

For Internal Use Only

PHOENIX CHILDREN'S

Scope: Department

Type of Policy: Revenue Cycle

Financial Assistance Policy

Effective Date: April 2026

RELATED DOCUMENTS

1. Financial Assistance Application
2. Financial Assistance Policy Plain Language
3. Financial Assistance Policy Provider List

REASON FOR POLICY

Phoenix Children's is committed to providing Financial Assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program and otherwise unable to pay, for Medically Necessary care based on their individual financial situation. Consistent with its mission to deliver compassionate, high quality, affordable health care services and to advocate for those who are poor and disenfranchised, PC/PCMG strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health and protection of their individual assets. PC has a Financial Assistance Policy with a sliding scale that addresses levels of financial support available for people who are uninsured or underinsured, based on family income, federal poverty level guidelines and availability/non-availability of payer resources.

The goal of PC financial assistance is to identify a payer source for a patient. This could include but is not limited to parents' employer-based coverage, the Affordable Care Act marketplace plans, AHCCCS, Medicare/SSI, FES (Federal Emergency Services – provided through AHCCCS), or ICE (Immigration and Customs Enforcement).

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with PC procedures for obtaining Financial Assistance and to contribute to the cost of their care based on their individual ability to pay.

POLICY OVERVIEW

This written policy describes:

1. the eligibility criteria for Financial Assistance;
2. the basis for calculating amounts charged to patients eligible for Financial Assistance;
3. the method by which patients may apply for Financial Assistance;
4. the method the hospital will use to widely publicize the policy within the community served by the hospital;
5. The calculation the hospital will use to determine the amounts charged for emergency or other Medically Necessary care provided to individuals eligible for Financial Assistance based on the amount generally billed by the hospital to commercially insured or Medicare patients.

The Financial Assistance procedures are designed to comply with:

1. AHCCCS patient eligibility requirements;
2. Applicable Medicare requirements;
3. Internal Revenue Service regulations relating to non-profit status and other Federal regulations;
4. State of Arizona regulations relating to non-profit status and other State regulations;
5. Commercial Insurance guidelines;
6. The Affordable Care Act; and
7. Arizona Pricing Transparency Law.

DEFINITION(S)

Amounts Generally Billed (AGB) - Limits amounts charged for emergency and other medically necessary care provided to individuals eligible for Financial Assistance to be not more than generally billed to insured patients. PC determines AGB by determining the average percentage of gross charges paid by commercial, AHCCCS and Medicare fee-for-service payers by dividing the sum of the amounts of all allowed claims during a 12-month period by the sum of the associated gross charges for those claims. The result is the AGB Percentage, and it will be applied to emergency and other medically necessary care over the next twelve-month period (May 1-Apr 30).

Balance Billing - Balance billing is a medical bill from a healthcare provider billing a patient for the difference between the total amount charged by the facility and the amount the non-contracted insurance plan allows.

Charity Care - A waiver of a patient's financial obligation for the entire amount of the charges. .

Cost-Sharing - The share of costs allowed by a member's insurance that the member is responsible for paying. Generally, this includes copayments, deductibles, and coinsurance, also known as member cost share.

Discounted Care - Limits amounts charged for emergency and other medically necessary care provided to individuals eligible for Financial Assistance to be not more than generally billed to insured patients. Refer to 'Amounts Generally Billed' definition.

Elective Care - Medical services that allow time to be scheduled.

Emergency medical conditions - As defined by EMTALA.

Family - Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the guarantor/responsible party claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of Financial Assistance.

Family Income - Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

1. Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
2. Noncash benefits (such as food stamps and housing subsidies) do not count;
3. Determined on a before-tax basis;
4. Excludes capital gains or losses;
5. If a person lives with a Family, includes the income of all Family members (non-

relatives, such as housemates, do not count).

Federal Poverty Level (FPL) - A measure defined by the United States Department of Health and Human Services based on gross income and household size to indicate poverty threshold.

Gross charges - The total charges at PC full established rates for the provision of patient care services before deductions from revenue are applied.

Medically Necessary - Services or items reasonable and necessary for the diagnosis or treatment of illness or injury as determined by PC Clinical Administration.

