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Financial Assistance Policy

I. Purpose Statement

The purpose of this policy is to define the criteria and procedures for determining eligibility for financial assistance offered to patients through McLeod Health in accordance with federal and state regulations. The intent is to ensure consistent application of assistance programs and to support access to care for patients experiencing financial hardship.

II. Policy

McLeod Health is committed to providing financial assistance to persons who need hospital services and are uninsured, under-insured, ineligible for government assistance programs, or are otherwise unable to pay for medically necessary care based on their individual financial situation.

Consistent with its mission to improve the overall health and well being of people living in our service areas, McLeod Health strives to ensure that individuals who require health care services are not prevented from seeking or receiving care because of an inability to pay or whose limited means makes it difficult to pay for services.

This policy includes:

A. Eligibility criteria for financial assistance

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B. Calculations for expected payments from patients

C. Application process

Definitions

Amount Generally Billed (ABG): Refers to the maximum amount that a hospital facility (or other eligible organization under Section 501(r) of the Internal Revenue Code) may charge individuals who qualify for financial assistance for emergency or other medically necessary care. McLeod Health uses the Look Back Method to calculate this percentage.

Eligible services: Health care services that have been or will be provided, but are not expected to result in cash inflows. Financial assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.

Family: Using the United States Census Bureau definition, a group of two (2) 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 their income tax return, they may be considered a dependent for purposes of the provision of financial assistance

Family Income Inclusions: Family Income is determined using the United States Census Bureau definition, which uses the following income sources when computing Federal Poverty Guidelines:

- Pre-tax Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rent, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.
- If a person lives with a family, the income of all the family members.
- For self-employed, adjusted or net income will be used as reported on the Profit and Loss statement (Schedule C).

Family Income Exclusions:

- Non-cash benefits (such as food stamps, housing subsidies)
- Capital gains or losses
- If a person lives with a family, but is not related, the income from Non-Family persons

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations. A patient whose treatment could be considered a non-covered service by their health insurance plan or who has exhausted benefits under their health insurance plan may be deemed to be an Uninsured Patient. A patient who is fully responsible for the entire allowable amount, based off a co-payment or deductible outstanding, is not deemed to be an Uninsured Patient. A patient who has insurance that does not have a contractual relationship with a McLeod entity (also referred to as Out-Of-Network) may not be deemed an Uninsured Patient. A patient who is covered by and/or has a claim against any Responsible Party for the hospital services provided will not be deemed to be an Uninsured Patient.

Under-insured: The patient has some level of insurance or third-party assistance but still has out-of-

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pocket expenses that exceed his/her financial abilities.

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

Emergency Medical Condition: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically Necessary: Shall in general mean not-elective inpatient and outpatient acute hospital services that are normally reimbursable under Medicare and/or Medicaid programs.

Term: The period of which a patient's financial assistance approval is active. Initial approval term refers to a 1-year term, extending 6 months prior and 6 months forward from the initial determination date. Renewal term refers to an additional 6 months after the initial termination date.

Scope

This policy applies to all McLeod Health hospital and physician services, ambulatory surgery center services, home health services, and hospice services.

III. Procedure

McLeod Health expects patients to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of (1) assuring access to health care services, (2) improving their overall personal health, and (3) protecting of their individual assets. Information is an essential part of the application/approval process and patients and/or families are needed to assist McLeod Health with obtaining financial assistance or other forms of payment or charity.

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A. **Discounts Available Under the Financial Assistance Program**

1. Full Financial Assistance: Patient whose gross family income is at or below 200% FPL will receive 100% on Uninsured or Balance After Insurance
2. Partial Financial Assistance: Patient whose gross family income is more than 200% and at or below 300% will be expected a partial discount on uninsured balances and balance after insurance.
3. Hardship Discount: Patients who are denied traditional financial assistance based on income guidelines that exceed 300% of the Federal Poverty Guidelines may be eligible for a hardship discount. Any patient whose uninsured balance or balance after insurance exceeds 20% of the patient's annual gross family income will be provided with a 100% charity care discount for the balance in excess of 15% of the patient's gross family annual income.
    a. All accounts for which the guarantor is responsible, including balances in bad debt, may be included in the calculation of medical debt. Hardship discounts do not apply for future visits.
4. Uninsured discount: Patients identified by McLeod Health as self-pay who are not covered by health insurance or another third-party source are provided with an uninsured/self-pay discount for eligible services received at McLeod Health.

