PURPOSE:
This Financial Assistance Policy ("FAP") is intended to set forth WakeMed's policies with respect to financial assistance for certain patients and to comply with Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder and shall be interpreted and applied in accordance with such regulations.

POLICY STATEMENT:
WakeMed provides Emergency Care and other medically necessary services that are reasonable and necessary for the diagnosis and treatment of illness or injury to individual patients without discrimination, regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage.

This policy is specifically targeted at low-income, uninsured and underinsured patients who are established residents of North Carolina and who meet certain eligibility requirements and is not intended to be applied to insured or self-insured patients who have the means to accept the responsibility for their incurred charges. Financial assistance does not apply to Elective Services, Non-Emergent Cosmetic Services.

If a financial assistance application is received, open accounts are identified as "pending charity" if the patient is uninsured, or their insurance does not pay 100% of contracted charges. All patients who are identified as "pending charity" will be screened for alternative sources of funding to meet their medical expenses at any point in the billing cycle. If no alternative sources are found, the patient will be considered for full or partial debt forgiveness as applicable and after receipt of a completed financial assistance form, as described below. Uninsured patients will remain classified as "pending charity" until information is received to validate otherwise or deadlines for submitting all the required information to assess eligibility for financial assistance have passed, whichever occurs sooner. The billing process will continue, but collections activity will not be initiated until after the applicable deadlines have passed without submission of all the required information or a patient has been determined not to be eligible for financial assistance, whichever occurs sooner.

Patients identified by WakeMed as self-pay who are not covered by health insurance or another third-party source, which is or may be responsible, are provided a 62% uninsured/self-pay discount for hospital charges and a 30% discount for physician charges prior to billing initiation.

ENTITIES AFFECTED BY THIS POLICY (SCOPE):
This policy applies to locations operated by WakeMed and Physician Practices. Specific locations include but not limited to:

- WakeMed Hospitals (WakeMed Raleigh CCN, including North, Rehab, WakeBrook, and WakeMed Cary CCN)

Origination date: *01/01/1992*
Prepared by: *Mgr, Patient Financial Services*
Approved by: *DIR, REVENUE CYCLE*
Reviewed: *11/05/2024*
Revised: *11/05/2024*

- Wake Pet Services LLC
- WakeMed Healthplexes & Medical Parks, including Apex, Brier Creek, Garner, Clayton, Wendell, and Raleigh.
- WakeMed Physician Practices: Cancer Care – Hematology & Medical Oncology; ENT – Head & Neck Surgery; Gastroenterology; General Surgery; Heart & Vascular; Maternal-Fetal Medicine; Obstetrics & Gynecology; Orthopedics; Pediatric Cardiology; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Primary Care; Pediatric Pulmonology & Sleep Medicine; Pediatric Surgery; Pediatric Urology; Physical Therapy; Primary Care; Pulmonology; Thoracic Surgery; Rheumatology; Urgent Care; Urogynecology; Urology

Services provided and/or billed by private or independent (non-WakeMed) entities, practice groups, physicians, or other providers are not covered by this policy. Patients should address any payment questions or concerns directly with the private physician practice. These groups include:

- Wake Emergency Physicians
- Raleigh Radiology Consultants
- Raleigh Pathology Laboratory Associates and Wake Medical Laboratory Consultants
- Mednax
- All private or independent physicians not employed by WakeMed or physician practices not owned by WakeMed

Hospital and Physician practice locations established after publication of this Policy are incorporated by reference, and services provided and billed by those locations will be subject to this Policy.

