ACADIA	Business Office	Policy# ALL,ACHC.BO,0160
	ACHC.BO.0160 – Financial Assistance	Effective: 06/01/2012
		Last Reviewed/Revised: 07/21/2026
		Superseded Policy

Financial Assistance Policy

SCOPE

Acadia Healthcare Co., Inc., including all subsidiaries, affiliates, facilities, and their personnel.

PURPOSE

To determine qualifications for financial assistance.

POLICY

It is the company's policy to provide financial assistance based on federal poverty guidelines to patients with no health insurance or other state or federal health assistance or for whom the out-of-pocket expenses are significant. All financial

assistance will be provided based on established protocols and completion of the San Jose Financial Disclosure Form and supporting documentation.

PROCEDURE

All facilities should maintain a goal to perform verification of benefits for each patient and each potential payer prior to or upon admission. If an admission occurs after normal business hours, the initial verification must be performed no later than the next business day. This insurance verification process should identify all potential resources for the patient's medical services, including federal or state governmental health care programs (e.g., Medicare, Medicaid, state or local government agency, Champus, Medicare HMO, Medicare secondary payer), private insurance, and other private, non-governmental third-party payer sources.

Financial assistance is not considered to be a substitute for personal responsibility. It is the responsibility of the patient/responsible party to actively participate in the financial assessment process and provide timely, accurate information, as requested. This requested information may include information concerning actual or potentially available health benefits such as COBRA or Medicaid/state or local government agency

coverage. Failure to provide accurate and timely information may subject the patient/responsible party to a denial or delay of financial assistance.

Self-pay/Uninsured Patients

All self-pay/uninsured patients (patients who hold no current insurance coverage) will be requested to pre-pay for all services at time of admission/registration. Each facility must have a self-pay deposit schedule based on various estimated lengths of stay and the facility's established self-pay rate. This deposit schedule should be used to estimate the upfront payment that is required for self-pay patients.

If the patient is unable to pre-pay for services, the patient will undergo a financial assessment during the pre-admission or admission process. The financial counselor or designated Business Office Representative will then meet with the patient and request that the San Jose Financial Disclosure Form be completed. This form must be completed verbally or in person before the Equifax reporting tool can be utilized.

Financially or Medically Indigent Patients

Financial assistance can be provided to qualified patients in accordance with the discount scale outlined below in this policy. Financial Indigent and Medically Indigent

patients may be determined by the verification of Medicaid eligibility for the dates of service. Financial and Medically Indigent patients are defined in further detail in the definitions found at the end of this policy.

Additionally, if the patient is unable to pay estimated out-of-pocket expenses, the patient will be financially assessed during the pre-admission or admission process in accordance with the financial counseling policy. During the counseling session, the financial counselor or Business Office Representative will meet with each patient or guarantor to assist with payment arrangements and facilitate completion of the Financial Disclosure Form. The Patient Responsibility Worksheet will also be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated cost-share.

COBRA

During the financial counseling process, the facility may reasonably determine that COBRA coverage is available to the patient. In these cases, the patient will provide the facility with information necessary to determine the monthly COBRA premium by completing the Application for COBRA Assistance (Attachment D). If the facility determines that the patient is financially unable to pay the COBRA premiums the

facility may decide to pay the COBRA premium on behalf of the patient/responsible party. Payment of any COBRA premiums must be approved by Facility Management such as the Chief Executive Officer (CEO) and Chief Financial Officer (CFO) prior to payment.

Determining Qualification for Financial Assistance

The Patient Responsibility Worksheet along with the Financial Disclosure Form will be reviewed by the Business Office Director (BOD) and facility CFO. These completed forms are required for the qualification of patients for financial assistance.

The BOD or financial counselor is responsible for ensuring the completion of the Financial Disclosure Form by the patient/responsible party during the financial counseling process to evidence their ability to pay. All supporting documentation should be attached to the Financial Disclosure Form such as recent paystubs or income tax returns. The BOD or financial counselor must verify the income of the patient/responsible party during the qualification process. Documentation for income verification must be provided to the facility in order for the patient/responsible party to be eligible for financial assistance. Eligibility for financial assistance may be determined at any time the facility is in receipt of documentation for income

verification. To complete Income Verification, the facility will accept one of the following:

- Most Recent Income Tax Return (document income for the year in which the patient/responsible party was first billed or 12 months prior to when the patient/responsible party was first billed).
- Most Recent Paystubs (must cover the 6-month period before or after the patient/responsible party was first billed, or for preservice, within 6-months of when application is submitted).

Equifax can be used to further analyze patient's financial status for medically indigent patients but cannot be the primary source of data in the qualification process. Income verification documentation is the primary method in which financial assistance will be determined.

Final approval of the financial assistance offered to the patient will be determined by facility Management (CFO/CEO), based on their review of the completed Patient Responsibility Worksheet, the completed Financial Disclosure Form and documentation required for verifying income of the patient/responsible party. The CFO/CEO will be responsible for reviewing eligibility disputes.

As noted in the Administrative, Denial, and Charity Care Adjustments Policy, the following approvals are required for any administrative or Charity Care patient account adjustment.

- BOD/CFO approval is required for financial assistance up to $5,000.
- Additional approval by CEO is required for financial assistance greater than $5,000 with Divisional CFO approval being required above $10,000 as stated in the Administrative, Denial, and Charity Care Adjustments Policy.