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B. **Services Eligible under This Policy.**

1. Emergency Medical Services provided in an emergency room setting
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of the patient.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting
4. Medically Necessary services, as determined by a McLeod Health Physician.

C. **Eligibility for Financial Assistance**

1. Eligibility for the program will be considered for those individuals who are uninsured, under-insured, or ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. Participation in the program will be based on an individual's financial need, and does not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

D. **Public Health Screening**

1. Patients will first be screened for a public health coverage program, including Medicaid. It is a McLeod Health policy to not offer financial assistance in situations where the applicant fails to cooperate with insurance company's application process or for health-sharing plans where the Applicant is paid benefits directly.

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E. **Disqualification for Financial Assistance**

1. The following patients or services shall be disqualified from financial assistance:
    a. Patients who have not cooperated with insurance or other payment source, which results in non-payment.
    b. Patients who had liability coverage or where the patient's insurance company paid directly to the patient;
    c. Patients eligible for workers compensation
    d. Services provided where a patient has a claim against a responsible party
    e. Patients with income > 300% of FPL, unless qualifying for the Hardship Discount
    f. If the applicant was eligible for group health insurance that would have covered services provided but elected not to have coverage through the employer, the account will not be eligible for financial assistance.
    g. Patients who have not met other enrollment criteria as determined by McLeod Health.
    h. Patients who have a network benefit with an in-network provider other than McLeod Health may choose to receive services as out of network. Financial assistance is not available for charges not covered due to the patient choosing to receive services out of network. Any out of network patient that receives emergent related care or needs a level of care only provided by McLeod Health is eligible to apply.

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i. Services provided and/or billed by private or independent entities, non-McLeod 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/provider practice. These groups include, but are not limited to the following:

i. Emcare
ii. Pee Dee Pathology
iii. Carolina Radiological Associates
iv. Florence Radiological Associates
v. Pediatrix Medical Group
vi. American Anesthesiology
vii. Mednax Services
viii. TeamHealth
ix. All private or independent physicians not employed by McLeod Health

F. **Presumptive Eligibility for Financial Assistance**

1. McLeod Health may use outside agencies in determining final presumptive qualification. As such, presumptive eligibility may also be determined on the basis of individual life circumstances that may include, but is not limited to, the following:
    a. Eligibility for Medically Indigent Assistance Program(MIAP)
    b. State-funded prescription programs;
    c. Homeless or received care from a homeless clinic;
    d. Participation in Women, Infants and Children programs (WIC);
    e. Food stamp eligibility;
    f. Eligibility for other state or local assistance programs that are unfunded (e g., Medicaid spend-down);
    g. Low income/subsidized housing is provided as a valid address; and
    h. Patient is deceased with no known estate.
    i. Eligibility for SC Medicaid Family Planning, NC Medicaid Family Planning, SC Medicaid Emergency Only on the date of service, but not filed to Medicaid
    j. Eligibility for McLeod's Cancer Clinic but not adjusted to Cancer Clinic.
    k. Eligibility for Best Chance Network and not filed to Best Chance
    l. Eligible for Medicaid out of state and unable to file to Medicaid
    m. Personal bankruptcy within the past 7 years
2. Independent Eligibility Assessments are administered by a third party to determine patients' eligibility status without a typical application. The assessment is proprietary and relies primary on a soft inquiry to the guarantors credit report. For

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patients with no or minimal credits history, there is a scoring process based on credit statistics and patient demographic to provide a propensity to pay. This model is enhanced by sending information about past bad debt balances, current balance, etc. For Emergency encounters on qualifying patients, the financial assistance adjustment is performed automatically. For qualifying patients with eligible encounters, the financial assistance adjustment is performed automatically.

