FINANCIAL ASSISTANCE POLICY

This policy is designated for those patients who do not qualify for State of Ohio medical aid, including the Hospital Care Assurance Program, who have no third-party coverage, whose income falls above the federal poverty guidelines and is generally unable to pay for hospital services provided. Patients falling from 101%-300% of the Federal Poverty Level will qualify to have all or a portion of the patient's charges written off. The amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance will not be more than the hospital's amounts generally billed (AGB).

It is the policy of Fisher-Titus Medical Center that no patients seeking medical service that can be provided by the hospital will be denied access to those services solely because of the inability to pay for those services. The Hospital will provide without discrimination, care for emergency services, and medically necessary services to individuals regardless of whether they are eligible based on the Hospital's Financial Assistance Policy (FAP). Debt collection activities in the emergency department or in other areas of the hospital facility where such activities could interfere with the provisions of emergency or medically necessary care are prohibited.

FAP Definitions

Amounts Generally Billed (AGB) means the Usual and Customary Charges for Covered Services provided to individuals eligible under the Basic Financial Assistance Program, multiplied by the Hospital-Specific AGB Percentage applicable to such services.

Assets Liquid assets that can be converted to cash to meet financial obligations.

Emergency Services means a medical condition of a patient that has resulted from the sudden onset of a health condition with acute symptoms which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions of the patient or result in serious dysfunction of any bodily organ or part.

Extraordinary Collection Actions (ECA) Actions taken by the Hospital against an individual related to obtaining payment of a bill for care that requires a legal process, selling an individual's debt to another party, or reporting adverse information to consumer credit reporting agencies.

FAP-Eligible means an individual eligible for financial assistance under this Policy.

Federal Poverty Guidelines measures of income levels issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for this financial assistance program.

Financial Services means Patient Financial Services, the operating unit of the Hospital responsible for billing and collecting self-pay accounts for hospital services.

Hospital Facility and Hospital Owned Entities the Hospital and all Hospital owned or partially owned entities that are disregarded as separate from the Hospital for federal tax purposes are required to follow the 501(r) requirements with respect to care provided for emergency and medically necessary services.

Limitation on Charges refers to limiting the amounts charged for emergency and other medically necessary care provided to individuals eligible for financial assistance to not more than the amounts generally billed to individuals who have insurance covering the same care. In addition, for billing and collection, the Hospital may not engage in ECAs before reasonable efforts have been made to determine whether the individual is eligible for financial assistance.

Medically Necessary Services means those inpatient and outpatient services required to identify and treat an illness or injury.

Plain Language Summary is a written statement that notifies an individual that the Hospital offers financial assistance under a FAP and provides the information in a clear, concise, and easy to understand description.

Uninsured Patient identified as having no insurance coverage.

Underinsured Insured patients who receive Medically Necessary Care that are determined to be non-covered services or have limited benefit coverage or benefits are exhausted by the insurance provider. This also includes patients that are unable to pay patient balances after insurance payment.

Amounts Generally Billed

A FAP-eligible patient will not be charged more than the hospital's AGB. An explanation of how the AGB is calculated and the hospital's current AGB is listed in Appendix A of the FAP.

Methods for Applying for Financial Assistance

Patients may apply for financial assistance by completing the FAP application prior to, at the time of, or after services are rendered. Applications may be accessed by visiting the Financial Counseling Department, the Patient Access Department, the Emergency Department, or at the Cashier's window at the hospital, from the hospital website at https://www.fishertitus.org/patients-guests/billing-financial-assistance/financial-assistance/, via email at financeservices@ftmc.com, or by requesting an application by phone at 419.660.2678 or 419.660.2679. Completed applications may be mailed to the Hospital at:

Fisher-Titus Medical Center
272 Benedict Avenue
Norwalk, OH 44857

Notification Requirements

The availability of the FAP will be widely publicized within the communities serviced by the Hospital. All admitting areas shall have posters prominently displayed that advise patients of the existence of the Hospital and will make reasonable efforts to distribute a plain language summary (PLS) of the FAP and offer a FAP application form to individuals before being discharged from the Hospital; or by including a PLS of the FAP with all billing statements during the 120-day notification period. There is direct web access to the PLS; and the Hospital will provide at least one written notification informing the patient of any ECAs the Hospital may take if the FAP application is not received or payment has not been received.

Proof Of Income Verification

Proof of income is determined by 1) check stubs, 2) a recent income tax return or W-2. 3) a signed statement from the patient or account guarantor stating their income or how they are supported. 4) acceptance into an income-based government assistance program. Financial Services will determine eligibility for a charity write-off using the following income guidelines

FAP Procedure

A. Patients requesting free care, who do not qualify for Medicaid or HCAP will be referred to Financial Services.

B. ITX Collection Services will also screen accounts for possible charity care and refer them back to Financial Services. Self-pay patients who qualify for 100% charity will qualify for a 50% discount at Fisher-Titus Medical Care LLC except for Behavioral Health. All insured and uninsured patients who qualify for charity at FTMC will have the same discount at Behavioral Health.

C. After identifying an account to be written off, Financial Services processes the application and provides the correct adjustments to accounts that have cleared insurance and/or self-pay. The patient is mailed a Charity Approval letter if qualified. Patients are also notified by mail if Ineligible.

D. Each account will be identified by:
   - Patient's name
   - Account Number
   - Amount of the write-off
   - Date of Service
   - Internal write off code.

E. Any total guarantor balance of $5,000.00 or above will be listed on a separate Charity Summary Sheet to be reviewed and signed by the Financial Counselor, Director of Business Office and the Controller. Any total guarantor balance write-off exceeding $15,000 should be reviewed and signed by the VP of Finance.