No Surprises Act - Federal law that protects patients with health insurance from unexpected "surprise" medical bills by imposing limits on balance billing.

Qualified Services - Qualified Services include: (a) services deemed medically necessary by PC professional, facility, and related services received at any hospital location and (b) all medically necessary professional services that are provided and billed by PC. PC does not provide financial assistance for certain services including, but not limited to, those outlined in Addendum 2.

Propensity to Pay - The likelihood the patient will pay PC based on methodologies PC establishes working with its third-party vendors to reasonably determine such likelihood.

Standard Sliding Scale - Variable prices for services based on a patient's ability to pay.

Underinsured - The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Uninsured - The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

POLICY STATEMENT(S)

Financial Assistance is available after all other financial resources have been exhausted and the patient and patient's family are without sufficient income to cover out of pocket expenses for services provided by PC. For emergent or urgent patients, information regarding a guarantor/responsible party's inability to pay may not become fully known until after the services are provided. Therefore, the Financial Assistance evaluation may not be completed until the full facts of the needs of the patient are known.

The following healthcare services are eligible for Financial Assistance, and outlined in Addendum 2:

1. Emergency medical services provided in an emergency room setting;
2. Medically Necessary services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual; and
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.

POLICY GUIDELINES

Overview

Types of Financial Assistance Offered

Discounted Care: Partial discount applied to eligible services for qualifying patients.

Charity Care: Full write-off for eligible services for qualifying patients.

Service eligibility applies to Emergency and other Medically Necessary services; excluded services are outlined in Addendum 2.

Patient eligibility is based on insurance status, financial need, and exhaustion of other payer sources.

1. **Eligibility Criteria and Amounts Charged to Patients**

- A. **Eligibility for Financial Assistance:** Eligibility for Financial Assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. If an uninsured or underinsured individual seeks a flat/self-pay pre-negotiated rate for services, he or she is not also eligible for financial assistance.
- B. **Income Verification:** Financial need will be determined by calculating the Family Income. Proof of Family Income is met by providing two of the three following documents:
 - i. Two most recent pay stubs;
 - ii. Two most recent monthly statements for all bank statements;
 - iii. Most recent filed tax return. (Annual income is determined by annualizing year to date Family Income).
- C. **Income Level Verification:** After determining Family Income, PC shall calculate the Family Income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the federal poverty level for a family of three is \$20,000, and a patient's Family Income is \$60,000, the Hospital shall calculate the patient's Family Income to be 300% of the FPL. PC shall use this calculation during the application process to determine whether a patient meets the income criteria for Financial Assistance. More details can be found in Addendum 1.
- D. Services eligible under this Policy will be made available to eligible patients on a sliding scale attached hereto as Addendum 1, in accordance with financial need, as determined by FPL standards in effect at the time of the determination. Once a patient has been determined by PC to be eligible for Financial Assistance, that patient shall not receive future bills based on undiscounted Gross Charges. Charges for qualifying services to treat Emergency Medical Conditions or other Medically Necessary care provided to persons who are eligible for Financial Assistance under this Policy cannot exceed the AGB to individuals who have insurance coverage for such care.
- E. Currently AGB is 24.8% for PC and 37.2% for PCMG (as of April 2026).
- F. **Available Programs:** Responsible parties must exhaust all other funding source options for which they may be eligible, including Medicaid and any other third-party coverage before they can qualify for financial assistance. Hospital reserves the right to obtain confirmation that a patient is ineligible for Available programs, including, copies of applicable AHCCCS and/or Marketplace application submission and determination status. Showing that financial assistance would be payer of last resort.
- G. **Residency Verification:** To be eligible for financial assistance, the patient or responsible party must reside in Arizona and have established residency in Arizona for the duration of one year preceding the assistance request. International patients will be directed to the International Services Department. Residency verification documents may include:
 - i. State issued driver's license
 - ii. Recent utility bill
 - iii. Most recent year's completed tax return

iv. Recent payroll check stubs

Phoenix Children's may grant financial assistance to patients residing outside of Arizona for specifically identified date(s) of service only when such patients have an unplanned, acute onset of illness and the patient and the responsible party meet all other financial assistance requirements under this policy.

