



## POLICY

<b>Policy Name:</b>	Financial Assistance Policy, Payment Plans and Uninsured Discount				
<b>Policy #:</b>	8227.038	<b>Policy Dept.:</b>	Patient Financial Services	<b>Population:</b>	<input checked="" type="checkbox"/> <b>Adult</b> <input checked="" type="checkbox"/> <b>Peds</b>
<b>Approval Authority:</b>	Chief Executive Officer	<b>Originally Effective:</b>	10/2017	<b>Revised Effective:</b>	4/1/2026
<b>Responsible Executive:</b>	Chief Financial Officer	<b>Revised:</b>	9/20/2020, 7/1/2022, 5/25/2023, 3/3/2026		
<b>Responsible Office:</b>	Patient Financial Service	<b>Contact:</b>	Vice President, Revenue Cycle		

**1. Policy Statement:**

It is the policy of Erlanger Health System (**Erlanger**) to grant our patients access to essential or non-elective care, regardless of their ability to pay, through a fair and equitable system for determining financial assistance with established guidelines.

**2. Who Should Read This Policy?**

All Erlanger Staff who regularly have patient or guarantor contact, particularly those staff members working in Patient Financial Services and Patient Access.

All individuals who may be eligible or would like to apply for financial assistance pursuant to this policy.

**3. Purpose**

The purpose of this policy is to explain the financial assistance available to patients, describe the application process, and highlight other discounts and payment plans.

**4. Definitions**

**Amounts Generally Billed (AGB):** The amounts generally billed for emergency or other Medically Necessary care to individuals who have insurance covering such care. The AGB percentage is a calculation of the percentage of the gross charges that Erlanger bills to individuals who have insurance. Using the prospective Medicare method, an individual who qualifies for financial assistance will never pay more than the AGB because an individual eligible for financial assistance pursuant to this policy is not charged for Medically Necessary care or care for an Emergency Medical Condition.

**Application Period:** A patient or guarantor may apply for financial assistance for Medically Necessary care up to 240 days **after** the date the first post-discharge billing statement for that care is provided. In the case of any billing statement that is mailed, the date of mailing is when it is "provided." The date that a billing statement is provided can also be the date such communication is sent electronically or delivered by hand. For example, an individual receives Medically Necessary care on February 1st and is discharged in mid-February. The billing statement for that care is provided on March 2nd. The individual may apply for financial assistance up to 240 days **after** March 2nd (which would result in a deadline of October 28th). This deadline may be extended in certain circumstances defined by applicable law. Once a timely application for financial assistance has been submitted, processed and approved, the determination of

eligibility for financial assistance from that application will apply to all dates of service for a term of 240 days from the date of service to which financial assistance was first applied unless otherwise specified. Note, if an applicant has previously submitted a complete application, any approval from a subsequent application will be effective from either the Application Period as defined above, or the date of the prior application, whichever is most recent.

Erlanger may accept applications for prospective care. Any determinations made for prospective care purposes may also be used in assessing eligibility for financial assistance regarding dates of service for which the first billing statement was provided 240 days prior to the date the application was received.

**Emergency Medical Condition:** A medical condition manifesting itself by severe, acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of an individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Despite any limitations or expansions contained the foregoing language, this policy explicitly adopts the definition of emergency medical condition contained in 42.U.S.C. § 1395dd.

**Family:** A group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on his or her income tax return, that person may also be considered Family for purposes of the provision of financial assistance.

**Family Income:** Income for all Family members residing in the same household, including earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the Family, and other miscellaneous sources of funds, including other income such as prizes, awards, and gambling winnings.

Income for the purposes of this policy is determined on a pre-tax basis, and it **does not** include: non-cash benefits (such as food stamps and housing subsidies); or income of non-Family, except to the extent that it is used for the benefit of Family members (assistance). If a Family member operates or has an ownership interest in a business, the gross receipts, deductions, income, capital, profit and loss statements, business banking information/statements and business operations of that business will also be evaluated in determining Family Income. Erlanger may refer to the Gross Receipts line of Schedule C, but due to the varying nature of businesses and related expenses, evaluation of any owned or operated business occurs on a case-by-case basis. Any determination that financial assistance should be denied because there are business assets or income that could be used to pay for care or health insurance is in the sole discretion of Erlanger.

