Granville Health System	Manual Business Office			
Subject **Medical Financial Assistance Policy (*Previously named Indigent Care Write Off Policy*)**	**Number** **PFS-517**	**Revised** **8/16/2017** **3/14/2018** **1/21/2019** **1/9/2020** **2/3/2020** **11/20/20** **02/03/21** **1/14/22** **2/3/23** **4/22/24** **12/12/24** **2/12/25** **6/1/25** **11/25/25** **4/20/26**	**Effective Date** **April 1, 1996**	**Page of** **1 6**
Distribution: ▪ **Business Office** ▪ **All Centralized and Decentralized Registration Points** ▪ **GHS Pre-certification Coordinator** ▪ **GHS Verification Representative** ▪ **GHS Financial Counselor** ▪ **Medicaid Eligibility Representative** ▪ **Outsource Billing Company Representatives** ▪ **Collection Agency Representatives**	**Supersedes All Previous**		**Prepared By:** **Josette R. Anzalone** **Revised by:** **Jamie Purvis**	**Approved by Administration / P & P Committee / Finance Committee**

PURPOSE:

Granville Health System recognizes that medical care is needed for patients who are unable to pay for services. This policy establishes the criteria for approval for indigent care write-off for scheduled or non-scheduled, urgent, or emergent care services rendered for uninsured or under insured patients at Granville Medical Center. The administration of this policy will be referred to as Granville Health System Financial Assistance Program (FAP)**.** This policy also incorporates processes for presumptive eligibility to expedite access to financial assistance for eligible patients based on non-income based criteria.

POLICY:

Granville Health System will offer medical financial assistance to all patients who qualify according to GHS guidelines. Account balances considered will include only self-pay balances after all third party, governmental and private funding grants have been exhausted. Qualifications for the GHS Financial Assistance Program will be based on the following criteria:

- Services rendered are medically necessary and are considered Urgent or Emergent. All elective services will be excluded from coverage under this policy.
- Family Gross Income as report on annual income tax return – Annual gross income will be based on amount up to 300% of the Federal Poverty Guidelines

    - If the patient is a minor, the income will be based on the patient's guardian's income taxes
    - A patient who is 18 years of age or older (or is an emancipated minor) will be considered the responsible party unless he or she is claimed as a dependent on the tax filing of another person. In that case, the assets and income of the person (or people) claiming the patient on their taxes will also be used in evaluating financial assistance eligibility based on this policy.
- Assets –
    - Resource limit not to exceed $3,000
    - Owned property will be limited to:
        - The home in which the guarantor resides as their main residence, which includes any land adjacent to the main residence.
        - Automobile(s) needed for transportation to work. One primary essential vehicle per person of driving age in the home.
- Medical Indigency – Outstanding self-pay non-routine (catastrophic) medical expenses will be taken into consideration. Medical expenses will be deemed catastrophic if they exceed the family's total annual gross income for the year.
    - Catastrophic expenses will warrant a 100% Medical Financial Assistance approval if all other program guidelines are met. Catastrophic expenses will be considered for applicants that exceed the resource limitations outlined above.

In addition to the above eligibility criteria, Granville Health System will:

- Evaluate all patients who are North Carolina residents and enrolled in Medicaid for past medical debt within 60 days of the patient's inpatient discharge or outpatient hospital encounter. Upon verification of Medicaid enrollment, any such past debt will be reclassified as charity care.

- Relieve all unpaid patient medical debt dating back to January 1, 2014, for North Carolina residents who are currently enrolled in Medicaid, including those covered under limited benefit family planning coverage. For purposes of this requirement, debts reclassified as charity care will be considered relieved.

Presumptive eligibility will be used to determine eligibility for financial assistance without requiring documentation for certain patients. See the process outlined below.

All balances which do not qualify for the GHS Medical Financial Assistance Program will be subject to a scheduled payment plan and are the responsibility of the patient. GHS has a separate Self Pay Financial Policy that outlines actions that may be taken in the event of non-payment.

PROCEDURE:

It is the intent of GHS to identify patients needing financial assistance as early as possible. Identification sources of these patients include but are not limited to:

- GHS Pre-Certified Coordinator
- GHS Verification Representative
- Patient Registrars
- GHS Financial Counselor
- Medical Eligibility Representative

- Extended Business Office Representatives
- Collection Agency Representatives

Upon identification of a candidate for Medical Financial Assistance, the patient or guarantor will be referred to the Financial Counselor for completion of a financial evaluation and all Collection Efforts will be suspended during the process for determination of assistance eligibility.

Additional Medicaid-Based Procedures:

60-Day Medicaid Evaluation Requirement:
Granville Health System will evaluate all patients who are residents of North Carolina and enrolled in Medicaid within 60 days of inpatient discharge or outpatient hospital encounter. The evaluation will be conducted by the Financial Counselor or designated team member using eligibility verification tools or state Medicaid portals.
• If Medicaid enrollment is confirmed, all self-pay account balances related to that patient will be reclassified as charity care.

