Charity Care Policy
Schneider Regional Medical Center

1. Purpose
At Schneider Regional Medical Center, we believe in providing access to essential healthcare for our community. This policy ensures that patients facing financial hardship are not denied emergency or medically necessary care due to their inability to pay. Our commitment to charity care reflects our core values of equity, dignity, and community service. Financial assistance is provided without discrimination based on race, color, religion, gender, national origin, age, disability, or any other protected status.

2. Scope
This policy applies to all patients receiving emergency, inpatient, and outpatient medically necessary care at Schneider Regional Medical Center. Coverage under this policy includes services provided in the emergency department, inpatient hospital setting, hospital-based outpatient clinics, and same-day or ambulatory procedures deemed medically necessary. Financial assistance is extended to uninsured, underinsured, and low-income individuals without discrimination.

3. Definitions

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- Financial Assistance Policy (FAP) is a hospital or healthcare facility's formal policy that outlines how it provides free or discounted care to patients who cannot afford to pay for medically necessary services.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Emergency care**" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.
- "**Medically necessary care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family,

- physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Patient**" means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.
- **Guarantor** is the financially responsible party for the services rendered to a patient.

3. Policy Statement

Schneider Regional Medical Center is committed to providing charity care in accordance with federal, state, and local regulations. We will:

- Screen -uninsured, underinsured, and low-income patients for financial assistance eligibility
- Provide clear accessible information about charity care in multiple languages, as well as support for individuals with disabilities who require additional assistance.
- Ensure fair and respectful treatment of all applicants.

4. Eligibility Criteria

Eligibility is based on household income and family size relative to the Federal Poverty Level (FPL). All financial resources of the family or anyone financially supporting the patient are considered when determining eligibility. Eligibility Criteria based on FPL and Family Size

Detailed by 2025 data and will change accordingly with the FPL bands from HHS poverty guidelines annually. FPL bands will be updated on the Financial Assistance application or website.

2025 FPL Data

Family Size	≤ 200% 100%	201–300% FPL 75% Discount	301–400% FPL 50% Discount	401–500% FPL 25% Discount
1	≤ $31,300	$31,301 – $46,950	$46,951 – $62,600	$62,601 – $78,250
2	≤ $42,300	42,301 – $63,450	$63,451 – $84,600	$84,601 – $105,750
3	≤ $53,300	$53,301 – $79,950	$79,951 – $106,600	$106,601 – $133,250
4	≤ $64,300	$64,301 – $96,450	$96,451 – $128,600	$128,601 – $160,750
5	≤ $75,300	$75,301 – $112,950	$112,951 – $150,600	$150,601 – $188,250
6	≤ $86,300	$86,301 – $129,450	$129,451 – $172,600	$172,601 – $215,750
Add'l Member	+$11,000	+$16,500	+$22,000	+$27,500

If a patient appears to be eligible for Medicaid or another public assistance program, the patient (or responsible party) must cooperate fully with the application process for such programs as a condition of receiving financial assistance through this policy. This includes timely completion and submission of required documentation and responding to requests for additional information from Medicaid or related agencies. SRMC's financial assistance will be considered only after the patient is determined ineligible for these external programs, or while an application is pending, as long as the patient demonstrates good faith effort to comply with the application requirements. Refusal or failure to complete the Medicaid application process may result in denial of financial assistance.

Presumptive Financial Assistance Eligibility

Presumptive Eligibility (PE) includes certain circumstances in which a self-pay patient may be automatically enrolled in Financial Assistance where there are life situations and extraordinary financial hardship. These additional considerations include:

- Catastrophic medical expenses exceeding 20% of annual income may qualify for assistance regardless of income level.
- Patient/guarantor(s) that have been declared bankrupt (Chapter 7) at the time of application process.
- Deceased patients who do not have an estate in probate or any assets available to cover outstanding medical expenses.
- Charity care, once approved, is valid for 6 months from the date of approval. The applicant has the option to reapply after the 6 months have expired or anytime there has been a significant change in family/support income.
- Homelessness
- Mental incapacitation with no responsible party

Data from public programs, charity organization, or credit reporting agencies confirming income at or below SRMCs FAP threshold will be accepted as presumptive evidence of eligibility. PE means-tested triggers include any of the following, but are not limited to, SNAP, WIC, TANF, CHIP, Section8/Public Housing Assistance, or National School Lunch Program. If the patient is currently enrolled in or has proof of recent enrollment in any of the programs listed above assumes the patient meets the income criteria for financial assistance.
SRMC will use electronic screening of state and national benefit program enrollment along with automated evaluation of homelessness and other life circumstances verified through data collection to grant presumptive financial assistance eligibility. No paper application or supplemental documents will be required if eligibility can be electronically verified.

5. Application Process

Patients may apply at any time before, during, or up to 2 months after receiving care. If the patient requires additional time to apply, a written request will be taken into consideration for a one-month extension. The financial assistance application is available free of charge at all registration areas, on the hospital website, or by request via mail, email, or phone. Assistance from financial counselors and the business office is available to help patients complete the application. Applications must include the required copies of the documentation as listed in the section below.