WHO SHOULD READ THIS POLICY:
All Revenue Cycle and Patient Access Staff

PROCEDURES:

I. ELIGIBILITY

a. WakeMed's Revenue Cycle Department is responsible for determining that reasonable efforts have been made to determine eligibility for financial assistance.

b. In order to be eligible for consideration for financial assistance under WakeMed's FAP:

i. The applicant must be a North Carolina resident (the criteria for determining residency is attached as Appendix A to this policy);
ii. The applicant's adjusted gross income must be within the ranges established by WakeMed based on federal government poverty guidelines (see WakeMed Health and Hospitals Charity Sliding Scale, attached as Appendix B); and
iii. WakeMed may also consider the following in assessing the applicant's ability to pay for services:
    1. The applicant's net worth, considering liquid and non-liquid assets;
        a. The following will be excluded from a calculation of the applicant's net worth:
            i. One essential automobile for a single applicant and two essential automobiles for a married couple;
            ii. The value of the primary residence;
            iii. Property owned in conjunction with a business for which a family is fully dependent upon for income if financial income from the business is included in determining if a patient or dependent meets the debt forgiveness guidelines.
    2. Payments due to the applicant or WakeMed from any source or under any agreement, including, but not limited to:
        a. Group or individual medical plan and/or health insurance;
        b. Medicare (Title XVIII);
        c. Medicaid (Title XIX);
        d. Other federal, state, tribal, or military programs (e.g., Indian Health Services, CHAMPUS);
        e. Third party liability insurance (e.g., resulting from automobile accidents or other personal injury);
        f. Workers' compensation programs;
        g. Designated grant funds for which the patient may be eligible;
        h. Any other persons or entities that may have a legal responsibility to pay for the patient's medical services, such as third-party liability sources;
        i. Government and public records;
        j. Prior applications for financial assistance; and
        k. Information posted on public websites.

c. U.S. citizens outside of North Carolina, legal residents and undocumented residents may be approved for debt relief with management approval.
d. Catastrophic medical debt may be used as a deduction from income on a case by

case basis with management approval.

e. The head of household must qualify for debt forgiveness when dependents are applying for assistance. Parents' income will be used to determine eligibility for an unemancipated minor.
f. A patient who is 18 years or older (or is an emancipated minor) will be considered the responsible party unless he or she is claimed as a dependent for tax purposes by another person, in which case that person's assets and adjusted gross income will be also be evaluated under this policy to determine the patient's eligibility for financial assistance. Such person will be considered the "responsible person" for purposes of this policy.
g. Eligible patients may qualify for a discount of an amount up to 100% off gross charges (or free care) for eligible services. Discount amounts off remaining gross charges will be determined based upon a patient's adjusted gross income compared to the percentages of the current Federal Poverty Income Guidelines as per the chart below after consideration of the applicant's assets available to pay for care.
h. WakeMed will use the "Look-Back Method," as defined in IRS regulations, to confirm that no FAP-eligible individual is charged more than the Amount Generally Billed ("AGB") to individuals who have insurance coverage. This method will be used for all FAP-eligible patients receiving Emergency Care or other non-elective, Medically Necessary care. The AGB amounts applied at each WakeMed entity and location covered by this policy are listed in the appendices.
i. Once a decision is made on the appropriate discount or adjustment amount, any remaining amount is the patient's liability and must be paid in full prior to the charity adjustment (applicable discount) being made.
j. Eligibility for catastrophic financial assistance is addressed in Section IV, below.

II. APPLICATION PROCESS

a. To apply for financial assistance, the applicant must:
    i. Complete a financial assistance application form (the form may be completed over the phone with a WakeMed employee); and
    ii. Submit the following information:
        1. A copy of the most recent tax return (to include all copies of applicable forms, schedules, and required attachments);
        2. Most recent pay stub(s) that show work history for the past 4 weeks;
        3. Written verification of other income sources (e.g. child support, social security, alimony) or if unemployed.
        4. Proof of the following (as applicable):
            a. Permanent residency (as outlined in Appendix A);
            b. Disability;

c. Medicaid Denial; and
d. Household Financial Income.

b. Completed financial assistance applications must be received within two hundred forty (240) days of the date on the first post-discharge billing statement sent by WakeMed that includes information about the availability of financial assistance. However, collections activities may begin if a completed application is not received within one hundred twenty (120) days of the first statement.
c. The applicant is responsible for furnishing documentation upon request and as required by the financial assistance application. The normal billing process will be reinstated if the documentation is not returned within thirty (30) days.
d. A new application must be completed for every twelve (12) month period.
e. The income of the applicant is calculated twelve (12) months forward.

