GRAND VIEW HEALTH
Sellersville, PA

FINANCIAL ASSISTANCE POLICY

Revised Effective July 1, 2016

POLICY

Grand View Health (GVH) grants consideration to each individual patient regarding his or her ability to pay for emergency and medically necessary health care.

SCOPE OF POLICY AND DISCOUNTS AVAILABLE

This Policy shall cover emergency and medically necessary health care services provided by GVH service lines. Patients residing within GVH's primary and secondary geographic service areas as defined on Schedule A *(attached)* are eligible for Financial Assistance in the form of a discount from charges as outlined in Schedule B *(attached).* Those persons residing outside of the GVH primary and secondary service areas are eligible for Financial Assistance in the form of a discount from charges in accordance with Schedule C *(attached).*

Attached to this policy as Schedule D *(attached)* is a complete list of providers, in addition to GVH itself, delivering emergency or other medically necessary care at GVH that specifies which providers are covered by this policy and which are not covered.

DEFINITIONS

AGB means amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage.

EMTALA means the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd.

Financial Assistance means either: (1) free care provided to patients who are uninsured/underinsured for the emergency and medically necessary service and who have family incomes not in excess of 200% of the Federal Poverty Level. *(See attached Schedules B & C);* or (2) discounts from charges afforded patients who are uninsured/underinsured for the relevant service and who have family incomes in excess of 200% but not exceeding 500% of the Federal Poverty Level. *(See attached Schedules B & C).*

Uninsured/ Underinsured Patient means an individual who lacks adequate health care insurance coverage through: (1) a third party insurer, (2) an ERISA plan, (3) a Federal or State Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), (4) Workers' Compensation, (5) Medical Savings Account or other coverage for all or any part of the pertinent bill, including claims against third parties covered by insurance to which a GVH entity is subrogated (if and when such payment is actually made by such insurance company).

COMMITMENT TO PROVIDE EMERGENCY MEDICAL CARE

GVH provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy. GVH will not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of emergency medical care. Emergency medical services, including emergency transfers, pursuant to EMTALA, are provided to all GVH patients in a non-discriminatory manner, pursuant to the GVH's EMTALA policy.

AVAILABILITY OF FINANCIAL ASSISTANCE WIDELY PUBLICIZED
Notification concerning the existence of GVH's Financial Assistance Policy *(Exhibit 5)* shall be posted on the GVH website and within the hospital and its service line sites which patients seek to obtain services, as well as offered to all patients at the time of their registration for services. GVH implements, as appropriate, additional measures to widely publicize the availability of financial assistance in the communities served.

ELIGIBLE SERVICES
Financial assistance is available to eligible patients for these services:

- Emergency medical services
- Medically necessary (not elective) services for urgent life-threatening conditions provided outside the Emergency Department
- Other medically necessary services as determined on a case-by-case basis

Financial assistance is not available for services such as:

- Services deemed "non-covered" by Medicare
- Services deemed not medically necessary by GVH, including but not limited to the following:
    - Cosmetic services
    - Elective services related to reproduction, such as in vitro fertilization or vasectomy/vasectomy reversal
    - Transplant surgery and related services
    - Bariatric (weight loss) surgery and related services
    - Complementary/alternative medicine services such as acupuncture
    - Routine eye examinations
    - Contact lenses, hearing aids, cochlear implants
    - Deep-brain stimulation
    - LDL apheresis

Financial assistance is also not available for services not provided directly by GVH (see Schedule D – Provider List).

ELIGIBILITY DETERMINATION
In addition to offering financial assistance information to all patients at the time of registration, for registered inpatient and outpatients GVH will also screen accounts in order to identify patient eligibility for Financial Assistance. This review and screening will occur both prospectively, at the time of admission or provision of services, and also during the course of patient account billing and insurance follow-up.

Consideration of patient eligibility for Financial Assistance may also occur upon the request of the patient or guarantor.

The Patient Financial Services staff will discuss the policy's potential applicability to the circumstances of that patient or prospective patient. Patient Financial Services staff will assist in obtaining government sponsored healthcare coverage and explain other payment options as appropriate.

