Policy:	SAMC Financial Assistance Policy		
Manual:	Corporate Finance	**Original Date:**	8/31/2003
Section:	Reimbursement / Revenue	**Revision Date:**	3/26/2026
Location(s):	SAMC	**Approved By:**	EVP/CFO
		Process Owner:	Patient Accounting Director, Contact Ctr

Revision Description (Most Recent): Updated FA Application Address

Policy Statement:

As part of the Sentara Health ("Sentara") mission to improve health every day, Sentara is committed to providing Emergency Services and other Medically Necessary Services to all patients within their respective communities, regardless of a patient's ability to pay for such services.

Purpose:

This Financial Assistance Policy ("Policy") establishes the policy to be followed by Sentara Albemarle Medical Center in: (1) determining the eligibility for Financial Assistance for those patients receiving Emergency Services and other Medically Necessary Services; (2) calculating amounts charged to a patient eligible for Financial Assistance; (3) facilitating the patient application process for Financial Assistance; and (4) Determining if patients are presumptively eligible for Financial Assistance. In addition, this Policy outlines Sentara Health's billing and collections practices for medical care services, including the efforts that Sentara Albemarle Medical Center - will make to determine a patient's eligibility for Financial Assistance.

Definitions:

Amounts Generally Billed or AGB – Amounts generally billed by a Hospital Facility for Emergency Services or Medically Necessary Services to individuals who have insurance covering such care, determined in accordance with Treas. Reg. Sec. 1.501(r)-5(b).

Application Period – Period of time beginning on the service date through 240 days after the provision of the patient's first billing statement for the service date.

Available Assets – The Household's total amount of assets available, including any liquid and/or fixed assets, for use in paying for medical care including, but not limited to cash and cash equivalents, bank accounts, certificates of deposit, investments, trust accounts, automobiles, recreational vehicles

and other forms of leisure transport, and real estate equity in real property other than the principal place of residence. Specifically excluded from Available Assets is the equity in an applicant's principal place of residence, primary source of transportation, IRS recognized retirement savings accounts, business assets, and 3.99 acres of land.

Covered Entity – Sentara Albemarle Medical Center

Covered Services - Emergency Services and other Medically Necessary Services provided by a Covered Entity.

Emergency Services – Care or treatment provided by a Covered Entity for an "emergency medical condition," as such term is defined in EMTALA.

EMTALA – Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd; 42 C.F.R. § 489.24).

Federal Poverty Guidelines - Federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. *See* http://aspe.hhs.gov/poverty/index.cfm for the current guidelines.

Financial Assistance – A reduction in the amount of Covered Entity Gross Charges for those patients who are eligible for financial relief under this Policy. This may also be referred to and is synonymous with the terms 'Charity', 'Charity Care', or 'Charity Assistance' for financial reporting, regulatory reporting, and compliance purposes.

Gross Charges – A Covered Entity's full, established price for medical care services that the Covered Entity consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

HITECH – Health Information Technology for Economic and Clinical Health Act of 2009. According to Section 13405 of Subtitle D of the HITECH Act (42 USC 17935) an Insured Patient may opt for their HIPAA protected information to not be reported to their health insurance whereby the Insured Patient elects to be a Self-Pay Patient and is therefore responsible to pay out-of-pocket for all charges.

Hospital Facility– A Sentara-operated facility requiring hospital licensure under Article 5, Chapter 131E of the North Carolina General Statutes.

Hospital Organization – An organization recognized or seeking to be recognized as described under Section 501(c)(3) of the Internal Revenue Code that operates one or more Hospital Facilities.

Household Income – The annualized gross income for a patient and all members of the household being claimed on the same federal tax return.

Child in Household – For the purposes of presumptive eligibility, a child in the household will be defined per 42 CFR435.603(f)(3) as a natural or biological, adopted child or stepchild under the age of 19 living in the household or in the case of a full-time student, under the age of 21.

Insured Patients – Individuals with any governmental, commercial, managed care, or private health insurance.

