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| GRACE COTTAGE FAMILY HEALTH & HOSPITAL | POLICY #16.0050 |
| SUBJECT/TITLE: FINANCIAL ASSISTANCE POLICY | PAGE: 1 OF: 17 |
| DEPARTMENT: REVENUE CYCLE | EFFECTIVE: 10/01/2017 REVISED:5/8/2026 |

Grace Cottage Family Health and Hospital (GCFHH) is a patient-centered organization committed to treating all patients with respect and dignity, regardless of a patient’s health care insurance benefits or financial resources. We are committed to providing financial assistance to persons who have healthcare needs and who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. Consistent with our mission to deliver affordable and compassionate care, and to fulfill our obligation as a non-profit organization, we strive to ensure that the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care.

Purpose

The financial assistance policy outlined herein is intended to address the interests of providing access to care to those with no or limited means to pay for emergency and medically necessary care. This policy sets forth the process for determining patient eligibility for financial assistance and is intended to comply with the applicable laws and regulations including those of the State of Vermont and the U.S. Internal Revenue Service including, but not limited to, Vermont Act 119 of 2022.

Non-Discrimination Statement

Grace Cottage Family Health and Hospital (GCFHH) does not discriminate on the basis of race, color, sex, sexual orientation, gender identity, marital status, religion, ancestry, national origin, citizenship, immigration status, primary language, disability, medical condition, or genetic information in the provision of patient financial assistance or in the implementation of this financial assistance policy.

Definitions

As used in this policy:

“Amount generally billed” means the amount a hospital generally bills to individuals for emergency or other medically necessary health care services, determined using the “look-back method” set forth in 26 C.F.R. § 1.501(r)-5(b)(3).

“Credit reporting agency” means a person who, for fees, dues, or on a cooperative basis, regularly engages in whole or in part in the practice of assembling or evaluating information concerning a consumer’s credit or other information for the purpose of furnishing a credit report to another person.

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“Health care provider” means a person, partnership, corporation, facility, or institution licensed, certified, or otherwise authorized by law to provide professional health care services in this State to an individual during that individual’s medical care, treatment, or confinement.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, or mental health condition or substance use disorder, including procedures, products, devices, and medications.

“Hospital” means a hospital licensed pursuant to Vermont Statutes Annotated (VSA) chapter 43 of title 18 or an outpatient clinic or facility affiliated with or operating under the license of a hospital licensed pursuant to VSA chapter 43 of title 18.

“Household income” means income calculated in accordance with the financial methodologies for determining financial eligibility for advance premium tax credits under 26 C.F.R. § 1.36B-1 & 2, including the method used to calculate household size, with the following modifications:

- domestic partners, and any individual who is considered a dependent of either partner for federal income tax purposes, shall be treated as members of the same household.
- married individuals who file federal income tax returns separately but could file jointly, and any individual who is considered a dependent of one or both spouses for federal income tax purposes, shall be treated as members of the same household.
- married individuals who are living separately while their divorce is pending shall not be treated as members of the same household, regardless of whether they are filing federal income tax returns jointly or separately; and
- household income for individuals who are not required to file a federal income tax return, and for undocumented immigrants who have not filed a federal income tax return, shall be calculated as if they had filed a federal income tax return.
- A summary of what type of income should be counter or excluded can be found @ <https://laborcenter.berkeley.edu/wp-content/uploads/2021/03/2021-03-MAGI-Summary.pdf>

“Household size” is determined based on the definition of “Household income” above.

“Liquid asset” means an asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, stocks, bonds, and certificates of deposit. For the purposes of determining financial assistance eligibility, liquid assets do not include the

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household's primary residence, any 401(K) or individual retirement accounts, or any pension plans.

“Medical creditor” means hospital to whom a consumer owes money for health care services.

“Medical debt” means a debt arising from the receipt of health care services.

“Medical debt collector” means an individual or entity that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due, or asserted to be owed or due, to another individual or entity.

