



Shepherd Center

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Owner Jim Kelly: VP
Revenue Cycle
Area Revenue Cycle
References CARF
Standards,
Outpatient
Access

Financial Assistance to Patients (AC.FS.01.11, 1/2011, AC.FS.01.03)

Overview of Shepherd Center's Charity Care Program

It is Shepherd Center policy to promote access to care by providing free or discounted medical services to those with a demonstrated financial need who qualify for assistance under Shepherd Center's Financial Assistance Program (the "Charity Care Program" or the "Program"). In furtherance of this commitment to providing charitable services to those in need, Shepherd Center is committed to the following actions in keeping with its status as a non-profit hospital:

1. Ensuring that patients, prospective patients, and their families are aware of Shepherd Center's Charity Care Program, through effective and easily accessible communication mediums.
2. Providing all prospective and current patients with a copy and summary of the Charity Care Program so that they understand the eligibility criteria.
3. Applying fair, equitable, and realistic criteria that account for the financial realities facing the patients and families of those seeking care at Shepherd Center.
4. Determining whether a patient is eligible for assistance from a public health insurance program and helping them apply for such assistance where eligible.
5. Where an individual and/or family lacks insurance that will cover that individual's care at Shepherd Center, assisting them with applying for financial assistance through the Charity Care Program.
6. For those patients who are not eligible to receive financial assistance, Shepherd Center will work with families to identify potential funding sources from state and federal governments, private foundations, and other health related and social service organizations.

Definitions

Amount Generally Billed (AGB) – Shepherd Center's AGB is calculated using the "look-back method" as defined by Internal Revenue Service Code 501(r)(5), using the previous year's closed patient accounts. Shepherd's AGB includes any fully paid hospital claims where the primary payer is Medicare fee-for-service

and all private health insurers. Shepherd Center's AGB is the ratio of total insurance allowable amounts for payments posted during the year to the total billed charges for those accounts.

The AGB will be based on insurance payments posted each calendar year. The percentage will be calculated March 31 each year and, if applicable, be used to calculate Guarantor amounts due for services beginning April 1 and continuing through March 31 of the following year to coincide with Shepherd Center's fiscal year.

The current AGB percentages and calculations for Shepherd Center services may be obtained in writing free of charge by contacting Shepherd Center's Vice President, Revenue Cycle at jim.kelly@shepherd.org.

Asset Threshold – This is the threshold beyond which an individual or qualifying household may not be presumptively eligible for financial assistance under the Charity Care Program, and the current threshold is \$500,000 USD. Note that individuals who do not meet the presumptive eligibility guidelines may still be considered for financial assistance under the household income standard.

Covered Services – Includes all medically necessary essential to sustain life or prevent the deterioration of a patient's health that are not eligible for reimbursement by a Payer (defined below), except those services specifically identified as Exempt Services under the Charity Care Program.

Federal Poverty Level (FPL) – This is an income measure published by the U.S. Census Bureau that is used as part of the determination of a patient's eligibility for financial assistance. The current FPL can be accessed here: [Federal Poverty Level \(FPL\) - Glossary | HealthCare.gov](#).

Guarantor – The person with financial responsibility for payment of a Shepherd Center account. It may be the patient, a parent or guardian, or whomever has been identified as the Guarantor for a Shepherd Center account.

Household Income – Includes the following for all members of the patient's household, consistent with the U.S. Census Bureau's American Community Survey criteria:

- Wages, salary, commissions, bonuses, and tips.
- Self-employment income.
- Interest, dividends, net rental income, royalty income, or income from estates and trusts.
- Social Security.
- Supplemental Security Income (SSI).
- Any public assistance or welfare payments.
- Retirement income, trust fund payouts, pensions, survivor, or disability income.
- Child support, alimony, unemployment compensation, or Veteran's payments.

Medically Necessary Care – Services or supplies that are proper and needed for the diagnosis or treatment of a patient's medical or behavioral health condition, meet the standards of good medical practice in the area, and are not mainly for the convenience of the patient or their provider.

