-Pay/Uninsured.

2. SSC personnel will load the approved discount percentages into the respective patient account systems for processing account adjustments at the time of final billing. Should a manual adjustment be necessary as required by this policy, the adjustment will be submitted through the standard SSC adjustment process for completion. Uninsured discount adjustments from personnel outside of the SSC are prohibited.

3. The Uninsured Discount is posted when the final bill is produced.

4. Each host system has specific transaction codes to identify the Uninsured Discount; these are automatically posted at time of final bill or are applied manually, as needed.

5. There should be one (1) financial class associated with the Uninsured Discount policy: Uninsured/Self-Pay. A patient's bill will reflect any and all applicable discounts, including the Uninsured Discount, based on patient classification.

v. **Insurance Coverage on Patients classified as Self-Pay/Uninsured.**

1. If after the Uninsured Discount is credited to a patient account and it is determined that the patient has adequate insurance within timely filing limitations, the payor should be added to the account and the account should be billed. The Uninsured Discount should be reversed by manual adjustment or automatically through the system if the patient's benefits cover the billed services.

2. The revenue will be "reclassified" from self-pay to the new insurance financial class.

3. An Uninsured Discount should be reversed using the Uninsured Discount code. A Prompt Pay Discount transaction code may not be used to reverse the Uninsured Discount.

C. Financial Assistance: Catastrophic Claim Discount

i. **Policy.**

1. Each Facility should have a Catastrophic Claim Discount policy that is approved and signed by the Facility's Chief Financial Officer, the Vice-President of Revenue Cycle and the Regional Vice-President that establishes the Catastrophic Claim Discount available at the Facility, attached here as **Appendix F**. If the Facility changes the percentage of Catastrophic Claim Discount they offer, a revised **Appendix F** should be issued and signed by the Facility's Chief Financial Officer, Vice President of Revenue Cycle and Regional Vice-President. The Facility should retain a copy of the signed Facility Catastrophic Claim policy. The Facility Catastrophic Care Discount will be reviewed annually.

2. The Catastrophic Claim Discount will be determined at the Facility level and identified on **Appendix F**. If the state where the Facility is located has specific guidelines that encompass the Catastrophic Claim Discount, the Facility should follow the state guidelines.

ii. **Eligibility.**

1. The Catastrophic Claim Discount only applies to Uninsured patients with a Catastrophic Claim. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:

a. The patient's insurance does not cover a portion or all of the services and treatment rendered during a patient visit; or

b. The patient's applicable benefits have been exhausted.

Appendix A

The 2025 poverty guidelines are in effect as of January 17, 2025, as published by the Department of Health and Human Services on its website: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

2025 POVERTY GUIDELINES FOR THE 48 CONTINIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,1508
For families/households with more than 8 persons, add $5,500 for each additional person.	
2025 Poverty Guidelines for Alaska	
Persons in family/household	**Poverty guideline**
1	$19,550
2	$26,430
3	$33,310
4	$40,190
5	$47,070
6	$53,950
7	$60,830
8	$67,710
For families/households with more than 8 persons, add $6,880 for each additional person.	

Appendix B

Lower Keys Medical Center's Charity Care Discount

[IF FACILITY PARTICIPATES IN ANY STATE, COUNTY OR HOSPITAL DISTRICT INDIGENT CARE OR CHARITY PROGRAM AND/OR PROVIDES PRESUMPTIVE ELIGIBILITY, FACILITY MUST ADAPT THE BELOW AND INCLUDE ANY STATE, COUNTY OR HOSPITAL DISTRICT OR PRESUMPTIVE ELIGIBILITY REQUIREMENTS AS APPROPRIATE]

As a service to our community, we participate in [INSERT STATE and/or COUNTY INDIGENT PROGRAMS WHERE APPLICABLE], and we offer a Charity Care Discount that applies a discount of the entire bill or on a sliding scale basis to patients eligible under our Financial Assistance Program ("FAP") who receive or are scheduled to receive Emergency and Medically Necessary services at our facility. The level of discount provided to eligible patients under our Charity Care Discount policy will depend on several criteria, including (a) whether the patient meets the eligibility criteria for the Charity Care Discount under the FAP, (b) whether the patient has other funding sources that can be applied to the patient account, (c) validation of the patient's gross family household income, and/or (d) whether the patient's income falls within a certain percentage of the current Federal Poverty Level ("FPL") Guidelines published by the Department of Health and Human Services at the time of evaluation, as further described below.