All documentation for financial assistance must be maintained in the patient financial file. The amount of financial assistance will only be applied after recovery from all third-party payers has been verified. Reductions in revenue deemed financial assistance shall not result in a credit balance or a refund situation. The Facility will reimburse the patient/responsibly party any amount over $5.00 actually paid in excess of the amount due including interest within 30 days.

Approval and Recording Financial Assistance

Financial or Medical Indigence (categorized as charity or indigent care on the facility's accounting records) must be identified upon receiving the proper patient

documentation and must be logged in the Charity Log within the month identified. Once approved, Charity Adjustments will be written off by the facility in the patient accounting system no later than the end of the month following discharge with the exception of insured patients which can be adjusted at the time of the payment is posted or reconciled. Facilities involved in a joint venture with a non-profit organization must be aware of the different guidelines for the time period in which a patient may qualify for charity care and follow the agreed policy.

Upon identifying a 100% self-paying charity patient at admission –staff shall enter the self-pay payer in the patient's account so that a self-pay discount will be posted. Patients being evaluated for Medicaid eligibility should remain in the Medicaid Pending Financial Class and be discounted at the Medicaid reimbursement rate. If, after discharge, the patient is determined to be ineligible for Medicaid but meets the facility's indigent criteria, the patient’s account shall be marked as financial class "SX" for self-pay charity and processed using a charity adjustment: the patient’s balance—gross charges less the Medicaid contractual adjustment. The expected payment for services provided to a patient or responsible party who is at or below 400% of the federal poverty level is limited to the amount of payment the facility would expect to

receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

SAN JOSE BEHAVIORAL HEALTH DISCOUNT SCALE 2025

Income Level	% Discount on Total Charges
Equal to less than 133% of FPG	100%
134%- 150% of FPG	75%
151% - 200% of FPG	50%
201% - 400% of FPG	25%
Greater than 400% of FPG	0%

Note: The expected payment for services provided to a patient/responsible party at or below 400% of the federal poverty level is limited to the amount of payment the facility would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

Payment Plans

Payment arrangements may be allowed, including extended payment plans. The facility may negotiate the terms of a payment plan with the patient or responsible party while taking into consideration the patient or responsible party's family income, essential living expenses, and/or health savings account when establishing a payment plan. If the facility and patient or responsibly party cannot agree on the payment plan, the facility will create a reasonable payment plan, where monthly payments are not more than 10% of the patient or responsible party's monthly family income, excluding deductions for essential living expenses.

How to Calculate the Amount of Financial Assistance (Discounts)

This calculation method uses the Federal Poverty Guideline (FPG) Schedule to provide a sliding-scale guide for facilities and individuals to use in conjunction with completing the Financial Disclosure Form and determining financial assistance. The schedule can be accessed from the internet by putting the following data in your web browser - https://aspe.hhs.gov/poverty-guidelines.

For San Jose Behavioral Health and facilities in California, a 100% discount applies up to 133% of the FPG, subject to the expected payment limit.

Steps to Calculate Assistance

- Find the number of the guarantor's dependents under the column labeled "Family Size".
- Then, locate the guarantor's gross annual income on the same row as the Family Size. In most cases, the guarantor's income will fall between two percentage categories (much like the tax schedule individuals use each year in determining how much they owe the government).
- With this information, determine the discount percentage based on the discount scale included herein. Example: Mr. Jones is uninsured and has met the criteria for the financially indigent. According to his federal income tax return, Mr. Jones earned $35,000 and has 4 dependents. Mr. Jones's total charges are $20,000. In this example, Mr. Jones's income level is 139% of the FPO and would therefore be eligible for a 50% discount of $10,000. Mr. Jones will be responsible for the remaining balance of $10,000. However, the expected payment from Mr. Jones will be limited to the amount of payment the facility would expect to

receive to provide services from Medicare or Medi-Cal, whichever is greater. If the service does not have an established payment by Medicare or Medi-Cal, an appropriate discounted payment will be established by the facility.

Definitions:

- Equifax is one of the largest sources of consumer and commercial data in the world and has been providing business solutions using advanced analytics and the latest technologies for over 100 years.
- Financial Assistance also known as Charity Care or Discount is defined as a reduction in the cost of health care services granted to patients based on their capacity to pay their estimated responsibility.
- Financially Indigent is defined as those patients who are accepted for medical care who are uninsured with no or a significantly limited ability to pay for the services rendered. These patients are also defined as economically disadvantaged and have incomes at or below the federal poverty guidelines. An individual may also be classified as "categorically needy" by proof of entitlement to some state or federal government programs such as SSI, Food Stamps, Aid to Families with Dependent Children (AFDC), or Medicaid for which entitlement has

been established, but for which coverage may not be available for the specific type or level of service.

- Medically Indigent is defined as those patients who incur severe or catastrophic medical expenses but are unable to pay and/or payment would require substantial liquidation of assets critical to living or would cause undue financial hardship to the family support system.
- The Notification of Determination of Approval/Denial for Financial Assistance can be used as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

REFERENCES

Attachments:

- Attachment A - Financial Disclosure Form
- Attachment B - Notification of Approval/Denial for Financial Assistance
- Attachment C - Charity Log
- Attachment D - Application for COBRA Assistance
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Related Policies:

- ACC-115.00 - Administrative, Denial, and Charity Care Adjustments
- ACHC.BO.0150 - Financial Counseling
- ACHC.BO.0140 - Insurance Verification

APPROVAL: Date: 07/27/2026

Lyna Zhang

San Jose Behavioral Health CFO