III. PRESUMPTIVE ELIGIBILITY:

WakeMed understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. WakeMed may engage in a review of publicly-available information to establish such patients' qualification for financial assistance ("presumptive eligibility screening"). Presumptive eligibility screening enables WakeMed to systematically identify financially in need patients, reduce administrative burdens, and provide financial assistance to patients and their guarantors.

a. WakeMed may use a third party to conduct a review of publicly-available information about the patient or guarantor to assess financial need. In no event will WakeMed or the third party access the patient's or guarantor's credit file.
b. Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:
    i. homelessness or receipt of care from a homeless clinic or shelter;
    ii. patient deceased with no known estate;
    iii. Women, Infants and Children (WIC) program;
    iv. SNAP benefits (Supplemental Nutritional Assistance Program, (formerly known as Food Stamps) as proof of need and are therefore presumptively eligible).
    v. Minors 17 years of age or younger who are deemed financially responsible for a minor child who has received services at WakeMed.
    vi. Minors 17 years of age or younger who WakeMed was unable to obtain a parent or legal guardian to be financially responsible for services rendered to the minor.
    vii. Eligibility in other state or local assistance programs, such as Victims of Violent Crimes.
c. The data returned from the presumptive eligibility review will constitute adequate

documentation of financial need under this Policy.

d. If a patient will be screened under the presumptive eligibility model, the screening should be completed prior to bad debt assignment or after all other eligibility and payment sources have been exhausted to ensure the patient is screened for financial assistance prior to pursuing any extraordinary collection actions.
e. If the information obtained through the presumptive eligibility screening does not support a finding that the patient qualifies for financial assistances, the patient may still apply through, provide the requisite information for, and be considered under the traditional financial assistance process.
f. Patient accounts granted presumptive eligibility will be reclassified as financial assistance. Any remaining balance due will be forgiven, but only for eligible services provided on the specific dates of service screened for presumptive charity eligibility. Refunds will only be granted for patient accounts granted presumptive eligibility if the patient subsequently completes the application process and is approved for financial assistance within two hundred forty (240) days of first billing statement from WakeMed.
g. Presumptive eligibility status will not constitute a state of free care as available through the traditional financial assistance application process. Instead, these accounts will be treated as eligible for financial assistance under this Policy. They will not be sent to collections, will not be subject to further collection action, and will not be included in WakeMed's bad debt expense. Patients/guarantors will not be notified to inform them of this decision when the patient/guarantor qualifies for the most generous level of financial assistance.
h. WakeMed reserves the right to reverse the presumptive charity discount if a potential payer source is identified. Eligible payer sources may include, but are not limited to, agency funding, government insurance, private insurance, or third-party liability coverage. Once the reversal is complete, the account will be reprocessed based on billing processes for the new coverage information provided.
i. WakeMed will only consider open hospital account balances for presumptive charity review.

IV. CATASTROPHIC FINANCIAL ASSISTANCE

a. Following financial assistance review and denial, patients who are denied traditional financial assistance based on income guidelines exceeding 300% of the Federal Poverty Guidelines may be eligible for catastrophic financial assistance.
b. To be eligible for catastrophic financial assistance, the patient must have open accounts with WakeMed that produce a medical debt-to-income ratio of greater than or equal to 20%.

i. Example: If a household of two has an annual income of $50,000.00, their combined balances (after all other means of payment, as defined below) must be at least $10,000.00.
ii. "Other means of payment" includes, but is not limited to, agency funding, government insurance, private insurance, or third-party liability coverage.

c. All accounts for which the guarantor is responsible, including balances in bad debt, may be included in the calculation of medical debt. Catastrophic financial assistance does not apply to future visits.
i. Any account pending third party payment at the time the approval occurs may be considered for catastrophic financial assistance but will be held until all third-party payments are received. This includes, but is not limited to, accounts pending Medicaid approval.

d. Catastrophic financial assistance may be granted once per year.

e. Upon approval of catastrophic financial assistance, the patient's medical debt will be reduced to 15% of the Household Financial Income.