Net Assets – Includes all assets owned or held by the Guarantor applying for financial assistance with the exception of the Guarantor's residence, retirement assets (401ks, IRAs, 403bs, etc.), college savings accounts, and the Guarantor's primary automobile.

Payer – Refers to any entity responsible for reimbursing Shepherd Center for medically necessary services provided to a patient. This includes, but is not limited to, government programs such as Medicare and Medicaid, commercial health insurance plans, employer-sponsored health benefits, and other third-party coverage sources. The term encompasses both primary and secondary insurers, managed care organizations,

and any foundation or public assistance program that provides coverage for healthcare expenses.

Under-Insured Patient – Includes patients or Guarantors who have insurance benefits but where those insurance benefits are not “in network” with Shepherd Center or where the limitation on benefits under the applicable insurance plan is likely to be exhausted during the patient’s stay at Shepherd Center.

Uninsured Patient – An Uninsured Patient is an individual who is not participating in or covered by a health insurance plan, including, but not limited to, federal or state public health insurance programs as well as workers’ compensation programs.

Eligibility for Financial Assistance

All qualification determinations will involve an evaluation of each patient’s clinical needs, an administrative review of the patient’s specific circumstances, and a determination of Shepherd Center’s available capacity for treatment at the time of the review. Decisions about whether an applicant qualifies for the Charity Care Program will be made without regard to any applicant’s ability to pay for services at Shepherd Center.

Patients will not be eligible to participate in the Charity Care Program if they are eligible to receive funding to cover all of their Medically Necessary Care from a third party, including but not limited to a commercial insurer or group health plan, liability insurance cover, workers’ compensation programs, and any other federal or state public health programs. Patients who are under insured and whose third-party coverage will not pay for all Medically Necessary Care may still be eligible for assistance under the Charity Care Program.

Eligibility under the Charity Care program can happen in two ways: Through **Presumptive Eligibility** or through an **Assessment of Household Income**.

Presumptive Eligibility

Under-Insured and Uninsured Patients with proof of Georgia residency* will be deemed presumptively eligible for a full discount (100%) from all amounts otherwise due for Medically Necessary Care they receive at Shepherd Center if any of the following circumstances are present:

1. A determination that the patient is Medicaid eligible but where the eligibility does not cover the dates of Medically Necessary Care provided, or where the Medically Necessary Care is not covered by Medicaid.
2. The patient is enrolled in the Supplemental Nutrition Assistance Program (SNAP) or the Women, Infants, and Children Food Assistance Program (WIC).
3. The patient has experienced a catastrophic injury or condition, and the following factors are present:
 - a. There exists a reasonable possibility that the patient’s condition may substantially limit his or her ability to resume activities necessary for financial support, including but not limited to a specific type of employment, training program, course of study, or other financial pursuit;
 - b. The patient’s condition is anticipated to require a full-time caregiver for at least a year following any inpatient discharge; and
 - c. The patient’s Net Assets fall below the Asset Threshold.
4. The patient demonstrates some other extraordinary hardship, including but not limited to limitations on services available due to a public health emergency, extraordinary care obligations post-discharge that are likely to exhaust a Guarantor’s Net Assets within five (5)

years, or circumstances that are likely to substantially limit a patient’s ability to receive assistance from his or her family. All hardship determinations shall be granted at the discretion of the Manager of Patient Financial Services or Vice President, Revenue Cycle.

*** Exceptions may be available to non-Georgia residents based on demonstrated need where the patient is not otherwise eligible based on household income (see below).**

In cases where Shepherd Center can reasonably presume that a patient qualifies for financial assistance, Shepherd Center may administratively designate a patient as having qualified for a financial assistance discount.

Eligibility Based on Household Income.

Shepherd Center will apply a sliding scale discount for all individuals who apply for financial assistance and whose Household Income is at or below 600% of the federal poverty level unless a patient is not otherwise eligible as outlined below.

Household Income Determination and Associated Financial Assistance Discounts.