**Federal Poverty Guidelines (FPG):** A measure of income issued every year by the Department of Health and Human Services (HHS) based on household size. It can be accessed at <https://aspe.hhs.gov/poverty-guidelines>. Eligibility for some of the financial assistance available in this policy is based on Family Income in relation to the applicable FPG. Erlanger adopts FPG on July 1 of each year, and such guidelines are effective and controlling through June 30 of the next year.

**Financial Advocate:** An Erlanger representative responsible for assisting patients and guarantors with identifying and applying for public fund options (Medicare, Medicaid, etc.). These representatives also assist in the financial assistance application and determination process.

**Gross Charges:** The total charges at Erlanger's full, established rates for the provision of patient care services before deductions from revenue are applied.

**Healthcare Share Program (HSP):** A program in which an individual pays a membership fee, premium, or other amount to join or remain active in the program, but the individual is not contractually entitled or guaranteed to have medical services covered and paid by the healthcare share program. Rather, the program relies upon voluntary contributions to satisfy any medical debt of its members and is not contractually obligated to make any payment towards its members' covered medical services. These

programs are not managed as traditional insurance plans. These programs are not flexible spending or health savings accounts (commonly known as FSAs and HSAs). As a courtesy to members of these programs, Erlanger may allow 30 to 90 days to receive payment from the HSP before an account is billed to the next responsible party.

**Health Insurance Market Place:** Organization set up to facilitate the purchase of health insurance in every state of the United States in accordance with Patient Protection and Affordable Care Act. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies.

**Medically Necessary:** Services or supplies that: (1) are proper and needed for the diagnosis or treatment of a medical condition; (2) are provided for the diagnosis, direct care, and treatment of a medical condition; (3) meet the standards of good medical practice in the local area; and (4) aren't mainly for the convenience of the patient or his or her doctor. For purposes of this policy Medically Necessary care does not include cosmetic/plastic, bariatric surgery, transplant services, or services provided at pre-paid or flat-rate pricing. Despite this definition, if a patient's insurance denies coverage for services as not medically necessary, then those services are not medically necessary for the purposes of this policy. For certain scheduled services for uninsured patients, Erlanger may require Utilization Management to review those services for medical necessity prior to the service being provided.

**Uninsured:** A person is uninsured if he or she has no health insurance and no third-party liability/recovery (such as legal claim or lawsuit against someone else) or other assistance in meeting his or her medical payment obligations. In other words, an uninsured person is a person who is solely responsible for the full balance of his or her own medical bills without any discounts or reductions due to a contractual relationship with an insurance company or government benefit plan and without an enforceable obligation against another person or entity for the payment of such medical bills.

## 5. Scope

This policy applies to the following Erlanger facilities and Erlanger-employed physicians providing services in these facilities:

**Baroness-Erlanger Hospital**  
975 East Third St.  
Chattanooga, TN 37403

**Children's Hospital at Erlanger**  
910 Blackford St.  
Chattanooga, TN 37403

**Erlanger East Hospital**  
1751 Gunbarrel Rd.  
Chattanooga, TN 37421

**Erlanger North Hospital**  
632 Morrison Springs Rd.  
Chattanooga, TN 37415

**Erlanger Bledsoe Hospital**  
71 Wheelertown Ave.  
Pikeville, TN 37367

This policy also applies to all Erlanger office and clinic locations, except those locations and services specifically excluded. This policy is NOT applicable to the following Erlanger facilities, clinics and locations:

Erlanger Community Health Centers  
All Erlanger ExpressCare locations  
The Walk-in-Clinic at Volkswagen Drive  
Erlanger Behavioral Health Hospital  
Erlanger Rural Health Clinics  
Erlanger Western Carolina Health Clinics  
Erlanger Western Carolina Hospital  
Erlanger Retail Specialty Pharmacy

The Rural Health Clinics, Erlanger Western Carolina Health Clinics, Erlanger Western Carolina Hospital and Erlanger Community Health Centers offer financial assistance pursuant to their individual policies. Please see those policies for further information about financial assistance available. Erlanger Behavioral

Health Hospital offers financial assistance in accordance with its financial assistance policy.