Retroactive Debt Relief – Medicaid (Dating Back to January 1, 2014):
Granville Health System will conduct a one-time review of all outstanding self-pay accounts with dates of service from January 1, 2014 through May 31, 2025, specifically for North Carolina residents.
• The Patient Financial Services team will query patient accounts to identify those currently enrolled in Medicaid (including limited family planning coverage).
• Once current Medicaid status is confirmed, the account will be flagged for relief (charity adjustment).
• All qualifying unpaid balances will be reclassified as charity care and marked as relieved under this policy.

Patients determined to qualify under either provision above will receive notification of the reclassification within 30 days of relieving the debt.

Presumptive Eligibility Process:

Patients presenting for non-emergency services will be screened prior to the date of service or at the time of registration for presumptive eligibility and notification of determination will be provided at that time or prior to discharge. Patients presenting for emergency department services will be screened at the time of registration or as soon as possible during the visit (if feasible) and will be notified of the determination prior to the initial bill being issued.

Non-Income Based Criteria:

Presumptive eligibility will be determined for patients who demonstrate indicators of financial hardship through non-income based criteria. The following non-income based criteria will be used to establish presumptive eligibility:

- Eligibility Based on Participation in Assistance Programs: Patients identified as participating in government assistance programs such as Medicaid, Nutrition Programs, or Supplemental Nutrition Assistance Program (SNAP) will automatically be presumed eligible. Enrollment in Medicaid of a household member will also meet presumptive eligibility requirements.

- Homelessness or Other Extreme Hardship: Patients identified as homeless or experiencing other extreme hardships (such as those residing in shelter organizations), or those that are mentally

incapacitated with no one to act on their behalf, will be presumed eligible.

Income Based Criteria:

Effective January 1, 2026, if non–income-based presumptive eligibility criteria are not met, patients will be evaluated for Income-Based Presumptive Eligibility. Patient household income will be verified through third-party software. Those with household incomes at or below 300% of the current Federal Poverty Level (FPL), based on household size, will qualify and be approved under Income-Based Presumptive Eligibility.

Once presumptive eligibility is established, patients will be granted financial assistance without requiring further documentation. Financial assistance will remain in effect for 12 months or until a change in financial position occurs, after which reevaluation may be required. Patients will receive notification of presumptive eligibility approval prior to the issuance of any bill for the associated debt.
Alternative Pathway for Non-Presumptively Eligible Patients:
Patients who are not deemed presumptively eligible may apply for financial assistance by completing a Financial Analysis Worksheet and providing supporting documentation as outlined in this policy.

Application Process:

The Application Period for Medical Financial Assistance begins at the time services are scheduled or ordered and ends **240 days** after the date of the first post-discharge patient billing statement. All accounts that fall into the Application Period will be included in the initial write-off. Once established, eligibility will remain in effect for one year (12 months). Re-verification will be completed for future services to ensure that the financial status has not changed as additional balances are identified. Additional documentation will be required from the patient if there have been any changes in the patient's financial information (for example, changing jobs or having a new baby).

All patients will be expected to comply and cooperate in all processes for third party payer programs and any other assistance that may be available (ex. Medicaid, Crime victim's compensation). Patients will be excluded from review for assistance if they have third party insurance available to them and choose not to purchase that coverage (ex. Employer coverage available).

A Financial Assistance Checklist must be completed by the Financial Counselor or other appropriate staff for the account in question and submitted to the Patient Financial Services Director for approval prior to write-off. (See copy attached.)

The guarantor will be expected to complete and sign a Financial Analysis Worksheet and submit all supporting documentation as verification of the criteria outlined below:

- Gross income must not exceed the guidelines provided in the sliding scale (see below)
- The applicant cannot own property except for the house and lot that is their primary residence.
    - Rental property will be excluding from this only if that is the applicant's primary source of income
- Savings and checking balances combined will not exceed $3,000.
    - Current bank statements for all accounts in the applicants' name will be required as proof
    - Amounts exceeding the $3,000 limitation can be paid toward the outstanding medical debt to bring the accounts below the limit. Once below, the applicant can be re-evaluated for Financial

Assistance.

- Verification of employment income - submission of three recent pay stubs.
  - Unemployment status – Written documentation from the previous employer stating that the applicant is no longer employed and date of last employment
  - Statement of unemployment from the Employment Security Commission
- Most recent year's tax return and supporting W2 documents
  - Schedule C of the tax return is required for patients with Self Employment Income
- Medical Indigency Documents – Outstanding self-pay non-routine (catastrophic) medical expenses.

A credit report may be reviewed for current credit extensions and identification verification. Recent credit extensions will be discussed with the guarantor for identification of possible payment resources.