1. When qualifying a Guarantor under the Charity Care Program, Shepherd Center will apply the discounts below to the amount charged to the patient based on the Guarantor’s household income as a percentage of the FPL. A patient who is eligible for financial assistance under the Program will not be charged more for medically necessary care than the AGB. For example, if the AGB for a given fiscal year is 50% and an eligible patient is to receive a medically necessary procedure for which the gross charges are \$10,000, the patient will not be charged more than \$5,000 for that procedure: $\$10,000 \text{ (in Gross Charges)} \times 0.5 \text{ or } 50\% \text{ (AGB Percentage)} = \$5,000$. The financial assistance discounts outlined below will then be applied to that latter amount.
2. Patients claimed as dependents by a parent or legal guardian will be assessed based on the income of their parent or legal guardian.
3. Shepherd Center may, in its discretion, adjust the income calculation to reflect a recent job loss or anticipated change in circumstances based on the patient’s ongoing care needs.
4. All patients are billed based on gross charges for the Medically Necessary Care provided, but a Guarantor will not be responsible for more than the AGB for any Medically Necessary Care for which they are personally responsible.
5. If Shepherd Center determines that a Guarantor has provided inaccurate, incomplete, or false information in support of an application for financial assistance where accurate and truthful information would have resulted in a different determination regarding eligibility, Shepherd Center may terminate the financial assistance under the Charity Care Program and all financial assistance previously provided will be reversed and billed to the Guarantor.
6. If Shepherd Center has reason to believe that a Guarantor’s income does not provide an accurate representation of the Guarantor’s financial ability to pay for Medically Necessary Care, Shepherd Center may require the Guarantor to provide additional information about their Net Assets, and unless otherwise prohibited by law, Shepherd Center may consider those Net Assets in determining the extent to which the patient is eligible to participate in the Program.

Household Income as a Percentage of FPL	Financial Assistance Discount

0 to 400%	100%
401% to 500%	80%
501% to 600%	70%

Household Income as a percentage of current FPL, based on U.S. Census Bureau 2025 guidelines:

		2025 Shepherd Center Financial Assistance Criteria		
		400% FPL	500% FPL	600% FPL
Family Size	100% 2025 FPL	100% Discount	80% Discount	70% Discount
1	\$ 15,650	\$ 62,600	\$ 78,250	\$ 93,900
2	\$ 21,150	\$ 84,600	\$ 105,750	\$ 126,900
3	\$ 26,650	\$ 106,600	\$ 133,250	\$ 159,900
4	\$ 32,150	\$ 128,600	\$ 160,750	\$ 192,900
5	\$ 37,650	\$ 150,600	\$ 188,250	\$ 225,900
6	\$ 43,150	\$ 172,600	\$ 215,750	\$ 258,900
7	\$ 48,650	\$ 194,600	\$ 243,250	\$ 291,900
8	\$ 54,150	\$ 216,600	\$ 270,750	\$ 324,900

Applying for Financial Assistance

1. All patients or Guarantors will be offered the opportunity to complete the Financial Assistance Application, included as Attachment 1 to this policy, and applications should occur, where possible, prior to a patient's admission at Shepherd Center. The application is meant to obtain additional information that allows Shepherd Center to assess eligibility for assistance.
2. One-time hardships and/or approvals (e.g., during declared public health emergencies) may be granted at the discretion of the Manager of Patient Financial Services or Vice President, Revenue Cycle due to extenuating circumstances and without formal screening or applications required.
3. In addition to submitting the Financial Assistance Application, applicants are expected to complete the application or authorization process for any appropriate Federal, State, or private foundation programs that may also provide coverage, including any of the following, as applicable:
 - a. Medicaid
 - b. PeachCare for Kids
 - c. Medicare
 - d. Group Health Insurance Plans
 - e. Employer continuation of coverage plans (COBRA)
 - f. Georgia Medicaid Health Insurance Premium Program (HIPP/CHIPRA)
 - g. Individual Health Insurance Plans, including those available on HealthCare.gov or

GeorgiaAccess.gov.

