St. Mary's Healthcare **ST. MARY'S Organizational Policy Manual**	**Policy # PR 4.9**	
	Title:	**Financial Assistance Policy**
	Replaces Policy:	**PR 4.7**
	Policy Originator:	Director, Patient Accounts
	Concurrence:	VP, Finance/CFO
Chapter **Patient Financial**	**Effective Date:**	08/01/2024
	Reviewed/ Revised Date:	07/15/2024, 10/12/2025, 06/09/2025, 03/31/2026
	Approval:	St. Mary's Board of Directors
	Date:	June 9, 2025

I. Policy Statement:

St. Mary's Healthcare ("Organization") wants to ensure a socially just practice for providing Emergency or other Medically Necessary care at the Organization's facilities. The Organization has designed this policy to address the financial assistance eligibility for patients who are burdened financially and receive care from the Organization.

1. All financial assistance will reflect the Organization's commitment to, and reverence for, individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all Emergency and other Medically Necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures and other care that is not Emergency care or otherwise Medically Necessary.

3. Appended to this policy is a list of providers delivering care within the Organization's facilities and which providers are covered and not covered under this financial assistance policy.

II. Definitions:

For the purposes of this Policy, the following definitions apply:

• "501(r)" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

• "Amount Generally Billed" or "AGB" means, with respect to Emergency or other Medically Necessary care, the amount generally billed to individuals who have insurance covering such care.

• "Emergency Care" means care to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention may result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or placing the health of the individual in serious jeopardy.

• "Homeless" means an individual or family who lacks fixed, regular, and adequate nighttime residence, meaning (i) has a primary nighttime residence that is a public or private place not meant for human habitation, (ii) Is living in a publicly or privately-operated shelter.

• "Household Income" means wages, salaries, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, rents from property, profits and fees from their own business, interest, dividends, rents, royalties, income from estates, trusts, alimony, child support and other miscellaneous sources. Family Income is determined on a before-tax basis and excludes capital gains or losses. If a person lives with a family, the income of all members may be considered. (Unrelated household members do not count). Non-cash benefits, such as food stamps and housing subsidies, are not considered income.

• "Medically Necessary Care" means as defined by section 1867 of the Social Security Act (42 U.S.C. 1395dd), also known as the Emergency Medical Treatment and Active Labor Act ("EMTALA"), a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ part. EMTALA also defines an Emergency medical condition to include a pregnant woman who is having contractions.

• "Organization" means St. Mary's Healthcare.

• "Patient" means those persons who receive Emergency or Medically Necessary care at the Organization and the person who is financially responsible for the care rendered.

III. Policy

Financial Assistance Provided

The Organization makes financial assistance available to all underinsured and uninsured individuals who qualify for assistance with their medical bills. No person who is found eligible for financial assistance will be charged more for Emergency or Medically Necessary care than the applicable discounted amount outlined in IRS regulations 26 CFR 1.501(r).

The Organization offers financial assistance in accordance with this Financial Assistance Policy (FAP). This FAP was developed to comply with all federal and state regulations, including IRS regulations 26 CFR 1.501(r) and NYS Public Health Law 2807-k(9-a).

1. Eligibility determination is based on the following:

    a. Household Income and family size*
    b. Patients' gross annual income cannot exceed 400% of the Federal Poverty Guidelines (Exhibit A).
    c. Underinsured Patients must have accrued a medical cost share of more than 10% of their gross annual income in the previous 12 months.
    d. Uninsured Patients will receive a sliding scale discount (Exhibit A)

    *Patient applications who are deemed to have a gross income at or under 200% of the Federal Poverty Guidelines based on household income and family size only will receive a discount of 100%

    Attachment A will be regularly revised to reflect updates in the Federal Income Poverty Guidelines as issued by the Secretary of the Department of Health and Human Services without need for further approval of this policy.

2. Homeless Patients are automatically eligible for financial assistance.

3. For patients who are non-responsive to The Organization's application process, other sources of information, such as estimated income and family size provided by a predictive model may be used to make an individual assessment of financial need. This information will enable The Organization to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient. The Organization may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for The Organization. The predictive model enables The Organization to assess whether a

patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. Information from the predictive model may be used by The Organization to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Where efforts to confirm coverage availability have been unsuccessful, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

4. Covered Services and Service Area: Covered services include all the Organizations locations that provide services deemed Medically Necessary. These services are covered based on the Patient's primary address located on their account. The Organization will accept applications for all zip codes. Approval will be at the discretion of the Organization to approve applications not included in our primary covered service area, as noted below:

   12032
   12835
   12117
   12134
   13470
   12010
   12025
   12068
   12069
   12070
   13339
   12078
   12086
   12095
   13452