F. Financial Services will scan all appropriate documents into Cerner for that Guarantor's record including proof of income, copies of applications or copies of insurance cards. (Documents prior to Jan 1, 2003 are kept on paper alphabetically.)

G. These files will be retained for a minimum period of seven years for audit purposes.

H. Specific write-off codes are used for this program in order to book these write-offs to a special general ledger account, providing readily available reporting and audit capability. Codes are assigned by the Controller.

I. Estates with exhausted assets, when verified by a Financial Counselor, will qualify for the program. This includes surviving spouse estates, although efforts for a completed application should first be exhausted.

J. Patients approved for the Fisher-Titus Medical Center Charity program will need a new application every 90 days. Patients with no foreseeable change in current year income may be approved for the entire remaining current year. (i.e., SSI and retirement income only)

K. Accounts identified by ITX Companies (Closed, No Assets) automatically qualify for this program. ITX will use all reasonable industry standards to attempt to collect the debt before identifying an account as "CNA". ITX will note and maintain the reason why the account is not collectable in their system.

L. For the purpose of income determination, "non-cash" deductions will not be allowed. Some examples include: depreciation, deducting personal vehicles for business, health savings account contributions, IRA deductions, etc. Conversely, certain benefits will be included in income, for example: minister' housing allowances.

M. For the purpose of income determination, income from seasonal employment will be adjusted to reflect a yearly wage.

N. Patients who qualify for a government assistance program based on income level automatically qualify for this program; after reasonable attempts to obtain a charity application are documented. Upon discovery of an approved program, accounts within a six-month look back will be included in the write-off. Examples of approved programs include, but are not necessarily limited to, Medicaid Family Planning Benefits and Breast and Cervical Cancer Project (BCCP) eligible patients.

O. Fisher-Titus Medical Center reserves the right to revoke and/or reverse charity approval to patients based on assets, income or non-taxable income (i.e., S.S., Pensions, Dividends, IRA / 401k withdraws, etc.,) that were not previously reported. The Fisher-Titus Medical Center Financial Assistance Policy is for those individuals and families that have no ability to pay.

P. Where none of the above programs apply, Fisher Titus Health reserves the right to also consider a Hardship application on a case-by-case basis for patients who otherwise demonstrate that a financial hardship is catastrophic, unusual, or extraordinary. The Fisher-Titus Health Financial Assistance Policy is a program of last resort, meaning that if another state or federal program is available to provide assistance, or if another resource is available to pay for a patient's care or reimburse the patient for charges relating to that care, that program or resource must be exhausted before the patient becomes eligible for the Fisher-Titus Health program.

Q. Our billing procedure (after insurance payments and/or self-pay) provides four statements to the patient. The first statement includes a 15% discounted amount as prompt payment in full. The second and third statements simply state the full balance due. The fourth and final statement has a large red Final Notice stamped directly across the page. If the patient ignores or does not respond to this notification, regardless of payments being made, the account then goes into a collection status. The account remains in that status for 30 days before being turned over to an outside collection agency. It is the patient's responsibility to contact the Financial Services office to set-up reasonable payment plans if they cannot pay in full within those four stmts. Fisher-Titus Medical Center will not engage in ECAs against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is FAP-eligible for the care. The hospital will notify the patient about the FAP before initiating any ECAs to obtain payment for care and will refrain from initiating such ECAs for at least 120 days from the date of the first statement. The hospital will provide at least one written notification informing the patient of any ECAs the hospital may take if the FAP application of payment has not been received. It is the responsibility of the patient to complete a charity app within 240 days of the date of the first statement if they believe their annual income for their family size may qualify them for possible assistance.

APPENDIX

Appendix A – AGB and sliding scale

APPENDIX A

Amount Generally Billed (AGB) is defined as the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. An individual eligible for assistance under the Fisher-Titus Medical Center's financial assistance policy will not be charged more than the AGB for emergency or other medically necessary care.

Fisher-Titus Medical Center uses the Look Back Method to calculate the AGB. The AGB is derived by dividing (1) the sum of all claims for Medically Necessary services provided at the Hospital and allowed by Medicare fee-for-service and all private health insurers as primary payers, by (2) the charges set forth in the Hospital chargemaster at the time the services are rendered. The Hospital-Specific AGB Percentage shall be calculated annually for a twelve (12) month period from January 1 to December 31 and allows 120 days for such calculation to be made and updated in the FAP. The calculation of the Hospital-Specific AGB Percentage shall comply with the Look Back Method described in the IRS Regulation 501(r)-5(b) (1) (B). The current AGB percentage is 54%.

Fisher-Titus Medical Center provides financial assistance on a sliding scale based on current Federal Poverty Guidelines:

2026 FPL INCOME GUIDELINES

Person(s) in family/ household	0%-100% FPL **HCAP**	101%-150% FPL **FREE CARE DISCOUNT**			151%-200% FPL **75% DISCOUNT**			201%-300% FPL **54% DISCOUNT**		
1	$15,960	$15,961	To	$23,940	$23,941	To	$31,920	$31,921	To	$47,880
2	$21,640	$21,641	To	$32,460	$32,461	To	$43,280	$43,281	To	$64,920
3	$27,320	$27,321	To	$40,980	$40,981	To	$54,640	$54,641	To	$81,960
4	$33,000	$33,001	To	$49,500	$49,501	To	$66,000	$66,001	To	$99,000
5	$38,680	$38,681	To	$58,020	$58,021	To	$77,360	$77,361	To	$116,040
6	$43,360	$43,361	To	$66,540	$66,541	To	$88,720	$88,721	To	$133,080
7	$50,040	$50,041	To	$75,060	$75,061	To	$100,080	$100,081	To	$150,120
8	$55,720	$55,721	To	$83,580	$83,581	To	$111,440	$111,441	To	$167,160

For families with more than 8 people, add $6,330 for each additional person.