Financial Assistance Policy (501r) **Holzer Health System**	Original Date of Issue:	12/23/09
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	Review without Revision Date:	12/25
	Effective Date:	02/03/2026, 04/24/2026
	Policy Number	
Department: Revenue Cycle		
Scope and Application: For the purposes of this policy, Holzer Health System includes Holzer Clinic LLC, Holzer Hospital Foundation dba Holzer and Holzer Medical Center Jackson.		
Policy: Holzer Health System (HHS) is dedicated to provide, where applicable, financial assistance for emergent and/or medically necessary care to patients who request and/or require assistance to determine if they qualify for financial assistance.		
Purpose: To provide fair and unbiased treatment in billing and collection procedures.		

Definitions:

- **501(r) –** Section 501(r) of the Internal Revenue Code and regulations promulgated thereunder.
- **Financial Assistance Program (FAP)** – A Holzer sponsored program providing temporary financial assistance to eligible patients who receive emergent or medically necessary healthcare.
- **Emergent –** 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, of (iii) serious dysfunction of any bodily organ.
- **Urgent –** A medical condition not considered to be emergent, but which requires care within 24 hours and a prolonged delay in administering treatment may jeopardize the health of the patient.
- **Elective –** A medical condition for which treatment is chosen (elected) by the patient or provider as being advantageous to the patient but is not urgent or emergent.

Introduction: HHS uses the following procedures as guidance to establish eligibility for its FAP. A patient will not be denied eligibility for the FAP on the basis of race, creed, color, sex, national origin, sexual orientation, handicap or age. Eligibility requires both the service and patient is eligible.

Eligible Services: The FAP is applicable to emergent, urgent and/or other medically necessary health care services provided at HHS. Holzer will provide, without discrimination, care of emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility for HHS FAP.

Ohio Hospital Care Assurance Program (HCAP)

Ohio Administrative Code (OAC) 5160-2-07, established by the Ohio Department of Medicaid (ODM) provides guidance to hospitals providing medically necessary hospital-level services without charge.

Eligibility:

1) Patient must be living in Ohio voluntarily and not participating in an ODM program or other public assistance program.
2) Cosmetic or elective procedures are not eligible HCAP coverage.
3) Patient household income must be at or below Federal Poverty Guidelines (FPG) in existence at the time the medical services are rendered.
4) The patient and/or legal representative must complete the HCAP application in its entirety, listing all members living in the household.

5) Proof of income will be used to determine eligibility for HCAP and Medicaid qualification via one of two methodologies: (i) three (3) months' income prior to the date of service, multiplied by four (4) or (ii) 12 months income prior to the date of service, multiplied by one (1).
6) Applications relating to a catastrophic or exceptional incident are referred to the Director of Revenue Cycle or Chief Financial Officer for consideration.
7) HCAP Applications expire ninety (90) days from the date of service for outpatient services and forty-five (45) days from the date of service for inpatient services, including readmissions so long as the admitting diagnosis is the same as the underlying condition as the initial admission.

HHS Financial Assistance Program (FAP):

Patient must have the ability and be within the Federal Government requirements to apply for Ohio Medicaid and/or any other public assistance programs within their state of residence. All other payer sources should be exhausted to be eligible for the HHS FAP.

Eligibility:

1) The patient's household income must be at or below 300% of FPG at the date of service. The amount of financial assistance available based on income is set forth in Attachment A, below.
2) Cosmetic and/or non-approved elective procedures are not eligible for the HHS FAP. Consideration may be given for elective procedures on a case-by-case basis consistent with this policy.
3) Non-covered or investigational-based medical services in accordance with Medicaid or Medicare coverage determinations are ineligible for the HHS FAP.
4) The patient or legal/authorized representative must request and complete a FAP application within 120 days from the first post-discharge billing statement. Applications are accepted for 120 days from the first post-discharge billing statement.
5) Patients are responsible to make payments on accounts until such time that financial assistance is approved. Payments made on patient account balances prior to the receipt and determination of eligibility for the FAP will be applied to the account balance if due. Payments made that result in an account credit will be refunded to the patient.
6) All household members under the age of eighteen (18) will be listed on the FAP application.
7) For patients under the age of eighteen (18), the family must include the patient, the patient's natural or adoptive parent(s), and the parent(s)' children, natural or adoptive under the age of eighteen (18) living in the home. If the patient is a child of a minor parent residing in the home of the patient's grandparents, the family must include only the parent(s) and any of the parent(s)' children, natural or adoptive.
8) Proof of income will be used to determine FAP eligibility via one of two methodologies:
(i) three (3) months' income prior to the date of service, multiplied by four (4) or (ii) 12 months income prior to the date of service, multiplied by one (1).
9) Patients who submit a claim to their contracted primary insurance carrier with/without secondary carrier coverage are eligible for the HHS FAP for deductibles, copayments and coinsurance.
10) Self-pay patients who do not qualify for HHS FAP receive an automatic 50% discount of billed charges.
11) Applications relating to a catastrophic or exceptional incident are referred to the Vice President of Revenue Cycle or Chief Financial Officer for consideration.
8) Holzer will work with a patient's Administrator or Executor of an estate, that may qualify for Financial Assistance.
1) Section 501(r)(5)(A) requires hospitals to limit amounts charged for emergent or other medically necessary care provided to individuals eligible for assistance under the organization's FAP (FAP eligible individuals) to not more than the amounts generally billed (AGB) to individuals who have insurance covering such care. Holzer uses Look Back method using Medicare and Commercial insurance, as defined in federal regulations.

Review Approval Level

All Account Types	Sign Off Position Authority/Amounts
All Payers	CFO = > $50,000 VP of Revenue Cycle = $10,001 - $50,000 Manager of Patient Accounts = $1 - $10,000

Related Policies

Billing and Collections:
Refer to the Billing and Collection Policy.

Credit Balances:
Refer to the Credit Balance Policy.

340B Drug Program:
Refer to the 340B Drug Program Policy.

ATTACHMENT A –

2026 Federal Poverty Guidelines for 48 Contiguous States and District of Columbia For families/households with more than 8 persons, add $5,680 for each additional person.			
	100%	**101% - 200%**	**201% - 300%**
	HCAP	**75% Assistance**	**69% Assistance**
Number of Household Members	Account Balance Adjusted 100%	Account Balance becomes 25% of total charges.	Account Balance becomes 31% of total charges.
1	$15,960	$31,920	$47,880
2	$21,640	$43,280	$64,920
3	$27,320	$54,640	$81,960
4	$33,000	$66,000	$99,000
5	$38,680	$77,360	$116,040
6	$44,360	$88,720	$133,080
7	$50,040	$100,080	$150,120
8	$55,720	$111,440	$167,160

ATTACHMENT B

Covered and Non-Covered Providers

Covered Provider Practice Groups:

Holzer Audiology, Holzer Behavioral Health, Holzer Cardiology, Holzer Chiropractic, Holzer Coagulation Clinic, Emergency Departments, Holzer ENT, Holzer Endocrinology, Holzer Family Practice, Holzer Gastro, Holzer Surgery, Holzer Hemocology/Oncology, Inpatient Services, Inpatient Psych Services, Holzer Internal Medicine, Laboratory Services, Radiology Services, Holzer Nephrology, Holzer Neurology, Holzer OB/GYN, Holzer Occupational Medicine, Holzer Opthamology, Holzer Orthopedics, Holzer Pediatrics, Holzer Podiatry, Holzer Pulmonology, Holzer Radiation Oncology, Holzer Urgent Care, Holzer Urology, Holzer Vein Center, Holzer Wound Care

Non-Covered Providers:

Holzer Inpatient Rehab, Holzer Sleep Labs, Physical Therapy, Retail Clinics, Holzer Pain Management, Holzer Plastics, Holzer Home Health, Hospice, Extra Care, Holzer Senior Care, Post-Acute Care, Holzer Dental Clinic/Dental Health Partners, and Holzer Vanguard.

Non-Covered Services:

- Cosmetic/Non-Approved Elective Surgery
- Eye Exams/Eyeglasses/Laser Eye Surgery
- Hearing Aids and Supplies
- Preventative Dental Services
- Durable Medical Equipment (DME) including Orthotics and Orthotic fitting
- Prosthetic devices including those that replace in internal body organ
- Infertility Services
- Weight Loss (pre/post service)
- Pain Management Services/Procedures
- Allergy Testing/Service