G. **Application of Sliding Fee Schedule**

1. Patients who do not qualify for financial assistance through the presumptive eligibility screening process described above may still be considered for eligible services under this policy through the Sliding Fee Schedule. Qualification will require completion of a written application and will be determined based on financial need, in accordance with the Federal Poverty Level (FPL) guidelines in effect at the time of determination.
    a. The Sliding Fee Schedule applicable shall be as follows:
        i. Family Income < 200% of FPL; eligible to receive free care;
        ii. Family Income >= 200% and < 225% of FPL; 10% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
        iii. Family Income >= 225% and < 250% of FPL; 30% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
        iv. Family Income >= 250% and < 275% of FPL; 50% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
        v. Family Income >= 275% and < 300% of FPL; 70% of the amounts generally billed to (received by the hospital for) patients with insurance coverage will be due as the expected payment;
        vi. Family Income > 300% of FPL; may be eligible to receive discounted rates on a case-by- case basis based on their specific circumstances, such as a catastrophic event or medical indigence, at the discretion of McLeod Health; however, the discounted rates shall not be greater than the amounts generally billed to (received by the hospital as expected payment from) patients with insurance coverage.

2. Once McLeod Health determines that a patient or responsible party is eligible to receive financial assistance under this policy, he or she will not be charged more than the Amounts Generally Billed (AGB). The AGB is determined through the "Look-back Method" as defined in the Federal Income Tax Regulations. This method accumulates the total amount that patients and their insurance carriers paid for certain medical services during the 12-month look-back period and then divides by the total gross charges for those services. The resulting percentage becomes the AGB discount that patients receive. In following this method, McLeod Health used medical claims from 06/01/2025 - 05/31/2026 to determine what portion of gross charges were typically paid (by the payer and the covered individual) for claims for

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Emergency Care and Medically Necessary Care by Medicare Fee-For-Service or a private commercial insurer as the primary payors. Using this methodology, the AGB is 29% for services provided and discharges on or after 07/01/2026.

3. A financial assistance application form shall be provided to any person requesting financial assistance. Referral of patients for financial assistance may be made by any member of the McLeod Health staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for Financial Assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.
4. The financial assistance application form must be completed and returned within 240 days of the first post discharge billing statement. Financial assistance may only be granted if sufficient information is available to allow for a determination to be made that establishes that the patient satisfies all applicable criteria. The qualifying period can be for a specific episode of care or for a 1 year term, extending 6 months prior to determination date and forward 6 months forward from determination date.
5. Qualification for the Sliding Fee Schedule shall be determined in accordance with procedures that involve an individual assessment of financial need; and may:
    a. Include personal, financial and other information and documentation relevant to making a determination of financial need;
    b. Include the use of external publicly available data sources that provide information on a patient's or a patient guarantor's ability to pay (such as credit scoring);
    c. Include reasonable efforts by McLeod Health to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients in applying for such programs.
    d. Take into account the patient's available assets and all other financial resources available to the patient. Reverse Mortgages issued on a residence shall also be evaluated as income. Based on the terms of the Reverse Mortgage, financial assistance may be denied.
    e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.
6. A financial assistance determination may be made at any point during the collection cycle. The patient's financial need will be re-evaluated at each subsequent date of service if the most recent financial evaluation was completed more than 90 days prior, or whenever new information becomes available that may affect the patient's eligibility for financial assistance.
7. Because McLeod Health values human dignity and the value of the person, financial stewardship shall be reflected in the processing of financial assistance applications. Such applications shall be processed promptly. McLeod Health shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

H. **Application Review & Account Management**

All financial assistance applications received shall be reviewed and evaluated as follows

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1. Upon receipt of an application submitted and signed by the patient or guarantor, McLeod Health shall review the application using all guidelines outlined in this policy to determine eligibility.
    a. If the application is deemed incomplete, it shall be returned to the patient or guarantor along with specific directions for re-submission in a complete and accurate manner not more than 30 days from receipt. In such cases, the patient or guarantor may provide the required missing or incomplete information and request the application be reconsidered if sure consideration is requested within a period of 120 days from the first post-discharge billing statement.