“Medically necessary health care services” means health care services, including diagnostic testing, preventive services, and after care, which are appropriate to the patient's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medically necessary care must:

- be informed by generally accepted medical or scientific evidence and be consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment or diagnose or manage the medical condition.
- be informed by the unique needs of each individual patient and each presenting situation; and
- meet one or more of the following criteria:
 - help restore or maintain the patient's health.
 - prevent deterioration of or palliate the patient's condition; or
 - prevent the reasonably likely onset of a health problem or detect an incipient problem.

“Out-of-pocket cost” means patient expenses for medical care that are not reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that are not covered.

“Federal Poverty Level” (FPL) is a measure of income issued every year by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, Children's Health Insurance Program (CHIP), and hospital patient financial assistance.

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“Patient” means the individual who receives or received health care services and shall include a parent if the patient is a minor or a legal guardian if the patient is a minor or adult under guardianship.

“Vermont resident” means an individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in this State in the normal course of the employee’s employment, or attends school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time that services are received but who lacks stable permanent housing.

Covered Services

This policy covers all emergency and medically necessary health care services provided by the hospital employees who are covered by this policy.

Non-Covered Services

Services that are typically not covered by this policy include but are not limited to: cosmetic services unless medically necessary based upon physician review; infertility/fertility services unless medically necessary based upon physician review; and services reimbursed directly to the patient by an insurance carrier or third party.

Providers Not Covered

This policy does not cover services rendered by medical professionals who are not employees of the hospital but who provide services at Grace Cottage Family Health and Hospital. A full list of the medical professionals whose services are not covered by this policy is available online at <https://gracecottage.org>

We understand that this a confusing issue and encourage patients to contact us at (802)365-3776, or email us at FinanceQuestions@gracecottage.org if you have questions about which medical providers and services are covered by our policy.

Provision of Policy Documents to Patients

In-Person: Free paper copies of this policy and the financial assistance application are available in the following locations:

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- the patient reception area,
- the patient admissions area,
- the billing office, and
- the office where patient financial assistance services are provided.

We will offer a free copy of this policy to patients as part of their first visit or, in the case of services delivered at the hospital, during the intake and discharge processes.

By Phone: Patients can call (802)365-3770 to request a free paper copy of this policy and the financial assistance application.

Online: This policy, the financial assistance application, and related materials are available online at <https://gracecottage.org/>

Patients may also access these documents by signing into their patient portal @ <https://gracecottage.org/patients-visitors/your-visit/patient-portal/>

By Mail: Free copies of this policy and the financial assistance application are available, upon request, via mail. Individuals can request paper copies by writing to the following address:

Jocelyne Smith, CAC
Patient Resource Advocate
Grace Cottage
P.O. Box 216
Townshend, VT 05353

Translations: An individual can request an oral or written translation of the financial assistance policy (see “Language Access Rights” section below for details).

Plain Language Summary: We shall produce and make available a plain language summary of our financial assistance policy.

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What We Will Do Before Seeking Payment for Emergency or Medically Necessary Services

Before we seek any type of payment from a patient for emergency and/or medically necessary services, we will do at least the following:

- Determine whether the patient has insurance to cover the provided emergency and/or medically necessary services including, but not limited to, health insurance, automobile insurance, worker's compensation, or some other type of policy.
- Offer to provide the patient with information about how to apply for health insurance and where they can get assistance with the application process.
- If available, we may use information in the hospital's possession to determine eligibility for patient financial assistance.
- For example, we may use:
 - Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down).
 - Supplemental Security Income (SSI) eligibility.
 - Food Stamp eligibility.
 - Fuel assistance eligibility.
 - Participation in Women, Infants and Children programs (WIC); or
 - Patients are incarcerated with no health care coverage.
- Offer the patient a financial assistance application at no cost.
- Offer to provide the patient with assistance completing and submitting the financial assistance application at no cost.

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Eligibility

GCFHH offers two types of financial assistance: general and catastrophic financial assistance.

