

ACADIA	Business Office	Policy# ALL, ACHC.BO,0160
	ACHC.BO.0160 - Financial	Effective: 06/01/2012
	Assistance	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		Superseded Policy#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.

**PACIFIC GROVE HOSPITAL 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/responsible party's health savings account when establishing a payment plan. If the facility and patient/responsible 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 Pacific Grove Hospital 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:

Debbie Krome  
VP Revenue Cycle Operations

Date: 10/30/2025



## **Help Paying Your Bills**

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. Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in our policy. If you need help paying your bill, there are organizations that will help patients understand the billing and payment process. Information regarding the Health Consumer Alliance can be found on its website at <https://healthconsumer.org>.

## **How to Apply**

Information for the company's patient financial policies, procedures, and/or eligibility information can be obtained by contacting the hospital's Business Office at (951) 275-8400 ext. 225. For a complete list of the facility's shoppable services, please visit 5900 Brockton Ave., Riverside, CA 92506 or visit online at [www.pacificgrovehospital.com](http://www.pacificgrovehospital.com).

If the patient is unable to pay the 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 (Attachment A -Policy ACHC.BO.0150 Financial Counseling) will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated cost-sharing amount.

### **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.

All supporting documentation should be attached to the Financial Disclosure Form such as insurance verifications, bank statements, proof of income and Equifax.

To complete Income Verification, the facility may 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 (CFO/CEO) based on their review of the completed Patient Responsibility Worksheet, the completed Financial Disclosure Form and documentation required for verifying income and assets of the patient/responsible party.

#### **How to Calculate the Amount of Financial Assistance (Discounts)**

This method uses the Federal Poverty Guideline (FPG) Schedule as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and

determination of any financial assistance.

This method. This schedule can be accessed from the internet by putting the following data in your web browser – <https://uspe.hhs.gov/poverty-guidelines>. For Pacific Grove Hospital in the State of California, scale is 100% discount up to 400% FPG 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).

Income Level	% of Discount on Total Charges*
Equal to or less than 133% of PG	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.

A Notification of Determination of Eligibility for Financial Assistance is provided as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

Hospital Bill Complaint	More Help	How to access if you have disability or need in another language
Contact HCAI	Contact our Business	Contact our Business Office
Department of Health Care Access and Information	Office	Tel: (951) 275-8400 ext. 225
Hospital Bill Complaint Program	Tel: (951) 275-8400 ext. 225	Fax: (951) 779-7826
2020 West El Camino Avenue, Suite 1101 Sacramento, CA 95833	Fax: (951) 779-7826	Fax: (951) 779-7826

--	--	--