V. COLLECTIONS ACTIVITIES

a. WakeMed shall not engage in actions that discourage individuals from seeking Emergency Care. WakeMed does not require that emergency department patients pay before receiving treatment for emergency medical conditions or permit debt collection activities that interfere with the provision of Emergency Care.

b. If a financial assistance application has not been received within one hundred twenty (120) days after the first post-discharge billing statement, WakeMed may initiate extraordinary collection actions ("ECAs"). WakeMed will not engage in ECAs during the one hundred twenty (120) day period after the first post-discharge billing statement.
i. ECAs include selling an individual's debt to another party, making an adverse credit report, requiring payment before providing non-emergent Medically Necessary care because of nonpayment of previous bills, or initiating legal action against the responsible party.

c. WakeMed's Collections Department is responsible for determining that all reasonable efforts have been made to determine whether an individual is FAP-eligible before engaging in any ECAs.

d. WakeMed will give notice of any ECAs that may be taken at least thirty (30) days before implementing the ECAs.

e. If a financial assistance application is received after ECAs have been implemented, but within two hundred forty (240) days of the first post-discharge billing statement, WakeMed will suspend such ECAs until a financial assistance determination has been made.

f. If the responsible party is determined to be eligible for financial assistance under this policy after ECAs have been initiated, WakeMed will refund any excess funds it collected over the amount the responsible party actually owes, as calculated under the FAP.

VI. AVAILABILITY OF INFORMATION

a. This policy, the financial assistance application, a plain language summary of this policy, and applicable billing and collections policies are available on WakeMed's website, www.wakemed.org, where they are accessible to view and print in English and Spanish.
   i. These documents are also available by request, without charge and in English and Spanish, in WakeMed Customer Service offices and by mail.
b. The availability of these documents and instructions for obtaining the documents are noted on billing statements sent out by WakeMed.
c. WakeMed's customer service representatives are available during regular business hours at (919) 350-8359 to provide information about the policy and assist with application questions.

DEFINITIONS:

Amount Generally Billed (AGB)	A discount applied to FAP-eligible patients receiving emergency and non-elective medically necessary care at our hospital. WakeMed uses the Look Back Method to calculate this discount. (See Appendix C)
Elective Services	Those services that, in the opinion of a physician, are not medically necessary or can be safely postponed without endangering the health and well-being of the patient.
Emergency Care	Immediate care that is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs and body parts, warranting the highest priority.
Household Financial Income	The modified adjusted gross income (AGI) of spouses, if filing jointly, plus the modified AGI of each individual in the patient's family whom he or she can claim as a dependent and who is required to file an income tax return because his or her income meets the income tax return filing threshold. Measured against Federal Poverty Guideline, income includes, but is not limited

	to, the following: • Annual household AGI or pre-tax job earnings • Unemployment Compensation • Worker's Compensation • Social Security and Supplemental Security Income • Veteran's payments • Pension or retirement income • Other applicable income to include, but not limited to, rent, alimony, child support, and any other miscellaneous source
Medically Necessary	Hospital services provided to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
Open Accounts	Accounts that have an active balance due.

THIS POLICY IS CROSS REFERENCED IN:

I. ASSOCIATED DOCUMENTS

a. Appendix A
b. Appendix B
c. Appendix C

II. ADDITIONAL RESOURCES

a. To obtain the Financial Assistance Application as well as learn more information regarding the policy, please visit https://www.wakemed.org/patients-and-visitors/billing-and-insurance/financial-assistance

Origination date: *01/01/1992*
Prepared by: *Mgr, Patient Financial Services*
Approved by: *DIR, REVENUE CYCLE*
Reviewed: *11/05/2024*
Revised: *11/05/2024*

APPENDIX A: CRITERIA FOR DETERMINING RESIDENCY

Per North Carolina DHHS definition of Family and Children's Medicaid MA-3335, "State Residence":