## 6. Financial Assistance

It is the policy of Erlanger to provide Medically Necessary and emergency medical care to all individuals without discrimination and regardless of their ability to pay or eligibility for financial assistance. Additionally, pursuant to EMTALA and billing and collections policies, Erlanger does not demand or require payment prior to rendering emergency medical services. Furthermore, as outlined in Erlanger's billing and collections policy, Erlanger does not engage in collection practices that interfere with the provision of any emergency medical care.

Erlanger provides financial assistance for Medically Necessary or emergency inpatient and outpatient care provided by Erlanger to those who qualify, as described more fully below. A list of providers covered by this financial assistance policy, and a list of providers who are excluded from this policy, can be found at <https://www.erlanger.org/patient-and-family-resources/billing-insurance-information/ehs-fap-providers-covered>, or by clicking on the link for "Providers Covered by Financial Assistance" at [www.erlanger.org/fap](http://www.erlanger.org/fap). A paper copy of this list is also available for free from Ambassadors/PSRs or by contacting Financial Advocates in person or by mail or telephone at:

Erlanger Financial Assistance  
975 E 3<sup>rd</sup> Street  
Box 243  
Chattanooga, TN 37403  
423-778-9805

To request more information or to contact an advocate who can assist you, please call the numbers listed above or request a Financial Advocate at the Registration Office, First Floor, Medical Mall, Erlanger Baroness Campus.

### Part I. Financial Assistance Available

Erlanger offers free Medically Necessary care and care for Emergency Medical Conditions covered by this policy to those individuals who qualify for financial assistance.

### Part II. Eligibility

To qualify for free care, a patient **must** have Family Income at or below 300% of the FPG and **must not** have assets sufficient to indicate that the patient can pay for his or her care. If Erlanger determines in its sole capacity that assets are available for payment of medical care, the patient will be required to use those assets for the payment of care. Any remaining amounts owed after use of those assets may then be subject to financial assistance under this policy.

Erlanger considers a patient's Family Income and assets in evaluating eligibility for financial assistance. In addition to income and assets that the patient or guarantor self-reports, Erlanger may rely upon its own records, real estate records, bankruptcy filings, probate filings, credit reports, and other searchable and available data to validate and evaluate an application for financial assistance. Erlanger will also consider temporary factors, such as short-term layoff, unemployment, disability or other demonstrated hardship. Generally, if assets exist to pay medical debt, financial assistance will be denied.

A patient whose Family Income is equal to or less than the FPG indicated above and who does not own assets sufficient to pay for his or her care is not financially responsible for any charge associated with care provided for under this policy, after application of any payment from insurance, any benefit program, or payment from a third-party (such as lawsuit proceeds). A patient must first exhaust all payment sources, including but not limited to insurance benefits, federal, state and local medical assistance programs, other forms of assistance provided by third parties, and potential claims/proceeds from third-party liability before financial assistance is applied to any account. Exhaustion of payment sources may include, but is not limited to, requiring the patient to: (i) apply for healthcare coverage as discussed below, (ii) see an in-

network provider, (iii) comply with any insurer or plan's medical necessity/utilization management guidelines or decisions, and (iv) seek payment from an HSP.

For non-emergent imaging, surgical, infusion and radiation oncology services, all uninsured patients must also:

- (1) exhaust payment sources by being ineligible for health benefit coverage under TennCare, CHIP, Medicaid offered by another state, Medicare, VA/TriCare, any other medical assistance programs, other forms of assistance provided by third parties, or an affordable health benefit plan offered by an employer, through COBRA or on the Healthcare Insurance Marketplace; **and**
- (2) be a resident of Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Polk, Rhea or Sequatchie Counties, in Tennessee, or Catoosa, Dade, Walker or Whitfield Counties in Georgia.

The affordability of any healthcare coverage through an employer, COBRA or the Health Insurance Marketplace is determined solely by Erlanger, but premiums will generally be considered affordable if the portion the patient is responsible for paying (after application of any subsidy, credit, assistance, reimbursement or similar) is equal to or less than 9% of gross household or Family Income. This exhaustion eligibility requirement can be satisfied through a phone screening with a Financial Advocate and/or the submission of additional documents, which may include applications for insurance or federal, state, local or third-party medical assistance programs. When Erlanger determines that this additional exhaustion screening is necessary, Erlanger will initiate this process. Despite the foregoing, if Erlanger determines, in its sole capacity, that a patient does not have appropriate access to care, it may grant Financial Assistance under this policy.