PRESUMPTIVE ELIGIBILITY
There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources that could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, GVH may use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, a 100% write off of the account balance will be made. Presumptive eligibility may be determined on the basis of individual

life circumstances that may include:

1. State-funded prescription programs;

2. Homeless or received care from a homeless clinic;

3. Participation in Women, Infants and Children programs (WIC);

4. Food stamp eligibility;

5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/subsidized housing is provided as a valid address; and

8. Patient is deceased with no estate

APPLICATION PROCESS

In connection with determining eligibility for financial assistance, GVH requires that the patient complete a Financial Assistance Application and provide other financial information and documentation relevant to making a determination of financial eligibility. Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with GVH's procedures for obtaining financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

Once a patient or prospective patient is identified as potentially being eligible for Financial Assistance, the Patient Financial Services staff will provide to the patient or guarantor a notice of possible qualification for Financial Assistance *(Exhibit 1)* along with a Financial Assistance Application *(Exhibit 2)* and Documents Checklist *(Exhibit 3).* In order for a formal determination of Financial Assistance eligibility to be made, it is necessary for the patient (or guarantor) to provide any and all information being requested, including, but not limited to, demographic and financial information, as well as information documenting income resources, financial assets, and household expenses. The hospital will hold all such financial information in confidence and will use it only for the purpose of evaluating a patient's eligibility for Financial Assistance. The Patient Financial Services staff will provide assistance to those patients needing aid to complete the Financial Assistance Application and the Documents Checklist. Sign and Language Interpreters will be provided as warranted in accordance with Grand View Health policy.

The financial resources of a parent or guardian may be considered in determining the Financial Assistance eligibility of a patient who is a legal dependent.

Patients who do not provide adequate information necessary to assess their financial situation completely and accurately may be deemed ineligible to receive Financial Assistance discounts; however, this will not be a precondition to the timely provision of emergency and medically necessary treatment.
See Exhibit 3A for the letter sent to applicants providing incomplete data.

Patients currently eligible for Medical Assistance will be deemed indigent and may qualify for full Financial Assistance for outstanding claims for dates of service prior to their Medical Assistance eligibility date. Additional information may be required to determine the exact date of eligibility for retrospective Financial Assistance.

Applications for Financial Assistance falling outside of established guidelines and involving extraordinary circumstances may be considered with the documented approval of the Senior Vice President/Chief Financial Officer.

Patients may reapply at any time if their original application is denied and they feel their financial circumstances have changed.

All applicant encounters will be entered into the patient accounting or billing system and all application documentation will be scanned to the patient's account or maintained in a paper file.

PARTICIPATION

Patients qualifying for Financial Assistance may be granted a discount from charges of up to a 100%. Patients who are extended Financial Assistance in the form of a discount from charges of less than 100% will be afforded written notification of the level of discount to be provided, with the pertinent GVH bill being adjusted to reflect any such discount (Exhibit 4). Payment terms will be discussed and agreed upon with the patient or guarantor. Financial Assistance eligibility will be in effect for 180 (one hundred eighty) days. After 180 days, patients will be required to repeat the Financial Assistance application process for ongoing eligibility.

ACTIONS TAKEN IN THE EVENT OF NONPAYMENT

Collection of amounts due from patients receiving Financial Assistance shall be handled pursuant to the GVH Billing and Collection Policy. Members of the public may obtain a free copy of this separate policy from GVH via the Hospital Contact Information listed below.

CALCULATION OF FINANCIAL ASSISTANCE DISCOUNT

GVH personnel will utilize the Financial Assistance Calculation Worksheet *(Exhibit 6)* to calculate the level of discount to be afforded an uninsured/underinsured patient based upon the patient's household income, family size, financial assets, and household expenses. GVH shall use the GVH Financial Assistance Calculation of Financial Responsibility *(Schedules B & C)* when determining the level of Financial Assistance discounting to be provided the uninsured/underinsured patient. Ten percent of the applicant's Net Asset Value, as determined during the application process, shall be credited as income when determining Financial Assistance eligibility and the granting of any related Financial Assistance discount.

Following a determination of FAP-eligibility, a FAP-eligible individual will not be charged more than AGB for emergency or other medically necessary care. Thus, patients who qualify for a Financial Assistance discount will be responsible for the lesser of the calculated patient responsibility amount due or the average Medicare rate for the services provided. GVH will annually apply the "Look-Back" methodology which utilizes the Medicare fee-for-service population to determine the amounts generally billed (AGB) as a percentage of charges.

GVH calculates the AGB percentage and applies it, as appropriate, to the Financial Assistance account. The current AGB percentage may be obtained free of charge via the contact information listed below.

The calculation year for the AGB percentages will be January 1 through December 31 and the AGB percentage will be updated by January 31 of the following calendar year.