- **General financial assistance:** A patient must meet two tests to be eligible for general financial assistance: (1) the residency test and (2) the general income test.
- **Catastrophic financial assistance:** A patient must meet two tests to be eligible for catastrophic financial assistance: (1) the residency test and (2) the catastrophic income test.

Residency test: To be eligible for general or catastrophic financial assistance, a patient must, at the time services are rendered, be a Vermont resident as defined in the “Definitions” section of this policy and copied here:

“**Vermont resident**” means an individual, regardless of citizenship and including undocumented immigrants, who resides in Vermont, is employed by a Vermont employer to deliver services for the employer in this State in the normal course of the employee’s employment, or attends school in Vermont, or a combination of these. The term includes an individual who is living in Vermont at the time that services are received but who lacks stable permanent housing.

There is no durational requirement for Vermont residency. It is irrelevant how long the patient has been a Vermont resident, and GCFHH explicitly recognizes that persons with unstable housing can be Vermont residents (even if they just moved to Vermont).

General income test: To be eligible for general financial assistance, a patient’s household income must be equal to or less than 400% of the Federal Poverty Level (FPL). To determine the applicant’s FPL, GCFHH shall use the “Household Income” definition in the “Definitions” section of this policy, which also contains guidance on determining household size. See also the “Application Processing” section of this policy below for further guidance. The applicable FPL standard shall be for the year in which services were or are rendered.

Catastrophic income test: To be eligible for catastrophic financial assistance, a patient’s household income must be equal to or less than 600% FPL. To determine the applicant’s FPL, GCFHH shall use the “Household Income” definition in the “Definitions” section of this policy, which also contains guidance on determining household size. See also the “Application Processing” section of this policy below for further guidance. The applicable FPL standard shall be for the year in which services were or are rendered.

Eligibility and health insurance sign-up requirements: If a patient is an undocumented immigrant, the patient’s refusal to apply for public health insurance shall not be used as a reason to deny them financial

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assistance. For all patients, regardless of immigration status, the patient's refusal to apply for private health insurance shall not be used as a reason to deny them financial assistance.

Eligibility Period

A patient shall be deemed eligible for patient financial assistance for twelve months from the date on which they were initially found eligible for patient financial assistance. The need for patient financial assistance shall be re-evaluated at each subsequent time of service if the last eligibility evaluation was completed more than twelve months prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known. Note: It is permissible for patients to submit new supporting financial documentation to an initial application provided the initial application is less than one year old.

It is preferred but not required that a request for financial assistance and a determination of eligibility occur prior to rendering of services. However, an application may be submitted at any point in the billing cycle and prior to a charge being levied so long as there is a reasonable expectation that services will be rendered.

Application Period

GCFHH will process applications submitted by individuals during the application period. The application period begins on the date a billing statement for the patient balance of care is first presented and ends 365 days later. If an account has been referred to a collection agency and an application is received and granted within the 365-day application period, accounts shall be recalled from the agency and processed under the financial assistance program.

Documentation

Residency

GCFHH will not ask an applicant to provide proof of residency. A signed financial assistance application will be considered sufficient attestation that the applicant meets the definition of Vermont residency included in this policy.

Income

A patient must provide proof of income along with their financial assistance application. A patient may provide their most recent state or federal income tax return, or in lieu of submitting a tax return, they may provide all paystubs, documentation of public assistance, or other documentation accepted as valid documentation of income by the Vermont Department of Health Access, such as a bank statement, profit

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and loss statement, letter from an employer, or self-attestation in extenuating circumstances in which no other documentation is available.

Note: Patients who are undocumented immigrants shall be given the option to submit other documentation of household income, such as a profit and loss statement, in lieu of a state or federal income tax return.

GCFHH does not require any other source of income verification aside from the documentation listed above.

GCFHH may rely on other evidence of eligibility but will not require a patient to provide any forms of documentation that are not listed in this policy.