4. Financial assistance under the Program will be considered for anyone who completes the Financial Assistance Application and submits supporting evidence to substantiate income levels. Minimum supporting evidence for income includes:
 - a. Proof of income representing current household income - i.e., pay stubs, W2's, Prior Year Income Tax forms, etc.
 - b. If there is no income, letters from the individual(s) providing room & board to patients are required.
 - c. **(Note: failure to provide appropriate information may result in rejection of the application).**
5. Where appropriate, Shepherd Center may require the applicant to provide information about the Guarantor's Net Assets to ensure that the applicant is eligible under the Program.
6. Financial Counselors will review the Application and supporting documents for completeness and eligibility. Eligibility will be based on the criteria established by Shepherd Center as set forth above, including Shepherd Center's current capacity to accept additional patients.
7. If the patient does not meet the criteria for financial assistance, or if the patient is only eligible for discounts under the Program, the Financial Counselor will establish deposit requirements based on the expected services and will offer payment options or a payment plan as appropriate.
8. If the patient is eligible for financial assistance, the Financial Counselor will present the application to the Manager of Patient Financial Services for written approval. If assistance is not approved, the Financial Counselor will coordinate the notification to the patient. Payment arrangements will be completed as described above.
9. Approved Applications are effective for six months from approval date, or the length of the inpatient confinement, whichever is shorter. Approved Applications for Day Program and outpatient services are effective for six months or the patient's outpatient treatment plan, whichever is shorter.
10. If a request for financial assistance under the Program is denied, the applicant may appeal the decision within thirty (30) days by contacting the Vice President of Revenue Cycle. The applicant is responsible for identifying any new or omitted information that may affect the determination regarding the applicant's eligibility.

Nonpayment

Shepherd Center does not engage in Extraordinary Collection Actions. ECAs are defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that involve selling an individual's debt to another party, involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"), involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP, or require a legal or judicial process. Examples of actions that may require a legal or judicial process include, but are not limited to:

- Placing a lien on an individual's property.
- Foreclosing on an individual's real property.
- Attaching or seizing an individual's bank account or any other personal property.
- Commencing a civil action against an individual.

- Causing an individual's arrest.
- Causing an individual to be subject to a writ of body attachment.
- Garnishing an individual's wages.

Shepherd Center approved collection activities include letters, statements, and phone calls to patients and guarantors. Additionally, a claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA. Shepherd Center may file such claims or liens on a case-by-case basis.

Covered and Exempt Services

Shepherd Center's Charity Care Program for free and discounted Medically Necessary Care only applies to **Covered Services**, as defined above. Services eligible for reimbursement by a Payer are not Covered Services under the Charity Care Program, but if an otherwise eligible applicant is responsible for co-pays and deductibles, some or all of those required payments may be waived under the Charity Care Program depending on the applicant's eligibility level (e.g., an applicant eligible for a 100% discount may have those charges waived, whereas an applicant subject to a 70% discount may be required to pay a percentage of those charges consistent with that applicant's eligible discount).

Various **Exempt Services** are typically outside the scope of the Charity Care Program and are generally ineligible for free or discounted care, unless otherwise approved by the Vice President of Revenue Cycle, including the following:

- Prescription drugs obtained by any patient from a pharmacy (including but not limited to the Shepherd Center Apothecary) unless such drugs are administered to the patient by Shepherd Center medical staff during a patient's clinic visit.
- Covered Services not billed to a patient's in-network health insurance plan, including Medicaid and Care Management Organizations (CMOs), when coverage is in effect at the time services are provided.
- The portion of any Medically Necessary Care for which Shepherd Center receives compensation from Guarantor's out-of-network insurance provider.
- Services provided by physicians and other providers who consult and see patients at Shepherd Center but who are not employed by Shepherd Center and who bill patients directly for their services.
- Services provided by other health care facilities when patients are transferred to those facilities for services not provided at Shepherd Center.
- Transplants, including both solid organ and bone marrow.
- Genetic testing that will not change the plan of care for an existing patient.
- Experimental treatments and other treatments such as Compassionate Use that are approved by the Food and Drug Administration (FDA) for limited and unique circumstances and administered pursuant to any applicable federal or state requirements.
- Transport services provided by any entity other than Shepherd Center.
- Services denied due to non-compliance by the Guarantor or insured (e.g., coordination of benefit requests or unpaid premiums).
- Services which cannot be authorized by the patient's in-network health insurance plan due to medical necessity when Shepherd Center providers have not exhausted options outlined by the insurance plan.