Excluded Services

Patient Financial Assistance will be utilized for all Medically Necessary services rendered by the Organization, except for elective or cosmetic procedures. Charges from private Physicians/Providers (not employed) who provide services at the Organization are not covered under the program. FAP will not be applied to Patient balances due to coordination of benefits issues, or the Patient's inability to provide the insurance with documentation they request or to provide the facility with the information needed to bill an insurance/carrier. Patients who opt out of available insurance coverage will not be eligibility for Financial Assistance, absent cultural prohibition. When evaluating Patient eligibility for Financial Assistance the Organization may consider a Patient's eligibility for other available sources of payment and a Patient's cooperation with securing such additional sources of payment (e.g., Medicaid and/or any available co-pay or deductible assistance programs such as Botox One Savings and Vyepti Co-pay Assistance).

Calculations

Financial assistance is provided in the form of a cost share percentage for underinsured Patients and a percent of the current Medicaid rate for uninsured Patients. For all Patients at or below 200% of the Federal Poverty Level, a 100% discount is provided. The Organization uses the current methodology represented in IRS Section 501(r) to determine financial discounts for those who have applied for financial assistance. The percentage discount provided is based on Household income and family size utilizing cost share methodology of up to 400% of the Federal Income Poverty Guidelines in effect at the time of the eligibility decision and annually updated. To become eligible for financial assistance the Patient must have accrued medical costs sharing more than 10% of their gross annual income in the last 12-months (e.g., medical, and dental statements with cost share amount).

Example: Underinsured Patient

Patient Balance	$50
Medical Cost Share (previous 12 months)	$5,000
Gross Monthly Income (Family of 1)	$4,000
Accrued Medical Cost Share Compared to Gross Annual Income	>10%
Patient Responsibility	20% of Current Patient Balance

Example: Uninsured Patient

Patient Balance	$100
Medical Cost Share (previous 12 months)	N/A
Gross Monthly Income (Family of 1)	$1,000
Accrued Medical Cost Share Compared to Gross Annual Income	N/A
Patient Responsibility	100% Discount Provided

IV. Procedure

Patients can apply for financial assistance at any time, including during the collection process. Patients have one hundred and eighty (180) days from the date noted on the first "post-discharge" billing statement before debt is sent to a debt collection agency. The debt collection agency's intent is to absolve the debt and not initiate any legal action against a Patient. Accounts placed in bad debt will be closed if the patient is approved for financial assistance. As per Internal Revenue Service guidelines, a billing statement for care is considered "post-discharge" if it is provided to an individual after the patient received care, whether inpatient or outpatient, and the individual has left the hospital. Approved applications are valid for one hundred eighty (180) days from the date of approval. Patient accounts will not be owed or placed with bad debt while a financial assistance application is in process with St. Mary's Healthcare.

The uniform NYS Hospital Financial Assistance Application released in October of 2026 is used for all patient applications.

1. When appropriate, patients will be asked to apply for Medicaid or other publicly sponsored insurance programs. Resources will be available to assist patients in that process. The patient may be required to meet a spend down amount in order to have services covered by Medicaid. Any payments the patient is required to make to the Organization may include, but are not limited to, the spend-down amount and co-pay and/or deductible amounts, which are eligible for consideration in our FAP. Failure to apply or comply with the Medicaid application requirements will result in denial of financial assistance.

2. Incomplete applications will be held, and the applicant will be notified of the missing required information which must be supplied within 30 days from the date of the written notification. If the patient does not meet this requirement, the application will be denied, and the Organization will resume billing and collection activities. The patient retains the option to provide the required information after the 30-day deadline.

3. A determination of whether a patient is qualified will be made within 30 days of receipt of a completed application. If a patient is qualified for Financial Assistance, he/she will receive written notification of the Financial Assistance discount amount as well as a Financial Assistance Approval letter indicating the coverage period, discount amount, and all eligible Household dependents.

4. Approved patients will be permitted to establish a reasonable monthly payment plan on any balance remaining after the Financial Assistance Discount. In no event will the monthly installments exceed 5% of the eligible Patient's gross monthly income or contain an acceleration clause or interest penalty. Financial counseling is available to arrange affordable monthly payment plans that can extend up to 2 years.

5. The Organization prohibits filing lawsuits to collect medical bills from patients whose income is at or below 400% FPL.

6. Financial assistance eligibility will be effective on the date of the covered service which the patient/guarantor applied for. The coverage period will extend for one hundred eighty days from the date the approval was granted. The Organization may ask Patients to reapply for financial assistance when there is a change in financial status.