Uninsured Patients

An Uninsured patient who has received or is scheduled to receive Emergency and Medically Necessary services may apply for a Charity Care Discount by submitting a complete FAP Application and all accompanying documentation requested on the FAP Application as part of our Asset Test to determine whether the patient's income falls within one of the below percentages of the current FPL, as validated through the FAP Application process and Asset Test under our FAP.[However, we recognize that not all patients and guarantors are able to complete the FAP Application or provide requisite documentation. Accordingly, we also provide certain screening services using a health care industry-recognized predictive model based on public record databases to evaluate a patient's adjusted individual or family gross income under current FPL Guidelines, as part of our eligibility screening services offered to Uninsured patients at our facility ("Presumptive Eligibility"). Information from the predictive model is used to satisfy the documentation requirements required in the FAP Application process for a Charity Care Discount.]

- Eligible patients with an adjusted individual or family gross income at or below 100% of the FPL may receive a balance adjustment of the entire bill, if their financial status is validated using documentation provided by the patient in the FAP Application process [or through the Presumptive Eligibility process].

- Eligible patients with an adjusted individual or family gross income of 101%-200% of the FPL may receive a balance adjustment of the entire bill, if their financial status is validated using documentation provided by the patient in the FAP Application process[, or 90% of their bill, if the patient's financial status is validated through the Presumptive Eligibility process. **Note: Income levels between 101% and 200% require completion and submission of an FAP Application to receive an adjustment for the entire bill]**.

- Eligible Patients with an adjusted individual or family gross income of 201%-300% of the FPL may receive a balance adjustment of 85% of their bill, if their financial status is validated using documentation provided by the patient in the FAP Application process [or through the Presumptive Eligibility process].

- Patients with an adjusted individual or family gross income of 301%-400% will receive a balance adjustment of 80% of their bill, if their financial status is validated using documentation provided by the patient in the FAP Application process or through the Presumptive Eligibility Process.

If an Uninsured patient qualifies for a partial discount based on gross family income validated through the Presumptive Eligibility process, the patient will still have an opportunity to qualify for a greater discount under the Charity Care Discount through the FAP Application process.

Insured Patients

We recognize that some patients may have public or private insurance coverage that fails to fully cover their medical expenses for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for the care received. Accordingly, we have expanded our Charity Care Discount policy to apply to accounts for which other payment or funding sources exist, including Medicare benefits, if the patient's income falls within a certain percentage of the current FPL; however, the patient's adjusted individual or family gross income must be validated through the FAP Application process and Asset Test under our FAP.

- Eligible patients with an adjusted individual or family gross income at or below 100% of the FPL will receive a balance adjustment of the entire Balance Due on the patient's account that is greater than $1,500.
- Eligible patients with an adjusted individual or family gross income of 101%-200% of the FPL will receive a balance adjustment of 50% of the Balance Due on the patient's account that is greater than $1,500.
- Eligible patients with an adjusted individual or family gross income of 201%-400% of the FPL will receive a balance adjustment of 20% of the Balance Due on the patient's account that is greater than $1,500.

Medical Indigency

Additionally, we have expanded our Charity Care Discount to patients who may exceed 400% of the FPL who meet our Medical Indigency criteria. Patients for whom the Balance Due on the patient's account exceeds 25% of the patient's annual gross income (after payment by third party payors) may receive a balance adjustment of 80% of the Balance Due.

Edna Buffington

Vice President, Revenue Cycle, CHSPSC, LLC

David Shan Carpenter

Regional Vice-President, CHSPSC, LLC

Christina Wright

Lower Keys Medical Center Chief Financial Officer

2025-04-22

Date

Appendix C

Form **4506-T** (June 2023)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	1b **First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ►

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

/ / | / / | / / | / / | / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► **Signature** (see instructions) | Date

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature** | Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 37667N Form **4506-T** (Rev. 6-2023)

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t*. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

The filing location for the Form 4506-T has changed. **Please see Chart for individual transcripts or Chart for all other transcripts** for the correct mailing location.