Because those who qualify for financial assistance under this policy will not pay any charges associated with an Emergency Medical Condition or Medically Necessary care covered under this policy, they will not pay more than the Amounts Generally Billed for those covered services.

### Part III. How to Apply for Financial Assistance

Patients can qualify for free care through two pathways: (a) presumptive eligibility screening or (b) the application process.

#### A. Presumptive Eligibility Screening

A patient may presumptively qualify for free care if:

- i. the patient is a Medicaid enrollee;
- ii. the patient is enrolled in Southeast Tennessee Project Access (STPA) during the period of care. The patient should provide his or her STPA card at the time of service;
- iii. the patient is deceased with no known estate or other known responsible party; or
- iv. the patient is uninsured and the patient's Family Income is at or below 200% FPG at the time of presumptive screening as determined by third-party software used by Erlanger or other information available to Erlanger as described in this policy.

If a patient is determined to qualify for free care, he or she will not be required to pay for the Medically Necessary care or care for an Emergency Medical Condition covered by this policy and subject to the terms in Part II regarding exhaustion and residency. Erlanger, however, will seek payment from insurance benefits or policies as well as other appropriate third-parties. If a patient is presumptively eligible under (i) or (ii), he or she will not receive a billing statement for the care received. Presumptive screening for eligibility under (iv) will occur prior to the account being sent to an external collection agency to ensure adequate time to assess need and obtain insurance status.

Erlanger may deny or reverse financial assistance based on a presumptive screening if it becomes aware of insurance coverage, third-party liability, or assets or income available to pay for medical care. Examples include but are not limited to: an individual's assertion that he or she can pay for care, assets or income disclosed in probate or bankruptcy proceedings, lawsuits for personal injury and notification of active insurance through any source.

Any person who does not qualify for free care through presumptive screening, or whose presumptive assistance is reversed, may apply for free care using the application process described below.

## B. Application Process

Any person may qualify for financial assistance through the application process by: (1) completing the application form and providing the required documents; (2) having a Family Income at or below 300% of the FPG; and (3) have no assets sufficient to indicate that the patient can pay for his or her care.

To apply for free care, a patient must complete the financial assistance application form and provide required documentation within the Application Period, and if applicable, meet the required exhaustion standards. The documents required for a complete application are listed on the application form.

A patient may also include a hardship letter with his or her application to justify the inability to pay. A hardship letter, however, is not required. The application form and the supporting documentation should be sent to:

Erlanger Financial Assistance  
975 E 3<sup>rd</sup> Street  
Box 243  
Chattanooga, TN 37403  
423-778-9805

An application for financial assistance, this financial assistance policy, and a plain language summary of this policy can be found online at [www.erlanger.org/fap](http://www.erlanger.org/fap) or requested by contacting a Financial Advocate in person, by mail or telephone at the address and number listed above. These documents are also available upon request at admission/registration areas of Erlanger. These documents are available in Spanish at the website listed and upon request.

Generally, the application form and all supporting documents must be provided. If a patient does not have one of the required documents, the patient should provide a written statement with the application form explaining why the patient is not including the required document with the application form. In appropriate circumstances, Erlanger will work with the patient to determine alternative supporting documentation.

If eligibility for financial assistance cannot be determined due to missing information or documents in the application packet, the patient will receive a written notice indicating the information or documents needed and providing a deadline by which that required information or documentation to be submitted. Failure to provide the requested information in the time allowed may result in a denial of financial assistance.

An individual may apply for financial assistance during the Application Period. Applications for assistance are reviewed as soon as practical after receipt of the completed form and all required documentation. However, the determination of whether a patient qualifies for financial assistance may be delayed until resolution of pending claims with other potential payment sources – such as lawsuits or insurance/other benefit programs.

Financial assistance may be denied under this policy if there is reasonable suspicion of the accuracy of an application. If the patient or guarantor supplies the needed documentation and/or information requested to clarify the application within the time provided, the financial assistance request may be reconsidered. Reconsideration will be reviewed and handled on a case-by-case basis.