GCFHH may presumptively deem a patient eligible for financial assistance based on information in the hospital's possession. We will not use information in our possession to presumptively deny an application.

We may waive documentation requirements at the discretion of the Director of Revenue Cycle or the CFO. Please call (802) 365-3770 to request or waiver or indicate this request on the financial assistance application.

Application Processing

Determining household income

Regardless of what type of income documentation the applicant submits, GCFHH shall calculate household income using the financial methodologies for determining financial eligibility for advance premium tax credits under 26 C.F.R. § 1.36B-1 & 2e.

This is the applicant's "modified adjusted gross income" (MAGI), defined at 26 CFR § 1.36B-1(e)(1) - (2), and summarized by the Internal Revenue Service:

"Modified adjusted gross income is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier one railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI)." (See Q8 on the [IRS Fact Sheet: Questions and Answers on the Premium Tax Credit](#))

GCFHH shall give a copy of this [handout](#) to all staff who help patients apply for financial assistance and process financial assistance applications. This handout is referenced on the Vermont Health Connect

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website and commonly used by assisters. Using this resource will help ensure that staff use the same standard to calculate income (i.e., what income should be counted or excluded). Attached to policy

Determining household size

GCFHH shall calculate the household size in accordance with the guidelines set forth in the definition of "Household Income" (see "Definitions" section above).

Financial Assistance Amount

Patients eligible for general or catastrophic financial assistance shall receive the discounts detailed below based on the federal poverty level (FPL) of the applicant's household.

General financial assistance amount

Insured patients: Insured patients shall have a discount applied to their out-of-pocket expenses.

- For insured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) all out-of-pocket costs for emergency and medically necessary services rendered (i.e., the care is free).
- For insured patients whose household income is between 250% FPL and 300% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 80%.
- For insured patients whose household income is between 300% FPL and 350% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 60%.
- For insured patients whose household income is between 350% FPL and 400% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 40%.

Uninsured patients: Uninsured patients who are eligible for financial assistance shall have a discount applied to the amount generally billed for the emergency and medically necessary services rendered.

- For uninsured patients whose household income is at or below 250% of FPL, we will waive (i.e., 100% discount) the amount generally billed for emergency and medically necessary services rendered (i.e., the care is free).
- For uninsured patients whose household income is between 250% FPL and 300% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 80%.
- For uninsured patients whose household income is between 300% FPL and 350% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 60%.

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- For uninsured patients whose household income is between 250% FPL and 300% FPL, we will discount all out-of-pocket costs for emergency and medically necessary services rendered by 80%.

Catastrophic financial assistance amount

For uninsured or insured patients: If the total amount owed for emergency and medically necessary services rendered exceeds 20% of the household income, then the amount owed shall be reduced so that it is equal to 20% of the patient's household's income.

In instances where a patient is eligible for both catastrophic and general financial assistance, we shall give the patient the larger of the two amounts of assistance.

In no case shall a patient who is eligible for catastrophic or general financial assistance be charged monthly payments of more than 5% of their household's gross monthly income for services rendered.

In no case shall a patient who is eligible for catastrophic or general financial assistance be charged interest on the amount owed for services or be charged any prepayment or early payment penalty or fee on the medical debt owed.

In no event will the amount from which the financial assistance discount is taken be more than the amount generally billed for uninsured patients. Similarly, for insured patients, in no event will the amount from which the financial assistance discount is taken be more than the charge allowed by the patient's insurance carrier.

Decision Timeline & Content

GCFHH will issue a written decision to the applicant no later than thirty calendar days after receiving the financial assistance application.

The written decision shall notify the patient that they have the right to appeal any decision and specify the method and timeline for such an appeal.

Additionally, the written decision will contain the following:

- If the patient's application is incomplete, GCFHH will notify the applicant of this fact and specify what information is needed to complete the application.
- If the patient's application is approved, GCFHH will include the amount of assistance provided, the basis for the calculation of the amount owed, and a revised bill. If the patient continues to owe a

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balance after financial assistance has been applied, GCFHH or a medical debt collector seeking payment for that medical debt, shall offer a payment plan that does not exceed five percent of the patient's gross monthly household income.