What's New. As part of its ongoing efforts to protect taxpayer data, the Internal Revenue Service announced that in July 2019, it will stop all third-party mailings of requested transcripts. After this date masked Tax Transcripts will only be mailed to the taxpayer's address of record.

If a third-party is unable to accept a Tax Transcript mailed to the taxpayer, they may either contract with an existing IVES participant or become an IVES participant themselves. For additional information about the IVES program, go to *www.irs.gov* and search IVES.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506-T to request tax return information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Customer File Number. The transcripts provided by the IRS have been modified to protect taxpayers' privacy. Transcripts only display partial personal information, such as the last four digits of the taxpayer's Social Security Number. Full financial and tax information, such as wages and taxable income, are shown on the transcript.

An optional Customer File Number field is available to use when requesting a transcript. This number will print on the transcript. See Line 5 instructions for specific requirements. The customer file number is an optional field and not required.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart shows two different addresses, send your request to the address based on the address of your most recent return.

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 5. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number **should not** contain an SSN. Completion of this line is not required.

Note. If you use an SSN, name or combination of both, we will not input the information and the customer file number will reflect a generic entry of "999999999" on the transcript.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.*

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 855-587-9604
Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094

Appendix D

Lower Keys Medical Center's FAP Application

Financial Assistance Program Application

NPMR

Financial Assistance Program Application

Our hospital is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for Financial Assistance. Please complete and return the following form with requested documents to the Facility Registration Department or Financial Counselor to be evaluated for Financial Assistance.

Patient Account(s) #: _____ Date of Application: _____

# of Qualified Household Members: _____ Dependent of Another: ☐ Yes ☐ No

(A Qualified Household Member includes any additional adult(s) and dependent(s) based on the tax filing status of the patient.)

PATIENT INFORMATION

Name: _____
Address: _____
City: _____
State/Zip: _____
SSN (last 4 digits): __ __ __ __
DOB: _____
Employer: _____
Address: _____
City: _____
State/Zip: _____
Work Phone: _____
Cell Phone: _____
Length of Employment: _____
Supervisor: _____

PARENT/GUARANTOR/SPOUSE

Name: _____
Address: _____
City: _____
State/Zip: _____
SSN (last 4 digits): __ __ __ __
DOB: _____
Employer: _____
Address: _____
City: _____
State/Zip: _____
Work Phone: _____
Cell Phone: _____
Length of Employment: _____
Supervisor: _____

RESOURCES

Checking: ☐ Yes ☐ No Amount: $_____
Savings (including flexible spending and health savings accounts): ☐ Yes ☐ No Amount: $_____
Bonds: $_____
Cash on Hand: $ _____
Certificate of Deposit(s): $ _____
IRA Account(s): $ _____
Roth Account(s): $ _____
Stock/Other Financial Investment Account(s) (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)): $ _____
Trust Fund Account(s): $_____

Vehicle 1: Yr:_____ Make:_____ Model:_____
Vehicle 2: Yr:_____ Make:_____ Model:_____
Vehicle 3: Yr:_____ Make:_____ Model:_____
Vehicle 4: Yr:_____ Make:_____ Model:_____
Vehicle 5: Yr:_____ Make:_____ Model:_____
(This includes recreational vehicles such as: boats, campers, etc.)

Patient Label

INCOME

Patient/Guarantor Wages (monthly): $_____

Spouse/Second Parent Wages (monthly): $_____

Other Income

Child Support: $_____
VA Benefits: $ _____
Workers Comp: $_____
SSI: $_____

Other Income

Child Support: $_____
VA Benefits: $ _____
Workers Comp: $_____
SSI: $_____

LIVING ARRANGEMENTS

Primary Residence:

☐ Rent: $_____ ☐ Own: $_____ ☐ Other (explain): $_____

Landlord/Mortgage Holder: _____

Phone Number: _____ Monthly Payment: $_____

Second Home/Other Property: ☐ Rent: _____ ☐ Own: _____ (check one)