2. Review of Family Income shall take place through recent pay stubs, W-2's, prior year tax returns, or written statements from employers. Review of other supporting documentation, as available and necessary, shall also take place.
3. If all eligibility criteria are met, the completed application and written recommendation for approval shall be submitted to the appropriate individual(s) for management approval:
    - <= $ 50,000.00 per Account - Director of Registration/Patient Access Director
    - > $50,000.00 per Account - Vice President of Business Operations or Chief Financial Officer
4. If the application is approved by management, the applicant will be notified of the approval in writing, or through electronic communications, within 30 days of initial receipt of the completed application and it shall continue through this procedure directly to item "(7)" below.
5. If an application is denied, the applicant will be notified of the denial, and the specific reason(s) for that determination in writing, or through electronic communications, within 30 days of initial receipt of the application.
    a. In such cases, related account(s) shall be re-altered to reflect the appropriate (original) financial class and payor code in the active accounts receivable file. If the patient or guarantor fails to pay the account(s) in a timely manner, the accounts(s) may be reported to the appropriate credit bureau and the account(s) will be referred to a bad debt vendor and collection procedures will begin.
    b. If patient or guarantor provides supplemental information and requests that the denied application be reconsidered, reconsideration shall be granted if the reconsideration request is made within 240 days from the date of the first post-discharge billing statement.
6. A Patient Account Representative shall be notified to manually demand a bill to drop for submission to the South Carolina Budget and Control Board, State Office of Research and Statistics.
7. If an applicant is determined to be eligible for financial assistance under this policy after collection activity has been initiated, McLeod Health will refund any excess

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funds it collected from the applicant over the amount the applicant actually owes.

8. Copies of all written notifications and related correspondence, inclusive of the original application and associated information, shall be retained by McLeod Health as part of the patient's account records.

I. **Financial Assistance Renewal Process and Eligibility**

1. Patients who have received initial approval may be eligible for an extension of up to six (6) months through an abbreviated application process.
    a. Patients seeking to renew financial assistance without re-submitting a full application must submit a renewal request within 60 days of the initial approved termination date. As part of the renewal request, patients must submit a signed affidavit affirming there have been no changes to their individual/family income, family size, or assets since their initial application.
    b. McLeod Health may utilize Independent Eligibility assessments to verify updates to a patient's eligibility for financial assistance.
    c. If approved, financial assistance will be extended for an additional 6 months from the initial termination date.
    d. If denied or patients' who fail to submit the renewal affidavit within 60 days of the initial termination date will be required to submit a full application with supporting documents.
    e. At the termination of the extension period, patients will be required to submit a full financial assistance application.
    f. McLeod Health reserves the right to request any additional financial information or documentation deemed necessary to evaluate eligibility during the renewal process. Failure to timely submit the requested documentation may result in denial of the renewal request.

J. **Communication of the Financial Assistance Program to Patients and Within the Community.**

1. Any person seeking health care services at McLeod Health should be provided written information about the McLeod Health financial assistance program as part of the admission process. Such information shall include a contact telephone number and shall be disseminated by various means, which may include but are not limited to, the publication of notices in patient bills and by posting notices in emergency rooms, in the appropriate admission- related consent form, in admitting and registration departments, hospital business offices, and patient financial services offices that are located on facility campuses, and at other public places as McLeod Health may elect. McLeod Health shall also publish and widely publicize a summary of this financial assistance policy on facility websites, in brochures available in patient access sites and at other places within the community served as determined by McLeod Health. Such notices and summary information shall be provided in the primary languages spoken by the populations' served by McLeod Health, but at a minimum shall be provided in English and Spanish.

K. **Relationship to Collection Policies**

1. McLeod Health management shall develop policies and procedures for internal and

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external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from McLeod Health, and a patient's good faith effort to comply with his or her payment agreements with McLeod Health. For patients who qualify for financial assistance and who are cooperating in good faith to resolve their discounted hospital bills, McLeod Health may offer extended payment plans. McLeod Health will not impose extraordinary collections actions for non-payment such as wage garnishments; liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for the financial assistance program under this policy.

2. Reasonable collection efforts shall include:
    a. Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by McLeod Health;
    b. Documentation that McLeod Health has or has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with McLeod Health application requirements.
    c. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

L. **Regulatory Requirements**

1. In implementing this policy, McLeod Health and its management shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

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IV. Equipment Needed

Not Applicable

V. Addendums

Not Applicable

VI. Attachments

Not Applicable

VII. Related Links

Not Applicable

VIII. References

Not Applicable

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Approval Signatures

Step Description	Approver	Date
	Dudley Harrington: VP OF BUSINESS OPERATIONS	06/2026
	Madge Hamer: AVP OF ACCREDITATION/ CERTIFICATION [LS]	06/2026
	Megan Duncan: AVP OF PATIENT ACCESS	06/2026

Applicability

MPA / Provider Based Clinics, McLeod Dillon, McLeod Family Medicine, McLeod Health, McLeod Health Clarendon, McLeod Hospice | Home Health, McLeod Loris Seacoast, McLeod Regional Medical Center, Mcleod Cheraw

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