A simplified assessment will be performed if available for presumptive eligibility cases not evaluated through electronic means if the patient is experiencing undue hardship and/or has documentation listed in the Documentation section related to existing approval of governmental assistance programs.

Financial counselors and the Business Office are available to answer questions and assist with the application process. Patients unable to provide the required documentation should contact the financial assistance office for assistance; inability to provide all documentation will not automatically result in a denial if eligibility can otherwise be reasonably established.

Applications will be reviewed promptly, and a written notice of the determination (approval or denial), including appeal instructions, will be provided. Confidentiality of all patient information is strictly maintained throughout the process. Presumptive eligibility may be determined using available electronic data, when applicable, without requiring a full application.

6. Required Documentation Requirements for FAP Considerations

- Completed financial assistance application
- Proof of identity and residency (e.g., driver's license, state ID, recent utility bill, or lease)
- Most recent federal tax return (Form 1040) or W-2 if tax return is not available or
    - Recent pay stubs (last 30 days or three most recent pay stubs)
- Proof of other household income sources (unemployment benefits, Social Security, disability, pension, Child support, alimony) or
    - Proof of participation in public assistance programs (Medicaid, SNAP, WIC, TANF or other legally approved programs) if applicable
- Insurance denial letter
- Attestation letter from person who is supporting the patient

7. Appeal Process

To ensure all patients have a fair and transparent means to contest or clarify financial assistance determinations, with the goal of correcting errors, addressing unique circumstances, and promoting equitable access to care regardless of ability to pay SRMC provides patients with an appeal process.

If a patient's application for financial assistance is denied, or if the patient believes an error was made in the amount or type of assistance offered, the patient (or their guarantor) has the right to appeal the decision.

- To request an appeal, the patient must submit a written request or contact the Financial Assistance/Business Office by phone within 30 days of receiving the determination notice.
- The appeal should include any additional information or documentation supporting the patient's case for financial assistance.

- All appeals will be reviewed for redetermination

- The patient will be notified in writing of the result of the appeal, typically within 30 days of receipt.
- If the appeal results in approval or a change to the patient's financial assistance status, billing and collection efforts will be updated accordingly.

Patients may request the assistance of a financial counselor at any point in the appeal process. All patient information remains confidential throughout the review.

Timeframes

Patients have 30 calendar days from the date of request to submit all required documentation. The hospital will make a determination within 14 business days of receiving a complete application. If documentation is missing, the hospital will notify the patient within 7 business days of receipt and provide an additional 15 calendar days to submit the missing information.

8. Communication with Patients

All communication regarding charity care applications will be made in writing and, when possible, by phone or email. Patients will receive written notifications of:

- Approval and the level of discount granted
- Denial, including the reason and instructions for appeal or resubmission.
- Requests for additional documentation or clarification.

9. Notification and Communication

Charity care information will be posted in registration areas, on the hospital website, and included in billing statements. Staff will be trained to assist patients in understanding and applying for financial assistance.

10. Billing and Collections

No extraordinary collection actions (e.g., lawsuits, wage garnishment) will be taken while your application is under consideration and until eligibility for charity care has been determined. Patients eligible for charity care will not be charged more than the amounts generally billed (AGB) to insured patients. Any account assigned to the collection agency that has been approved for charity will be cancelled and returned to the hospital. A request will be submitted to have account(s) removed from credit report. Patients who are approved for discounts and are unable to make payment in full may request a payment arrangement.

11. Excluded Services

The following services are excluded from charity care eligibility:

- Elective cosmetic procedures
- Non-medically necessary services
- Services provided by out-of-network providers not affiliated with the hospital
- Services not covered under the hospital's definition of emergency or medically necessary care.
- Medicare accounts that are covered under the Medicare Bad Debt program.
- While Schneider Regional Medical Center's Charity Care Policy applies to hospital facility charges, it does not automatically extend to all professional services rendered by physicians or other providers who may treat patients within the hospital. Some providers, such as radiologists, anesthesiologists, pathologists, or other physicians, may bill separately for their professional component of care. If the hospital directly bills for a professional component, eligible discounts under this policy will be applied. However, when the hospital does not bill for the professional component, patients may still receive a separate bill from the provider. Patients are encouraged to contact the provider's billing office to inquire about financial assistance or charity care programs offered by that provider..

12. Reporting and Transparency

Annually Charity Care reporting will be provided to the Territorial Board Finance Committee for transparency. This policy is available for the public to view and if requested, a copy of the policy can be made available.

13. Review and Oversight

This policy will be reviewed annually by the SRMC Finance Department . Feedback from patients and community stakeholders may be considered for future policy updates.

Signatures:

This public online document reflects the official text of the Schneider Regional Medical Center (SRMC) Charity Care / Financial Assistance Policy, as formally approved by executive leadership. Signature lines are omitted for digital distribution; physical signatures are on file with the SRMC Compliance and Executive Offices.