Failure to provide required application and supporting documentation within 30 days of the written request or upon completion of the Application Period outlined above will result in denial of the application. Providing false information will disqualify the applicant from approval.

The following documents will be utilized in evaluating the GHS Medical Financial Assistance Program:

▪ Cover letter including: o Confidential Financial Analysis Worksheet o Document Check List	Attachment I A Attachment I B Attachment I C
▪ Medical Financial Guidelines	Attachment II
▪ Letter requesting additional information	Attachment III
▪ Approval letter – 100%	Attachment IV
▪ Approval letter - <100%	Attachment V
▪ Non Approval Letter	Attachment VI

Documentation will be presented to the Patient Financial Services Director and when appropriate, the Chief Financial Officer. Determinations will generally be made on the status of the application within 30 business days. Once the determination is made, a letter will be sent to the patient outlining the level of assistance granted or the reason for denial. This letter will be reviewed and signed by the Patient Financial Services Director.

Approval limits will be as follows:

- Patient Financial Services Director – All Accounts
- Chief Financial Officer - >$50,000

Approved balances will be posted in a Meditech batch using the appropriate adjustment code:

- AINDOP - Outpatient
- AINDIP - Inpatient

The Adjustment Batch will be signed by the Patient Financial Services Director.

All criteria will be verified prior to submission for approval. All supporting documentation will be maintained for audit purposes.

A monthly total will be submitted to the CFO by the Patient Financial Services Director.

Extenuating circumstances will be reviewed by the Patient Financial Services Director and Chief Financial Officer. Based on this review, Medical Financial Assistance Applications outside of the above stated guidelines may be approved.

Poverty Guidelines for Assistance Eligibility:

Granville Health System

Financial Assistance Guidelines

Annual Salary Based on 2026 Federal Poverty Guidelines

Federal Poverty Guidelines for use in 2026

Family Size	FPL Guidelines 100%	FPL Guidelines 200%	FPL Guidelines 210%	FPL Guidelines 220%	FPL Guidelines 230%	FPL Guidelines 240%	FPL Guidelines 300%
1	$15,960	$31,920	$33,516	$35,112	$36,708	$38,304	$47,880
2	$21,640	$43,280	$45,444	$47,608	$49,772	$51,936	$64,920
3	$27,320	$54,640	$57,372	$60,104	$62,836	$65,568	$81,960
4	$33,000	$66,000	$69,300	$72,600	$75,900	$79,200	$99,000
5	$38,680	$77,360	$81,228	$85,096	$88,964	$92,832	$116,040
6	$44,360	$88,720	$93,156	$97,592	$102,028	$106,464	$133,080
7	$50,040	$100,080	$105,084	$110,088	$115,092	$120,096	$150,120
8	$55,720	$111,440	$117,012	$122,584	$128,156	$133,728	$167,160
For each addtiional person add	$5,680	$11,360	$11,928	$12,496	$13,064	$13,632	$17,040
Percentage of Discount	100%	100%	90%	80%	75%	75%	72%

Source: Federal Register

Patients with incomes between 200-300% of the federal poverty guidelines, as indicated in the table above, that may or may not qualify for financial assistance based on other criteria will be offered payment plans for up to 36 months in duration with no monthly payments exceeding 5% of their monthly household income. Any amount exceeding this criteria will be considered financial assistance and the balance of the account will be adjusted accordingly.

Amounts Generally Billed: **28.22% of total charges**

Amounts charged to a patient eligible for Medical Financial Assistance under this policy will be based on the applicable discount stated in the federal poverty table above. The total charges owed by the patient are multiplied by the defined discount percentage based on household income and size. These discounts have been established in a manner that is intended to ensure that, for purposes of Internal Revenue Code section

501(r), a patient eligible for Medical Financial Assistance under this policy is not charged more than the amount generally billed to individuals who have insurance covering such care ("AGB"). For Calendar Year 2026, this percentage is 28.22% of total charges.

Granville Health System has elected to calculate AGB using the "look back method" described in applicable Treasury Regulations, based on claims approved by Medicare and private insurers during a 12-month measurement period. Further information about the AGB percentage currently in use and a description of how the AGB percentage was calculated may be obtained in writing and free of charge by sending a written request to Granville Health System, Patient Financial Services, 1010 College Street, Oxford, NC 27565; this information may also be downloaded at http://ghshospital.org/.

To obtain free copies of this policy, a plain language summary of this policy, the Financial Analysis Worksheet, and the associated instructions, please write to Patient Financial Services at 1010 College Street, Oxford, NC 27565. These policies can be found in the emergency room and admission areas of the main Facility or may be downloaded at http://ghshospital.org. Further information about the Medical Financial Assistance Policy and assistance with the application process are available by phone at 919-690-3254 or in person during normal business hours at Granville Health System, 1010 College Street, Oxford, NC 27565.