To verify residency, the applicant may provide documentation that verifies the address he has listed on his application as his physical or mailing address. Documents from at least two of the following categories may be provided. This means a document or proof must be from two of the little letters below. Example: An item from c. and d. would be acceptable. Two documents outlined in b. are not acceptable.

a. A valid North Carolina drivers' license or other identification card issued by the North Carolina Division of Motor Vehicles.

b. A current North Carolina rent, lease, or mortgage payment receipt, or current utility bill in the name of the applicant or the applicant's legal spouse, showing a North Carolina address.

c. A current North Carolina motor vehicle registration in the applicant's name and showing the applicant's current North Carolina address.

d. A document verifying that the applicant is employed in North Carolina.

e. One or more documents proving that the applicant's home in the applicant's prior state of residence has ended, such as closing of a bank account, termination of employment, or sale of a home.

f. The tax records of the applicant or the applicant's legal spouse, showing a current North Carolina address.

g. A document showing that the applicant has registered with a public or private employment service in North Carolina.

h. A document showing that the applicant has enrolled his children in a public or private school or a child care facility located in North Carolina.

i. A document showing that the applicant is receiving public assistance (such as SNAP benefits (Supplemental Nutritional Assistance Program, formerly known as Food Stamps)) or other services which require proof of residence in North Carolina. Work First and Energy Assistance do not currently require proof of NC residency.

j. Records from a health department or other health care provider located in North Carolina which shows the applicant's current North Carolina address.

k. A written DMA-5152, North Carolina Residency Declaration, from an individual who has a social, family, or economic relationship with the applicant, and who has personal knowledge of the applicant's intent to live in North Carolina permanently, for an

indefinite period of time, or residing in North Carolina in order to seek employment or with a job commitment.

l. A current North Carolina voter registration card.

m. A document from the U.S. Department of Veteran's Affairs, U.S. Military or the U.S. Department of Homeland Security, verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.

n. Official North Carolina school records, signed by school officials, or diplomas issued by North Carolina schools (including secondary schools, colleges, universities, community colleges), verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or with a job commitment.

o. A document issued by the Mexican consular or other foreign consulate verifying the applicant's intent to live in North Carolina permanently or for an indefinite period of time, or that the applicant is residing in North Carolina to seek employment or has a job commitment.

APPENDIX B: WAKEMED HEALTH & HOSPITALS CHARITY SLIDING SCALE

% of Poverty Guidelines		250%	275%	300%
Discount		100% Discount	90% Discount	80% Discount
Family Size	1	$37,650.00	$41,415.00	$45,180.00
	2	$51,100.00	$56,210.00	$61,320.00
	3	$64,550.00	$71,005.00	$77,460.00
	4	$78,000.00	$85,800.00	$93,600.00
	5	$91,450.00	$100,595.00	$109,740.00
	6	$104,900.00	$115,390.00	$125,880.00
	7	$118,350.00	$130,185.00	$142,020.00
	8	$131,800.00	$144,980.00	$158,160.00

- For families with more than eight (8) members, add $13,450, $14,795, and $16,140 respectively for each additional member.
- The figures provided are based on the federal poverty guidelines published in the *Federal Register*, which may be updated from time to time.

APPENDIX C: AMOUNT GENERALLY BILLED (AGB) CHARGED TO FAP-ELIGIBLE PATIENTS

The Amount Generally Billed is a discount applied to FAP-eligible patients receiving emergency and non-elective medically necessary care at our hospital. WakeMed uses the Look Back Method to calculate this discount. WakeMed's calculation is based on discount percentages from BlueCross Blue Shield, Commercial & Managed Care Payors, and Third-Party Liability Payors. For more information on how to obtain the current discount percentage and how it was calculated, please submit a request in writing to:

Attn: WakeMed Financial Assistance
3000 New Bern Ave
Raleigh, NC 27610

Request can be made in person at our WakeMed Raleigh or WakeMed Cary Customer Service Offices:

WakeMed Raleigh	3000 New Bern Ave	Raleigh, NC 27610
WakeMed Cary	1900 Kildaire Farm Road	Cary, NC 27518