- If the patient's application is denied, GCFHH will include the factual grounds for any reasons of the denial.

Applications for financial assistance shall be reviewed by the GCFHH Resource Advocate and the Director of Revenue Cycle

Extenuating Circumstances

GCFHH acknowledges that extenuating circumstances may exist in which a patient does not satisfy the criteria for financial assistance detailed in this policy, yet the patient is unable to pay for emergency or medically necessary healthcare services received or needed. A patient or hospital staff may request a waiver of the financial assistance eligibility test outlined in this policy due to an unusual or unanticipated circumstance which warrants special consideration. Such requests will be reviewed by Susan Kapral, Director of Revenue Cycle, or Stephen Brown, Chief Financial Officer. This request must outline the unusual or unanticipated circumstances in writing, the patient will be notified within 30 days of the decision.

Language Access Rights

GCFHH is committed to ensuring that patients whose primary language is not English can effectively communicate with us. We provide free language services to persons whose primary language is not English. This includes qualified interpreters and written information in non-English languages. If you need these services, please contact us at (802)365-7357 or email us at info@gracecottage.org

GCFHH is committed to providing free aid and services to deaf people and persons with disabilities to communicate effectively with us. This includes qualified sign language interpretation and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, please contact us at (802)365-7357 or email us at info@gracecottage.org

Although contacting us at the phone number provided above is preferred, requests related to a disability can be made at any time, to any staff member, and in any form.

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Appeal Rights

A patient has 60 days following the receipt of a written financial assistance decision to appeal the decision. GCFHH shall inform the patient no later than 60 days after receipt of the appeal as to whether the appeal was approved or denied.

The patient will notify the resource advocate that would like to appeal the financial assistance decision. The notification will include the reasons for the appeal.

Jocelyne Smith, CAC
Patient Resource Advocate
Grace Cottage
P.O. Box 216
Townshend, VT 05353
(802) 365-3770

Appeals shall be reviewed by the following: Director of Revenue Cycle and/or Chief Financial Officer.

Complaints

If you have concerns or complaints about our financial assistance program, please contact our office at: (802)365-3707 or quality@gracecottage.org.

If we are unable to resolve your complaint, you may contact the Vermont Office of the Attorney General which is named as the enforcement entity under Vermont Act 119 of 2022: (802)828-3171 or email: <https://ago.vermont.gov/contact-form>

If you would like to talk to a Health Care Advocate about your concerns, you may contact the Office of the Health Care Advocate (HCA). The HCA is a free resource available to help all Vermonters solve problems related to health care. It is not an insurance company and is not part of Vermont state government. You can contact them at: 1-800-917-7787 or hca@vtlegalaid.org.

Publicity

GCFHH is committed to making information about our policy widely available. In addition to making free written copies available (see "Provision of Policy Documents to Patients" section above), we take the following steps to widely publicize this information:

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- We conspicuously post notices of and information regarding the financial assistance policy in the facility's offices, including patient reception and admission areas, as well as locations where patient financial assistance and billing services are provided.
- We ensure that patient facing staff and medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors, have sufficient knowledge of the policy to inform patients of their options related to patient financial assistance.
- We notify and inform members of the community served by the facility about the financial assistance policy in a manner reasonably calculated to reach the members of the community who are most likely to need financial assistance, including members who are non-native English speakers.

These efforts include:

- Providing information, rack cards and fliers to health, social services, and other community organizations that regularly interact with potential patients.
- Conduct community outreach activities.
- Provide financial assistance information on our statements.

Patient Billing or Collection Statements

All billing statements, whether sent by this hospital or a medical debt collector, shall include a conspicuous written statement that some patients may be eligible for financial assistance. This statement shall include the telephone number a patient can call to obtain more information about our policy and the application process. It should also include the web address where this policy, the financial assistance application, and the plain language summary are posted.