- Except as provided below, the following drugs will not be eligible for charity funds - Botox, Hymovis, Prialt, Tysabri, Ocrevus, Rituxan, Truxima, Uplizna, Xeomin, Dysport, Capsaicin topical, immune globulin/gamma globulin (IgG) 10%, and Briumvi (the "Presumptively Ineligible Drugs"). In addition, the Iovora and PRP procedures are also ineligible under the Charity Care Program. Associated costs (MRIs, office visits, labs, infusion administration) for these drugs and procedures remain eligible for charity care/financial assistance. Outpatient case managers will assist patients interested in drug manufacturers' drug assistance programs. Notwithstanding the foregoing, Shepherd Center's Charity Care Program will cover all Presumptively Ineligible Drugs for inpatients where the administration of the drug is medically necessary and where Shepherd Center is unable to secure a discount from the supplier through the supplier's charity or financial assistance program.
- Outpatient therapy sessions that total more than twelve (12) visits per discipline per year unless otherwise noted below. For purposes of this policy, the following constitute separate and discrete "disciplines" under the policy: Speech Therapy, Occupational Therapy, and Physical Therapy. In addition, any sessions that fall under the umbrella of psychological and behavioral health shall be treated as a single discipline subject to a 12-session cap (e.g., two visits to a counselor and three visits to a psychologist would count as 5 visits toward the 12-visit cap on psychological and behavioral health therapy services).
 - Except as noted below, this limitation on outpatient therapy sessions applies to all individuals seeking outpatient therapy, including individuals who have been discharged from SCI Day Program or Shepherd Pathways. This limit applies to each visit in a year regardless of whether they are standalone outpatient therapy visits or outpatient therapy visits that are part of a therapy series. For example, if an individual has one (1) standalone outpatient therapy visit and then begins a therapy series consisting of four (4) different outpatient therapy visits in the same year, that individual will have had a total of five (5) outpatient therapy visits that count toward the twelve (12) visit limit per year.
 - This limitation on outpatient therapy sessions does not apply to individuals admitted to and attending the SCI Day Program or Shepherd Pathways for two (2) months or less. Additionally, if an individual is discharged from SCI Day Program or Pathways and is then readmitted to SCI Day Program or Pathways, that individual will not be subject to the twelve (12) visits per year cap for that first readmission for two (2) months or less. All subsequent readmissions to SCI Day Program or Pathways for that individual will be subject to the twelve (12) visits per year cap.
- The MS Integrated Therapy Program (MS ITP) after the first four (4) weeks of treatment. All services included within the ITP during the first four weeks, including outpatient therapy sessions, shall remain eligible for financial assistance under the Charity Care Program regardless of whether they exceed the annual cap on therapy visits.
- Outpatient pain management services are typically only covered under the Charity Care Program during the patient's first year of receiving pain-management related services, with the first appointment constituting the first day, or "Coverage Date," by which the coverage period will be measured. Any pain management services provided on or after the first anniversary of the Coverage Date are typically ineligible for coverage under the Charity Care Program without the approval of the VP of Revenue Cycle.
- Assessments and tests by the Neuropsychology Staff are not eligible for coverage under the Charity Care Program unless specifically approved in advance by the VP of Revenue Cycle.
- Driver evaluations are not covered under the Charity Care Program unless specifically approved in advance by the VP of Revenue Cycle.

Attachments

[10.02.25 Updated Financial Assistance Policy Attachment 1.docx](#)

Approval Signatures

Step Description	Approver	Date
Chief Financial Officer	Beth Boatwright: Chief Financial Officer	10/2025
	Jim Kelly: VP Revenue Cycle	10/2025

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