Medically Necessary Services– Reasonable and necessary services required for the diagnosis or treatment of an illness, injury, or pregnancy-related condition that are performed in accordance with recognized standards of care at the time of service and that are not primarily for the convenience of the patient or the patient's physician or other health care provider.

Non-Covered Services – Health care services provided by Covered Entity that are not covered under this policy. These services include, but may not be limited to, all cosmetic, elective, retail services or packaged price services in which a discount has already been applied, cash only priced services, and all services in which there is a Third-Party Liability Claim.

Non-Hospital Facility – A facility not requiring hospital licensure under Article 5, Chapter 131E of the North Carolina General Statutes, including, but not limited to, the office of a physician owned and operated by a Hospital Organization.

Public Health Emergency (PHE) – An official declaration made by the Secretary of the Department of Health and Human Services (HHS), under section 319 of the Public Health Service (PHS) Act. The declaration can last for the duration of the emergency or 90 days but may be extended or renewed by the Secretary for subsequent 90-day terms. A Presidential declaration of an emergency or disaster order under the Stafford Act may also accompany a PHE but is not required to declare a PHE nor is it necessary that a State of Emergency be declared by a state's Governor to have a Public Health Emergency.

Self-Pay Patient – Insured Patients that choose prior to receiving Covered Services from the Covered Entity to not bill their insurance for a healthcare related service as is required under the HITECH Act.

Sentara MyChart – A tool that provides secure and convenient electronic access to a patient's personal medical information and healthcare provider. With Sentara MyChart, a patient can access billing information, submit an electronic payment, start a financial assistance application, upload support, and submit it to Sentara Health for review and processing.

Substantially-Related Entity – With respect to a Hospital Facility operated by a Hospital Organization, an entity treated as a partnership for federal tax purposes in which the Hospital Organization owns a capital or profits interest, or a disregarded entity of which the Hospital Organization is the sole member or owner, that provides Covered Services in that Hospital Facility.

Third-Party Liability Claims – Any claim a patient may have against another individual, non-health insurer, or entity responsible for covering the patient's cost of medical services.

Uninsured and Self-Pay Discount – A fixed discount percentage applied to Covered Entity Gross Charges on Covered Services of Uninsured Patients and Self-Pay Patients.

Uninsured Patients – Individuals who do not have any form of healthcare insurance (Governmental, commercial, managed care, or private health insurance).

Covered Services:

Only Covered Services provided by Sentara Albemarle Medical Center are considered eligible patient care under this Policy. Services provided by Non-Hospital facilities, such as physician offices of Albemarle Physician Services – Sentara, Inc., and Non-Covered Services, by definition, are specifically excluded as a Covered Service.

A list of any providers, other than a Hospital Facility itself, delivering Emergency Services or other Medically Necessary Services in each Hospital Facility and whether or not their services are covered under this Policy is maintained in a separate document that may be obtained, free of charge: (1) from patient registration areas within each Hospital Facility; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Financial Assistance Disqualification:

Financial Assistance is not available for patients who fail to reasonably comply with applicable payor requirements, including, but not limited to, obtaining authorizations, referrals, or responding to health insurer inquiries or other requirements for claim adjudication.

Financial Assistance is not available when a related Third-Party Liability Claim is available to the patient. Exceptions are determined by the applicable Covered Entity on a case-by-case basis, based upon the particular facts and circumstances.

Financial Assistance will be denied if a patient or patient's responsible party/guarantor provides false information regarding household income, household size, assets, liabilities, expenses, or other resources available that might indicate a financial means to pay for Covered Services.

Eligibility Criteria and Determination of Financial Assistance Amount:

Patients are eligible to apply for Financial Assistance for Covered Services under this Policy at any time during the Application Period. Each patient's Household Income is evaluated in light of relevant facts and circumstances, such as reported income, assets, liabilities, expenses, and other resources available to the patient or patient's responsible party, when determining the level of Financial Assistance that an applicant qualifies for under this Policy.