All oral or written communication attempts by a medical creditor or a medical debt collector, including the Grace Cottage Family Health and Hospital to collect a medical debt arising from health care services delivered at this facility shall include information about our financial assistance policy.

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Questions?

Individuals can direct questions about the financial assistance policy to the Resource Advocate Office located at GCFHH The office can be reached via telephone (802)365-3770 via email @ jsmith@gracecottage.org

Policy Review

This financial assistance policy shall be reviewed, updated, and approved by the hospital's governing body at least once every three years.

Medical Bill Collections

Our full medical billing and collections policies are detailed in our Billing & Collections Policy available at <https://gracecottage.org/>

- All billing statements, whether sent by us or a medical debt collector, shall include a conspicuous written statement that some patients may be eligible for financial assistance. Further, such statements shall include both the telephone number a patient can call to obtain more information about financial assistance and the specific web addresses where the financial assistance policy, the financial application, and plain language summary are posted.
- All oral or written communication from us or a medical debt collector shall include information about our financial assistance policy.
- We do not sell any medical debt.

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**2026 Grace Cottage Family
Health and Hospital Sliding
Fee Scale**

| Household Size | ≤ 250% of Poverty Earnings | ≤ 300% of Poverty Earnings | ≤ 350% of Poverty Earnings | ≤ 400% of Poverty Earnings |
|----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1 person | \$39,900 | \$39,961-\$47,880 | \$47,881-\$55,860 | \$55,861-\$63,840 |
| 2 people | \$54,100 | \$47,881-\$64,920 | \$55,861-\$75,740 | \$63,841-\$86,560 |
| 3 people | \$68,300 | \$64,921-\$81,960 | \$75,741-\$95,620 | \$86,561-\$109,280 |
| 4 people | \$82,500 | \$81,961-\$99,000 | \$95,621-\$115,500 | \$109,281-\$132,000 |
| 5 people | \$96,700 | \$99,001-\$116,040 | \$115,501-\$135,380 | \$132,001-\$154,720 |
| 6 people | \$110,900 | \$116,041-\$133,080 | \$135,381-\$155,260 | \$154,721-\$177,440 |
| 7 people | \$125,100 | \$133,081-\$150,120 | \$155,261-\$175,140 | \$177,441-\$200,160 |
| 8 people | \$139,550 | \$150,121-\$167,160 | \$175,141-\$195,020 | \$200,161-\$222,880 |
| % of Financial Assistance | 100% | 80% | 60% | 40% |

**Add \$5380 for each
Additional household
member**

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| SUBJECT/TITLE: FINANCIAL ASSISTANCE POLICY | PAGE: 17 OF: 17 |
| | EFFECTIVE: 10/01/2017 |
| DEPARTMENT: REVENUE CYCLE | REVISED:7/01/2024 |

APPENDIX B

| | | | |
|---|------------------------------|-------------------|-------------------|
| Calculation of AGB for 10/01/2025 | | | |
| 12 month period: 07/01/2024-06/30/2025 | | | |
| Total charges generated for Medicare and Commercial patients: | | | |
| MCR | 4100, 4110, 4120, 4130 | 20,547,866 | |
| COM/MHMO | 4100, 4110, 4120, 4130 | <u>20,365,083</u> | |
| | | | 40,912,949 |
| Total contractual allowance for Medicare and Commercial patients: | | | |
| MCR | 4200, 4210, 4215, 4220 | 4,538,733 | |
| COM/MHMO | 4200, 4210, 4215, 4220 | <u>7,661,170</u> | |
| | | | <u>12,199,903</u> |
| | Total Allowed Charges | | 28,713,046 |
| Total percentage of allowed charges: | | | |
| | | <u>28,713,046</u> | = 70% |
| | | 40,912,949 | |