Value: $_____ Loan Amount: $_____ Payment: $_____

House Rent/Mortgage Payment: $_____

Other Property Payment: $_____

Utilities: $ _____ Gas: $ _____

Auto: $ _____ Loans: $_____

Medical Bills: $_____ Food: $_____

Child Support: $_____ Other: $ _____

REQUESTED AVAILABLE DOCUMENTS

Proof of Income:

☐ Last 4 paystubs
☐ Letter from employer
☐ Social Security benefits (if applicable)
☐ Last 3 months bank statements
☐ Previous year's Federal Tax Return

Proof of Expenses:

☐ Copy of mortgage payment OR
☐ Copy of rental agreement
☐ Other documents requested
☐ Copies of monthly bills

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in the denial of any financial assistance by the hospital.

Signature of Applicant: _____

Hospital Representative completing the application: _____

Financial Assistance Program Application
Not Part of the Medical Record
100-ADM-1202 03/21 (Rev. 08/21, 06/23) Page 2 of 3

Patient Label

Financial Assistance Approval Worksheet

Hospital Name:	Date Submitted:
Patient Name:	Account Number(s):
# in Household:	Balance Due:
Total Yearly Income:	Service: OP/IP/ER
Comments:	

Check box the appropriate financial assistance being offered by the hospital.

☐ YES Approved for 100% financial assistance

☐ YES Approved for partial financial assistance _____% assistance

☐ NO Patient does not qualify for financial assistance

Hospital Representative completing this review: _____

Approved by:

_____ _____

SSC Director Date SSC CFO/VP Date

_____ _____

CFO Date CEO Date

Financial Assistance Program Application
Not Part of the Medical Record
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Patient Label

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Appendix E
Lower Keys Medical Center's Uninsured Discount

Lower Keys Medical Center offers a discount of 65% from inpatient gross charges for all Uninsured patients eligible for the Uninsured Discount under this Policy

Lower Keys Medical Center offers a discount of 73% from outpatient gross charges for all Uninsured patients eligible for the Uninsured Discount under this Policy

Edna Buffington

Vice President, Revenue Cycle, CHSPSC, LLC

David Shan Carpenter

Regional Vice-President, CHSPSC, LLC

Christina Wright

Lower Keys Medical Center Chief Financial Officer

2025-04-22

Date

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Appendix F

Lower Keys Medical Center's Catastrophic Claim Discount

Lower Keys Medical Center offers a discount for patient accounts that meet the eligibility requirements for the Catastrophic Care Discount under this Policy. For eligible Uninsured patient accounts with balances of at least $50,000.00 after applying Lower Keys Medical Center's Uninsured Discount or a partial charity discount, the patient balance for a Catastrophic Claim will be reduced to a maximum patient responsibility of $50,000.

Edna Buffington

Vice President, Revenue Cycle, CHSPSC, LLC

David Shan Carpenter

Regional Vice-President, CHSPSC, LLC

Christina Wright

Lower Keys Medical Center Chief Financial Officer

2025-04-22

Date

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Audit trail

Details

FILE NAME	Lower Keys Medical Center Financial Assistance Policy 2025 - 4/22/25, 8:18 AM
STATUS	Signed
STATUS TIMESTAMP	2025/04/28 21:27:45 UTC

Activity

SENT	katrina_lintemuth2@chs.net **sent** a signature request to: • Edna Buffington (edna_buffington@chs.net) • Christina Wright (christina.wright@lkmc.com) • David Shan Carpenter (shan_carpenter@chs.net)	2025/04/22 13:19:21 UTC
SIGNED	**Signed** by David Shan Carpenter (shan_carpenter@chs.net)	2025/04/28 21:27:45 UTC
SIGNED	**Signed** by Edna Buffington (edna_buffington@chs.net)	2025/04/22 13:31:42 UTC
SIGNED	**Signed** by Christina Wright (christina.wright@lkmc.com)	2025/04/22 13:23:31 UTC
COMPLETED	This document has been signed by all signers and is **complete**	2025/04/28 21:27:45 UTC

The email address indicated above for each signer may be associated with a Google account, and may either be the primary email address or secondary email address associated with that account.