The following Household Income criteria is used to determine what amount, if any, of the outstanding patient account balance related to Covered Services for a patient will be written off as Financial Assistance:

- Uninsured Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of Covered Entity Gross Charges related to Covered Services under this Policy.
- Self-Pay Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of Covered Entity Gross Charges related to Covered Services under this Policy.
- Insured Patients with a Household Income at or below 300% of the then-current Federal Poverty Guidelines are eligible for a full, 100% write-off of any remaining patient responsibility balance after insurance has paid on Covered Services under this Policy.
- Uninsured Patients and Self-Pay Patients with a Household Income above 300%, but at or below 400%, of the then-current Federal Poverty Guidelines qualify for a discount of 80% off Covered Entity Gross Charges related to Covered Services under this Policy.
- Uninsured Patients and Self-Pay Patients with a Household Income above 400% of the then-current Federal Poverty Guidelines are not eligible for Financial Assistance under this Policy. For these Uninsured Patients and Self-Pay Patients that are excluded from Financial Assistance under this Policy, a discount equal to 50% of Hospital Gross Charges will apply. For additional information, refer to the separate Uninsured and Self-Pay Discount Policy.

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- Insured Patients with a Household Income above 300%, but at or below 400% of the then-current Federal Poverty Guidelines qualify for a discount of 80% write-off of any remaining patient responsibility balance after insurance has paid on Covered Services under this policy.

- Catastrophic Financial Assistance is available on Covered Services for patients who do not qualify for free or reduced care based on the above criteria however due to the nature and extent of services provided have significant care-related financial obligations to Sentara Health in relation to Household Income and other potentially available resources. In such circumstances when the patient responsibility amount due on Covered Services exceeds 100% of Household Income the Covered Entity will adjust the patient responsibility balance to 25% of the applicant's Household Income.

Applicants are expected to apply for available insurance including Medicaid prior to applying for financial assistance. The Covered Entity has enlisted services of Medicaid Eligibility Vendors to assist Uninsured Patients in applying for government programs. Covered Entity also utilizes technology and other vendor services to help identify a patient's payor information when such information is not communicated to the Covered Entity during the patient's registration process.

In accordance with the North Carolina Department of Health and Human Services Hospital Medical Debt Relief Program, the Covered Entity shall relieve unpaid patient hospital medical debt dating back to January 1, 2014, for patients with incomes at or below 350% FPL or for whom total debt exceeds 5% of annual income. Beginning July 1, 2025, the Covered Entity will evaluate all Medicaid enrolled patients to provide debt forgiveness for unpaid hospital medical debt dating back to January 1, 2014.

For patients that are determined presumptively eligible for Financial Assistance, documentation will not be required. For patients not presumptively eligible, documentation may be required. Applicants for Financial Assistance under this Policy may be required during the Application Period to submit any of the following documents to verify Household Income, three most recent pay stubs at time of application; most recent annual Federal tax return or W-2 at time of application, employer verification; governmental assistance documents; social security, workers compensation, or unemployment compensation determination letters; bank statements; or such other documents that provide proof of Household Income and Available Assets. A Covered Entity may also utilize the income, asset, liability, expense, and other resource data from third-party credit inquiries and publicly available data sources as evidence in determining and validating an applicant's Household Income and Available Assets for Financial Assistance eligibility under this Policy.

A patient's prior eligibility determinations with respect to Financial Assistance are not presumed to apply to new episodes of care for that patient after the eligibility approval period has expired. A new application for Financial Assistance must be completed.

If a patient meets one of the following non-income-based criteria, the patient is deemed presumptively eligible for financial assistance under this policy; and 100% of the patient's remaining balance for Covered Services will be written off:

- Homelessness
- Mental incapacitation with no one to act on the patient's behalf
- Enrollment in Medicaid of patient or a child in household
- Enrollment in another means of public assistance including but not limited to: Women, Infants and Children Nutrition Program or the Supplemental Nutrition Assistance program.