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Modified Adjusted Gross Income under the Affordable Care Act

updated March 2021

Under the Affordable Care Act, eligibility for income-based Medicaid¹ and subsidized health insurance through the Marketplaces is calculated using a household's Modified Adjusted Gross Income (MAGI). The Affordable Care Act definition of MAGI under the Internal Revenue Code² and federal Medicaid regulations³ is shown below. For most individuals who apply for health coverage under the Affordable Care Act, MAGI is equal to Adjusted Gross Income. This document summarizes relevant federal regulations; it is not personalized tax or legal advice. Consult the Health Insurance Marketplace for your state, your local Medicaid agency, or a legal or tax advisor for assistance in determining your MAGI.

Modified Adjusted Gross Income (MAGI) =

Adjusted Gross Income (AGI)

Line 11 on Form 1040

See page 2 for clarifications related to common benefits or sources of assistance provided during the COVID-19 pandemic

Include:

- Wages, salaries, tips, etc.
- Taxable interest
- Taxable amount of pension, annuity or IRA distributions and Social Security benefits⁴
- Business income, farm income, capital gain, other gains (or loss)
- Unemployment compensation
- Ordinary dividends
- Alimony received under settlements executed before 2019
- Rental real estate, royalties, partnerships, S corporations, trusts, etc.
- Taxable refunds, credits, or offsets of state and local income taxes
- Other income

Deduct:

- Certain self-employed expenses⁵
- Student loan interest deduction
- IRA deduction (traditional IRAs)
- Moving expenses for active members of the military
- Penalty on early withdrawal of savings
- Health savings account deduction
- Alimony paid under settlements executed before 2019
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Educator expenses

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veterans' disability payments, workers' compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.



Add back certain income

- Non-taxable Social Security benefits⁴ (Line 6a minus Line 6b on Form 1040)
- Tax-exempt interest (Line 2a on Form 1040)
- Foreign earned income & housing expenses for Americans living abroad (Form 2555)

For Medicaid eligibility

Exclude from income

- Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance

¹ Medicaid eligibility is generally based on MAGI for parents and childless adults under age 65, children and pregnant women, but not for individuals eligible on the basis of being aged, blind, or disabled.

² 26 CFR 1.36B-1(e)(2)

³ 42 CFR 435.603(e)

⁴ "Social Security benefits" includes disability payments (SSDI), but does not include Supplemental Security Income (SSI), which should be excluded.

⁵ Deductible part of self-employment tax; SEP, SIMPLE, and qualified plans; health insurance deduction. See IRS Publication 974 for further details about calculating the deduction for tax households that also receive ACA premium tax credits.

Modified Adjusted Gross Income and COVID-19 relief policies:

Which common benefits or sources of assistance provided during the COVID-19 pandemic are included in calculating MAGI for purposes of determining health insurance program eligibility?

This table addresses common benefits and sources of assistance, including select provisions in federal policies enacted in response to the COVID-19 pandemic as of March 19, 2021. This document is not personalized tax or legal advice. Consult the Health Insurance Marketplace for your state, your state Medicaid agency, or a legal or tax adviser for assistance in determining your MAGI.

| Income type | Included in income for Medicaid/Children's Health Insurance Program eligibility? <i>(based on current monthly income)</i> | Included in income for Marketplace subsidy eligibility? <i>(based on projected annual income)</i> |
|--|--|--|
| Recovery rebates—one-time cash payments for individuals | No | No |
| Unemployment insurance (UI) | | |
| Regular "base" UI | Yes | Yes |
| Supplemental UI payments (currently \$300 per week) | No | Yes |
| Pandemic Emergency Unemployment Compensation (PEUC)—assistance available after exhausting state UI benefits | Yes | Yes |
| Pandemic Unemployment Assistance (PUA)—for workers left out of state UI, including self-employed individuals | Yes | Yes |
| Paid sick leave | Yes | Yes |
| Paid family leave | Yes | Yes |
| Workers compensation | No | No |
| Severance benefits | Yes (in month received) | Yes |