Erlanger has Financial Advocates available to assist with obtaining, completing and/or submitting the

financial assistance application. Financial Advocates can be reached at the address and phone number listed above.

Part IV. Other Sources Used to Determine Eligibility and Use of Financial Assistance Applications

In addition to the third-party software used for presumptive eligibility screenings and the application packet provided in the application process, Erlanger may conduct asset and other financial or credit investigations on individuals and households as part of the eligibility review. If it is determined that assets exist or that the patient otherwise may be able to pay for care, financial assistance may be denied.

Erlanger routinely uses data provided by outside agencies to verify information provided and evaluate applications, such as credit-type reports and scores, assets searches, public records, etc. This outside information (combined with the information provided by a patient or guarantor) is used in deciding whether the patient is eligible for financial assistance, determining medical indigence, screening for other funding and programs as well as assessing the viability of collection on the patient's account.

Any individual misrepresenting his or her income or assets will be disqualified for consideration for financial assistance and may be denied the benefit of any previously provided financial assistance. In the event the applicant makes significant misrepresentations, the account balance will be billed to the responsible party, rather than being written off as free care.

Part V. Term of Financial Assistance Eligibility

If a patient is determined to be presumptively eligible for free care at or near the time of service or upon presumptive screening review of an open account, the charges for **that** service date will be written off as free care as provided under this financial assistance policy. Furthermore, a presumptively-qualified individual **may** receive financial assistance under this policy for a period of 60 days after a presumptive eligibility determination, assuming all requirements listed under Part II and Part III continue to be met. If a person who is presumptively-qualified under presumptive factors (ii) or (iv), above, becomes covered by insurance, he or she must apply for financial assistance through the application process to receive any further financial assistance.

If a patient is qualified for free care through the **application process**, free care will be provided for a term of 240 days from the date of service to which free care assistance was first applied, despite the actual date a timely application was received within the Application Period. At the end of that 240-day period, the patient may re-apply for free care using the processes described above.

Part VI. Additional Extension of Financial Assistance

Erlanger reserves the right to extend financial assistance to individuals outside of the guidelines identified above, including expanding the medical services covered, extending the time period to apply for financial assistance or offering financial assistance to those to whom payment of medical debt would be a particular hardship, despite having Family Income above 300% of the FPG. Any such extension of financial assistance is within the discretion of the Vice President of Revenue Cycle or his or her designee; however, such discretion shall not be used to discriminate against persons on the basis of race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, or political beliefs. Further, in any extension of financial assistance, the eligible patient will pay no more than AGB.

Part VII. Billing and Collections

The actions Erlanger may take in the event of nonpayment are described in its billing and collections policy, which can be accessed at [www.erlanger.org/fap](http://www.erlanger.org/fap). Individuals may also request a free paper copy of that policy from Ambassadors/PSRs or by contacting Patient Financial Services at 423-778-3296 or requesting a copy from a Financial Advocate at the contact address and location provided above.

**Payment Plans**

Erlanger does not typically provide payment plans directly. It does, however, partner with a third-party vendor that provides interest-free financing for Erlanger patients with monthly repayment options. If a patient decides to take advantage of the payment plans offered by that vendor, the vendor will invoice the patient directly. Patients can learn more about payment plans and request that their accounts be transferred to the payment plan vendor by contacting Patient Financial Services.

### **Tennessee Uninsured Patient Discount**

Pursuant to Tennessee law, Erlanger will not require an "uninsured patient" to pay more than the amounts allowed by Tenn. Code Ann. § 68-11-262 for care or services provided in Tennessee. For these purposes, an "uninsured patient" is a person with no public or private source of payment for medical services, including, but not limited to, Medicare, TennCare, a contract of insurance, an employer-sponsored health plan, or other enforceable obligation under which a person is responsible for payment for healthcare services provided to the patient. The calculation of the appropriate discount to apply to Gross Charges is performed by the Tennessee Hospital Association, and the amount of discount varies among hospital facilities located in Tennessee. When Erlanger determines that an individual is an uninsured patient, the discount described in this paragraph is applied to applicable services and charges.



\_\_\_\_\_  
Chief Executive Officer

3-6-2024

\_\_\_\_\_  
Date