When a patient fails to qualify strictly on income guidelines, then monthly household and monthly medical expenses will be reviewed and considered by the Patient Financial Services staff. Fifty percent (50%) of documented household monthly expenses up to a maximum of $2,000.00 per month will be considered in determining eligibility. One hundred percent (100%) of monthly medical expenses will be considered by Patient Financial Services staff in determining eligibility.

ACCOUNTABILITY

GVH will review the Financial Assistance policy at least annually when the new Federal Poverty income limits are published. Annual audits will be completed to verify that applications are being handled fairly, respectfully, and consistently. The Financial Assistance policy will be reviewed annually with the Patient Financial Services staff and training needs will be addressed and provided, as necessary.

HOSPITAL CONTACT INFORMATION

Website: https://www.gvh.org/financial-assistance-gvh

Telephone: 215-453-4608

Mail or In Person:

Grand View Health
Patient Financial Services Department
Attention: Financial Assistance Representative
700 Lawn Avenue
Sellersville, PA 18960

SCHEDULE A

GVH PRIMARY SERVICE AREA (16 Zip Code Areas)

18915	Colmar
18917	Dublin
18041	East Greenville
18054	Green Lane
19438	Harleysville
19440	Hatfield
18927	Hilltown
19446	Lansdale
18932	Line Lexington
18073	Pennsburg
18944	Perkasie
18951	Quakertown
18076	Red Hill
18960	Sellersville
18964	Souderton
18969	Telford

GVH SECONDARY SERVICE AREA (19 Zip Code Areas)

19504	Barto
18913	Carversville
18914	Chalfont
19426	Collegeville
18036	Coopersburg
18901	Doylestown
18923	Fountainville
19435	Frederick
18056	Hereford
18930	Kintnersville
18934	Mechanicsville
18936	Montgomeryville
19454	North Wales
18942	Ottsville
18070	Palm
18074	Perkiomenville
18955	Richlandtown
19473	Schwenksville
19492	Zieglerville

CALCULATION OF FINANCIAL RESPONSIBILITY

FINANCIAL ASSISTANCE DETERMINATION

For Patients Residing **within** GVH's Primary or Secondary Service Areas

HOUSEHOLD INCOME	Household Size								% OF PATIENT LIABILITY DUE
	1	2	3	4	5	6	7	8	
Household income ≤ 200% of HSS Poverty Income	$30,120	$40,880	$51,640	$62,400	$73,160	$83,920	$94,680	$105,440	0%
Household income ≤ 300% of HSS Poverty Income	$45,180	$61,320	$77,460	$93,600	$109,740	$125,880	$142,020	$158,160	5%
Household income ≤ 400% of HSS Poverty Income	$60,240	$81,760	$103,280	$124,800	$146,320	$167,840	$189,360	$210,880	10%
Household income ≤ 500% of HSS Poverty Income	$75,300	$102,200	$129,100	$156,000	$182,900	$209,800	$236,700	$263,600	20%

* Income Guidelines as Published in the Federal Register on January 21, 2024.

Patients who qualify for a charity care discount will be responsible for the lesser of the calculated patient responsibility amount due or the comparable Medicare rate as per the "Look Back" method outlined on page three for the services provided.

CALCULATION OF FINANCIAL RESPONSIBILITY

FINANCIAL ASSISTANCE DETERMINATION

FOR PATIENTS RESIDING **OUTSIDE** PRIMARY OR SECONDARY AREAS

HOUSEHOLD INCOME	Household Size								% OF PATIENT LIABILITY DUE
	1	2	3	4	5	6	7	8	
Household income ≤ 200% of HSS Poverty Income	$30,120	$40,880	$51,640	$62,400	$73,160	$83,920	$94,680	$105,440	0%
Household income ≤ 300% of HSS Poverty Income	$45,180	$61,320	$77,460	$93,600	$109,740	$125,880	$142,020	$158,160	10%
Household income ≤ 400% of HSS Poverty Income	$60,240	$81,760	$103,280	$124,800	$146,320	$167,840	$189,360	$210,880	20%

* Income Guidelines as Published in the Federal Register on January 21, 2024.

Patients who qualify for a charity care discount will be responsible for the lesser of the calculated patient responsibility amount due or the comparable Medicare rate as per the "Look Back" method outlined on page three for the services provided.