Uninsured Patients/Anabaptist Christian Group

Patients who are not eligible for Financial Assistance will not be charged individually more than AGB, or the amounts generally billed for the same services by the Organization's highest volume commercial payor, for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization will calculate an AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation and percentage may be obtained from the Organization, Finance Department, 518-841-7434. Uninsured Patients will be provided with the AGB

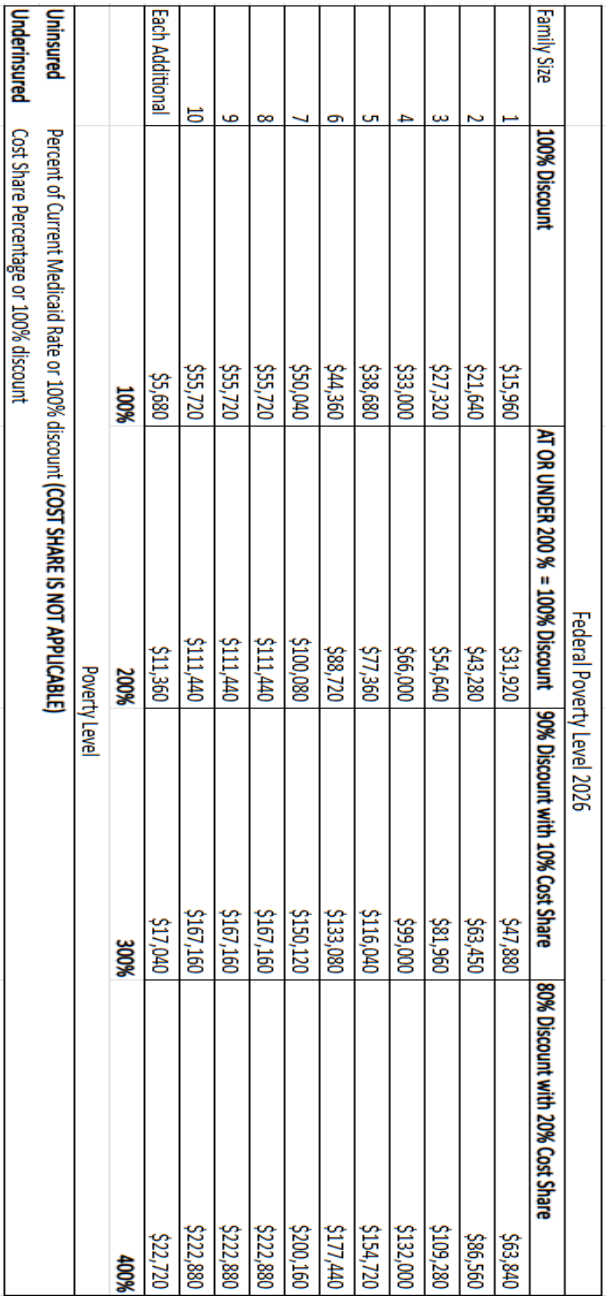
discount based on the time of services rendered along with a prompt pay discount of 10% if the total account balance paid in full within 30 days of the first statement mailed.

Members of the Amish community will also be provided with the AGB discount at the time services are rendered and will be eligible for a prompt pay discount of 10% if the full portion of the balance on the account is paid within 30 days of the first statement mailed.

Additional discounts for those of the Anabaptist Christian Group who cannot meet the financial assistance requirements for a successful application will be determined by the Chief Financial Officer.

V. Appendix

Exhibit A



Federal Poverty Level 2026				
Family Size	100% Discount	AT OR UNDER 200 % = 100% Discount	90% Discount with 10% Cost Share	80% Discount with 20% Cost Share
1	$15,960	$31,920	$47,880	$63,840
2	$21,640	$43,280	$63,450	$86,560
3	$27,320	$54,640	$81,960	$109,280
4	$33,000	$66,000	$99,000	$132,000
5	$38,680	$77,360	$116,040	$154,720
6	$44,360	$88,720	$133,080	$177,440
7	$50,040	$100,080	$150,120	$200,160
8	$55,720	$111,440	$167,160	$222,880
9	$55,720	$111,440	$167,160	$222,880
10	$55,720	$111,440	$167,160	$222,880
Each Additional	$5,680	$11,360	$17,040	$22,720
	100%	200%	300%	400%
	Poverty Level			
Uninsured	Percent of Current Medicaid Rate or 100% discount **(COST SHARE IS NOT APPLICABLE)**			
Underinsured	Cost Share Percentage or 100% discount			

Patients are eligible for NYS Medicaid with Household Income up to 138% of the Federal Poverty Level (FPL). Pregnant women and infants are eligible up to 223% of the FPL.

Household Income guidelines are derived from the Federal Poverty Income Levels published in the Federal Register.

Applicants that meet these criteria will have their application reviewed by the Organization for approval and applicable cost share or current Medicaid rate percent responsibility.