If a patient does not meet non-income-based criteria, a presumptive determination will be made by utilizing third-party income inquiries and publicly available data sources to determine if a patient qualifies for Financial Assistance under this Policy. If this data suggests that an Insured Patient, Uninsured Patient, or Self-Pay Patient's total Household Income is at or below 300% of the then-current Federal Poverty Guidelines, 100% of the patient's remaining balance for Covered Services will be written off.

Patients meeting Presumptive Financial Assistance eligibility through non-income-based criteria and receiving emergency department services will be notified of eligibility prior to issuing a bill to the patient. For all other services, notification of eligibility will be completed prior to discharge.

A patient's eligibility for presumptive Financial Assistance may not be presumed to apply to future episodes of care, and the Covered Entity may generate new inquiries to assess eligibility for each episode of care.

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Once a patient is determined to be eligible for Financial Assistance under this Policy, they will not be charged more for Covered Services under this Policy than AGB. AGB is determined by multiplying the Gross Charges for the provision of any Emergency Services or other Medically Necessary Services by the Covered Entity's AGB percentage, which is based on all claims allowed under both Medicare and private health insurance. An information sheet stating the AGB percentage of the Covered Entity and how the AGB percentage was calculated may be obtained free of charge: (1) from patient registration areas within the Covered Entity; (2) by calling the telephone number set forth in this Policy; (3) by sending a written request to the address set forth in this Policy; or (4) by visiting www.sentara.com/financialassistance.

Uninsured Patients and Self-Pay Patients that do not satisfy the eligibility requirements for Financial Assistance under this Policy should contact Sentara as described in this Policy to determine if they may qualify for discounts offered outside of this Policy.

Methods for Applying for or Obtaining Financial Assistance:

The Application for Financial Assistance is available at patient registration areas of Sentara Albemarle Medical Center and may also be downloaded from the internet free of charge at www.sentara.com/financialassistance. The Application for Financial Assistance may also be mailed free-of-charge to patients upon request by phoning 757-233-4600, or by sending a written request to the following address:

Sentara Health
ATTN: Financial Coordinator
P.O. Box 117839
Atlanta, GA 30368-7839

Completed Applications for Financial Assistance, along with proof of Household Income and all other support, should be mailed to the address set forth in this Policy or the application and support may be submitted through Sentara MyChart. Alternatively, a patient may return a completed application, along with proof of Household Income and all other support, to any patient registration area of a Hospital Facility.

Patients who need additional information about this Policy, or who need assistance with the Financial Assistance application process, may call or visit the above location Monday through Friday between 8:30AM and 4:30PM to speak with a Sentara Financial Coordinator.

Length of Eligibility:

Eligibility determinations approved through the application process under this Policy are effective for Covered Services rendered up to 240 days prior to the application date and for Covered Services 6-months after the final approval date or 12 full months after the final approval date if the applicant's only means of Household Income is from a verifiable fixed-income source such as a pension or Social Security.

Actions Taken in the Event of Non-Payment (Collections/Bad Debt):

The collection process is the same for all Insured Patients regardless of their type of insurance, i.e. Medicare, commercial insurance, managed care, or private health insurance. Patient collection efforts start after all insurances have paid. Any balance remaining after all insurances have paid is considered the patient responsibility amount. Sentara attempts to collect the patient responsibility amount from Insured Patients for a minimum of 120 days with at least three balance due notifications before the account/visit becomes bad debt at which time the account/visit may be placed with Sentara's collections department or an outside collection agency.

Uninsured Patients and Self-Pay Patients follow the same collection process as Insured Patients with regards to the patient responsibility amount. Sentara's collections department or the collection agency makes at least three additional attempts over the next 120-day period to collect the amount due from the patient, and this also covers the Application Period for a patient to apply for Financial Assistance. Bad debt accounts placed with an outside collection agency remain with the agency until they are paid or returned to Sentara. Accounts returned to Sentara may receive additional collection efforts or Sentara may choose, at its own discretion, to cease all collection efforts based on the patient's individual circumstances.