SCHEDULE D

PROVIDER LIST

Set forth below is a complete list of providers, in addition to GVH itself, delivering emergency or other medically necessary care at GVH that specifies which providers are covered by the Financial Assistance Policy and which are not covered:

PROVIDERS COVERED BY GVH FINANCIAL ASSISTANCE POLICY:

Not all services rendered by the following providers are covered by the GVH Financial Assistance Policy. Please refer to the "Eligible Services" section of the policy for additional information.

Grand View Health Providers listed on the following website:
https://www.gvh.org/locations/grand-view-medical-practices/

Grand View Home Care
Grand View Hospice
Grand View Palliative Care
Grand View Medical Company
Grand View Health Emergency Medical Services Medic 151
Grand View Sports Medicine

PROVIDERS NOT COVERED BY GVH FINANCIAL ASSISTANCE POLICY:

All other physicians listed on the following website, *OTHER THAN*, the Grand View Health Providers:
https://www.gvh.org/find-a-physician/

Exhibit 1

[date]

[name]
[street]
[city, state, zip code]

Dear [name]:

Based upon our review/your request and consistent with our Financial Assistance Policy, your account has been identified as one that may qualify for reduction of the balance owed.

In order for Grand View Health to fully evaluate your eligibility under this policy, it is necessary that you complete and return the enclosed application, along with the information requested. Grand View Health requires your cooperation with this request as incomplete applications will not be considered. Grand View Health staff is available to assist you with this process and can also assist you in determining eligibility for any government programs.

Please forward all requested information to the Hospital Patient Financial Services Department within the next 30 days. Our office is open every day, except holidays as follows:

Monday through Friday:	8:30 a.m. to 4:45 p.m.
Saturday & Sunday	8:00 a.m. to 4:15 p.m.

If you have any questions or concerns, please feel free to contact us.

Sincerely,

[name]
Patient Financial Services Department
215-453-4608

Enclosures

Exhibit 2

GRAND VIEW HEALTH

FINANCIAL ASSISTANCE APPLICATION

Please complete all questions in this section. Failure to complete this section could result in delays in evaluating eligibility for financial assistance.

Patient Information

Patient Name_____ Date of Birth: _____

Patient Social Security Number: _____

Street Address _____

City/State/Zip: _____

Home Telephone:_____ Work Telephone: _____

Current Health Insurance Company Name: _____

Policy Number:_____ Group Name/Number: _____

Household Members

Please attach additional sheets of paper if household has more than eight members.

Name:	Relationship:	Age:
1.	Self	
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Exhibit 2
(Continued)

Monthly Household Income

Wages/Salaries (Before Taxes):_____ Pensions: _____

Social Security:_____ Other Disability: _____

SSI:_____ Cash Assistance: _____

Unemployment Compensation: Worker's Compensation:

Child Support:_____ Spousal Support: _____

Veteran's Administration (VA) Benefits: _____

Other Unearned Income (*includes Trusts, Interest/Dividends, etc.):* _____

_____

_____

Household Countable Resources:

Please list your available accounts and liquid assets for your household. A liquid asset is defined as cash or any type of negotiable asset that can be converted quickly and easily into cash. Do not include your home, household items, vehicles, IRAs, 401(k) accounts and other non-liquid assets.

Certificates of Deposit:_____ Stocks or Bonds: _____

Trust Fund:_____ Savings Account: _____

Checking Account:_____ Savings Certificates: _____

U.S. Saving Bonds:_____ Christmas or Vacation Club: _____

Health Savings Account (HSA) Funds: _____

Other *(Please Explain)*: _____

Exhibit 2
(Continued)

Monthly Household Expenses

Please answer the questions below to provide a better understanding of your ability to pay for medical care. Higher-than-average or otherwise unusual expenses may result in an adjustment if income downward. Lower-than-average expenses will not result in an adjustment of income upward.

Mortgage/Rent:_____ Property Taxes: _____

Insurance:_____ Auto Loan: _____

Credit Cards (*Total*):_____ Water: _____

Gas:_____ Oil: _____

Electric:_____ Telephone: _____

Child Support:_____ Spousal Support: _____

Health Savings Account (HSA) Contributions: _____

Other *(Please Explain)*: _____

Monthly Medical Expenses

Insurance Premiums:_____ Equipment: _____

Doctors' Visits: Prescriptions:

