ACADIA	**Business Office**	**Policy# ALL,ACHC.BO,0160**
	ACHC.BO.0160 - Financial Assistance	**Effective: 06/01/2012**
		Last Reviewed/Revised: 10/30/2025
		Superseded Policy#

1. SCOPE

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

2. PURPOSE

To determine qualifications for financial assistance.

3. 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 Financial Disclosure Form (Attachment A) and supporting documentation.

4. PROCEDURE

All facilities must 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 verification must be performed no later than the next business day. This Insurance verification process should be completed to identify any potential resources for the patient's medical services, whether federal or state governmental health care program (e.g. Medicare, Medicaid, state or local government agency, Champus, Medicare HMO, Medicare secondary payer), private insurance company, or other private, non-governmental third party payer source.

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 coverage or Medicaid/state or local government agency coverage. Failure to provide accurate and timely information may subject the patient/responsible party to a denial of financial assistance.

Self-pay/Uninsured Patients

All self-pay/uninsured patients (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 be financially assessed during the pre-admission or admission process. The Financial Counselor, or designated Business Office staff member, will then meet with the patient and request that Attachment A - Financial Disclosure Form be completed. This form must be completed verbally or in person before the Equifax reporting tool can be utilized.

As stated in further detail in ACHC.BO.0150 Financial Counseling policy, the Financial Counselor or Business Office Representative will meet with each patient or guarantor expected to have an out-of-pocket responsibility to discuss payment arrangements and facilitate the completion of the Financial Disclosure Form.

Financially or Medically Indigent Patients

Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in this policy. Financial Indigence can be determined by the verification of Medicaid eligibility for the dates of service. Financially and medically indigent patients are defined in further detail in the definitions found at the end of this policy.

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 ACHC.BO.0150 Financial Counseling policy. During the counseling session, the Patient Responsibility Worksheet will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated cost-share.

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 the facility CEO and 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 insurance verifications, proof of income and Equifax.

The BOD or Financial Counselor must verify the income of the patient/responsible party during the qualification process. The facility must have at least one form of documentation from the list below in order to verify and analyze the information received on the Financial Disclosure Form to determine financial assistance available for a patient/responsible party.

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 (must 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)
- Social Security Statement of Earnings
- SSI Disability Benefit Letter or Current Bank Statement showing Monthly Deposit
    - SSI Income via Direct Express is acceptable when a bank statement is unavailable.
- Unemployment Vouchers (must span 4 weeks or 30-day period)
- Letter from a Third Party Source such as a Shelter, Mission or Group Home confirming Financial Status

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 the facility management, such as the Chief Financial Officer or Chief Executive Officer (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. Facility management (CFO/CEO) will be responsible for reviewing eligibility disputes.

Approval and Recording of Financial Assistance

Financial or medical indigence (categorized as charity or indigent care on the facility's accounting

records) must be identified prior to the patient's discharge and must be logged on 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 upon policy.

Upon identifying a self-pay 100% charity patient at admission --enter the self-pay payer in the patient's account so that a self-pay discount will post. Indigent accounts pending Medicaid approval should not be immediately written off as Charity. Patients who are in process of being qualified for Medicaid eligibility should be included in the Medicaid Pending Financial Class and discounted at the Medicaid reimbursement rate. If it is determined after discharge that the patient is not eligible for Medicaid coverage, however the patient meets indigent criteria for the facility, move the account to financial class "SX" for self-pay charity and process the patient's account balance (gross charge less Medicaid contractual) for a charity adjustment. 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.

SAN JOSE BEHAVIORAL HEALTH DISCOUNT SCALE 2022

Income Level	% of Discount on Total Charges*
Equal to or 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%

* 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 include an extended payment plan. The facility may negotiate the terms of the payment plan with the patient/responsible party while taking into consideration the patient/responsible party's family income and essential living expenses. The facility may consider the patient/responsibly party's health savings account when establishing a payment plan. If the facility and patient/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/responsible party's monthly family income, excluding deductions for essential living expenses.

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 liability.

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.

As noted in Accounting Policy # 115.00 Administrative, Denial, and Charity Care Adjustments, 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 Policy #115.00 Administrative, Denial, and Charity Care Adjustments.

A form letter provided, Notification of Determination of Eligibility for Financial Assistance (Attachment B) can be used as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

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. 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.

How to Calculate the Amount of Financial Assistance (Discounts)

This method is intended to illustrate a sliding scale. It should be used as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and determination of any financial assistance.

This method uses the Federal Poverty Guideline (FPG) Schedule. This 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 in the State of California scale is 100% discount up to 400% FPO subject to the limit on expected payment. First, 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 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.

5. REFERENCES

Attachments:

Attachment A -Financial Disclosure Form

Attachment B - Notification of Approval/Denial for Financial Assistance

Attachment C - Charity Log

Attachment C - Charity Log

Attachment D - Application for COBRA assistance

Related Policies:

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

APPROVAL: Signed by: Lyna Zhang 9618A29938C84B5... Date: 10/30/2025

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