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Reasonable efforts are taken by Sentara to determine a patient's eligibility for Financial Assistance under this Policy with respect to Covered Services prior to engaging in collection efforts with respect to such patient. Such efforts include notifying a patient about this Policy, helping a patient remedy an incomplete Application for Financial Assistance, and informing an applicant for Financial Assistance regarding the eligibility determination once a completed application has been received.

If, after reasonable efforts are taken, a patient is found to either not qualify for Financial Assistance under this Policy or is unresponsive to the Covered Entity's efforts to obtain the information necessary to determine eligibility for Financial Assistance, the patient's account may be moved to bad debt and the delinquent account turned over to Sentara's collections department or an outside collection agency. ***Neither the Covered Entity nor outside collection agencies acting on its behalf ever engage in extraordinary collection actions as defined under section 1.501(r)-6(b)(1) of the U.S. Treasury regulations.***

After a reasonable period, a Covered Entity will also attempt to presumptively qualify a patient and write-off balances related to that patient's Covered Services under this Policy when a patient does not provide financial or non-income-based information or respond to attempts to provide Financial Assistance based on non-income-based criteria or credit reporting data that assists in determining income and credit worthiness. When the credit data suggests that an Insured Patient, Uninsured Patient, or Self-Pay Patient's total Household Income is at or below 300% of the then-current Federal Poverty Guidelines, the account balance for that patient's Covered Services will be written-off to presumptive financial assistance.

A patient is deemed eligible for presumptive financial assistance on Covered Services under this Policy and may have their account balance written-off if the patient is deemed eligible for or has Medicaid coverage, deceased with no estate, is receiving healthcare services at a non-Sentara free clinic, a Sentara Community Care Clinic, a Federally Qualified Health Center (FQHC).

Prior to categorizing patient accounts as bad debt, a Covered Entity, as part of its routine collections process, will mail or make available in Sentara MyChart a series of no less than three balance communications or patient statements, and may also make attempts by phone to contact patients. In the event of non-payment or the absence of any mutually agreed-upon payment arrangement, a Covered Entity will consider an account to be bad debt and may undertake ECAs after 120 days from the provision of a patient's first post-discharge billing statement or first balance due communication in Sentara MyChart. A patient will be mailed an additional series of three patient statements when the account is in bad debt. Any unpaid account(s) remaining at the end of this second series of statements to the patient will be reviewed for possible placement with an outside collection agency.

Patient balances are eligible for Financial Assistance evaluation during the Application Period. An applicant for Financial Assistance who provides incomplete information during the Application Period is given a reasonable period of time, as determined by Sentara, and based upon the particular facts and circumstances, to respond to the Covered Entity's written notice describing the additional information and/or documentation required to complete the application.

The Director of Patient Accounting is responsible for determining that a Covered Entity has made reasonable efforts to determine patient eligibility for Financial Assistance under this Policy.

Exceptions to this Policy

The Director of Patient Accounting, Associate General Counsel, Vice President of Revenue Cycle, Senior Vice President of Corporate Finance, and Chief Financial Officer of Sentara are each granted the authority to provide eligibility and determination exceptions to this Policy on a case-by-case basis as appropriate to an individual patient's facts and circumstances. If a Public Health Emergency is declared, Sentara leaders authorized on a case-by-case basis to make eligibility and determination exceptions to this Policy may temporarily modify the eligibility and determination requirements of all applicants for the duration of the Public Health Emergency. In no case will a patient be denied Financial Assistance if they meet the stated eligibility and determination requirements for Covered Services set forth in this Policy.

Monitoring:

Outcomes Monitoring – The Director of Patient Accounting, Associate General Counsel, Vice President of Revenue Cycle, and Senior Vice President of Corporate Finance are responsible for enforcing this policy.
Document Management – The contact listed will be responsible for developing, communicating, and maintaining this policy and related procedures and job aids necessary for the implementation and continuance of the policy. This policy shall be reviewed at least every 3 years for repeal or amendment as appropriate.

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Related Documents:

Policy	SAMC Medical Debt Mitigation Policy
Procedure	List Procedures.
Job Aids	List Related Job Aids.
Regulatory References	List Regulatory References.

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