Other *(Please Explain)*: _____

Exhibit 3

GRAND VIEW HEALTH

Verification of Income, Countable Resources & Household Expenses

Please attach proof of income from the past 30 days, your monthly household expenses, and current resources to this application. Please verify all income, expenses and resources listed in Exhibit 2. If you are unable to verify some or all of your income, expenses, or resources, please explain why on an attached sheet of paper. Applications will not be rejected for inability to verify income, expenses, or resources, provided that reasonable explanation for the inability is given. Acceptable sources of verification include, but are not limited to:

- □ Pay stubs or letters from employers, listing wages before taxes.
- □ Award letters or bank statements showing deposits of Social Security, other disability, pension, worker's compensation, or unemployment compensation payments.
- □ Award letters, court documents, or bank statements showing deposits of child or spousal support payments.
- □ Documentation of other sources of income
- □ If the household has no income, letters from persons who are assisting with daily living needs, explaining the help that the persons provide (e.g., grocery purchases or rent and utility payments).
- □ Health Savings Account (HSA) and other dedicated account statements.
- □ Checking and Savings account statements.
- □ Copy of Health Insurance Card(s), if applicable.

Expenses

- □ Bills or statements for any expenses you have listed.

Certification

Please sign and return the completed application with the items listed above.

I certify that the information contained in this application is true and complete. I understand that willful falsification of information contained in this application will result in denial of financial assistance.

Signed:_____ Dated: _____

Exhibit 3A

[Date]

[Name]
[Street]
[City, State, Zip Code]

Dear [Name]:

Thank you for your application for financial assistance.

We are unable to complete your application with the information provided.

In order for us to make a determination of eligibility, we need the following information:

[1]

[2]

Please forward this information to the Patient Financial Services Department as soon as possible.

Your application for financial assistance will be closed if this information is not returned within 30 days.

If the requested information is not received, your account(s) will be returned to our normal collection process, and you will be expected to pay in full. Accounts not paid in full could be referred to a collection agency and may be reported to a credit reporting agency.

Please call Patient Financial Services at 215-453-4608 with any questions.

Sincerely

Coordinator
Patient Financial Services
215-453-4608

[date]

[name]
[street]
[city, state, zip code]

Dear [name]:

We have reviewed your application for Financial Assistance and have determined that your present financial situation does / does not qualify you for reduction or forgiveness of your hospital balance due. Please note that physician charges are not included. The following represents the calculation of payment due Grand View Health:

Total Charges for Services	_____
Less: Payments Received	(_____)
Outstanding Balance	_____
Amount of Reduced Charges or Forgiveness of Balance Due	_____
Amount Generally Billed*	_____

**Grand View Health does not charge anyone eligible for financial assistance more than Amounts Generally Billed (AGB) for emergency or other medically necessary care. To obtain further information on AGB, please call the telephone number below.*

Adjusted Balance Due from Patient	_____

Failure to pay the adjusted amount due will result in your account(s) being returned to GVH's normal collection activity including referral to a collection agency and to a credit reporting agency. Please contact our Patient Financial Services Department at the phone number below if you have any questions or to arrange payment terms of the adjusted balance due.

Sincerely,

[name]
Patient Financial Services Department
215-453-4608

GRAND VIEW HEALTH

FINANCIAL ASSISTANCE

Grand View Health is proud of its mission to provide quality care to the communities which we serve, 24 hours a day, 7 days a week, 365 days a year.

If you do not have health insurance or worry that you may not be able to pay for part or all of your care, we may be able to help. Grand View Health provides financial assistance to patients based on their income, assets, and financial needs. In addition, we may be able to help you apply for insurance coverage through the State Medical Assistance Program or to work with you to arrange a manageable payment plan.

For more information, please contact Hospital Patient Financial Services at 215-453-4608 or visit www.gvh.org. We will treat your questions and any information you provide us with confidentiality and courtesy.

Exhibit 6

GRAND VIEW HEALTH

FINANCIAL ASSISTANCE CALCULATION WORKSHEET

For Hospital Use Only

Patient Name:
Account Number:

A) Number in Household	0
B) Annual Income	$0.00
C) Net Asset Value	$0.00
D) Net Asset Value times 10%	$0.00
E) Eligible Household/Medical Expenses	**$0.00**
F) TOTAL (B plus D minus E)	**$0.00**
G) Financial Assistance Discount % (Exhibit B or C)	
H) Total Charges	**$0.00**
I) Financial Assistance (G times H)	**$0.00**
J) Patient Liability (H minus G)	**$0.00**
K) Medicare Rate/AGB Rate	**$0.00**
L) Final Patient Pay Lesser of (J) or (K)	**$0.00**