- H. Retail Pharmacy: As a last resort, financial assistance for retail pharmacy medication is available to responsible parties if they meet the financial assistance criteria set forth in this policy. Retail pharmacy financial assistance is only offered through the hospital outpatient pharmacies.

2. **Determination of Presumed Financial Assistance**

- A. Presumed Financial Assistance will be determined based on best available information after all efforts to contact the patient or guarantor/responsible party to obtain financial information have been exhausted. Determination may be made during the collections process if efforts to collect information are exhausted at that time. Factors used to determine presumed Financial Assistance could include one or all the following:

- i. Financial Applications;
- ii. Out of Country addresses;
- iii. Inability to contact families by phone or mail (disconnected phones and returned mail);
- iv. The Propensity to Pay – likelihood to pay;
- v. Non-qualifying event with AHCCCS denial;
- vi. Homeless patient or guarantor/responsible party;
- vii. Incarcerated patient or guarantor/responsible party;
- viii. Medicaid accounts-Exhausted days/benefits/non-covered days; FES coverage.

- B. Grounds for Denial: Falsification of information or incomplete documentation from the patient or guarantor/responsible party is considered grounds for a denial of Financial Assistance. In cases where the patient is unable to provide documentation verifying income, PC may at its discretion verify the patient or guarantor/responsible party's income by having the patient or guarantor/responsible party sign a financial application attesting to the veracity of the information provided. In special instances, Financial Counselors/Patient Access Management may take a verbal verification from the patient for the financial evaluation. A written denial will be provided to the responsible party within a 30 day timeframe and will include the reason(s) for denial, the date of decision.

- C. Catastrophic Circumstances: If a patient has out of pocket expenses that total more than 25% of the patient's/family's Gross Income in any one year, PC will work with them on a payment plan such that they will not be required to pay more than 25% of their Gross Income to PC/PCMG in that year.

- D. Professional Services Covered: Professional services provided by Non-Covered Providers on the Financial Assistance Policy Provider List on the Financial Assistance website are NOT covered under this Policy. Professional services provided by Covered Providers on the Financial Assistance Policy Provider List on the Financial Assistance website are covered under this Policy.

3. **Method of Applying for Financial Assistance** - Patients or guarantor/responsible party will be encouraged to apply for Financial Assistance before, during, or within a reasonable time after care is provided.

- A. Financial Assistance Application: Patients or guarantor/responsible party may apply for Financial Assistance via the following options:
- i. At the Financial Counselor Offices or Customer Service Department in person;
 - ii. The [PC website](http://www.phoenixchildrens.org/), <http://www.phoenixchildrens.org/>;

- iii. By phone at 602-933-2000 or 1-800-549-3743;
 - iv. By mail;
 - v. Through a surrogate, through a family member or through another appropriate party.
- B. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and will:
- i. Include an application process, in which the patient or the patient's guarantor is required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need;
 - ii. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (Propensity to Pay);
 - iii. Include reasonable efforts by PC to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs.
 - iv. Consider the patient or guarantor/responsible party available assets, and all other financial resources available to the patient; and
 - v. Include a review of the patient or guarantor/responsible party outstanding accounts receivable for prior services rendered and the patient's or guarantor/responsible party payment history.
- C. Request for Financial Assistance: For routine and non-emergent Medically Necessary services a request for Financial Assistance and a determination of financial needs to occur prior to rendering of services. However, the determination may be done at any point in the collection cycle. If a patient is non-compliant with providing required documentation, the appointment may result in being rescheduled.
- D. The need for Financial Assistance shall be re-evaluated every calendar year for recurring patients and each subsequent time of service if the last financial evaluation was completed more than a year prior. Additionally, a review will be done at any time new information relevant to the eligibility of the patient for Financial Assistance becomes known.
- E. Notification of Decision: Financial Assistance level determinations will generally be issued via paper mail or email communication within a reasonable period (usually 30 days) after receiving the patient's or guarantor/responsible party request for assistance. PC will also advise the patient of his or her responsibilities and next steps under this Policy. Missing documentation must be provided within 30 days of notice. Inactive or incomplete applications will be denied, and a new application will need to be submitted.
- F. Eligibility Period, Effective Date, and Retroactive Coverage:
- i. Approved assistance may apply retroactively to eligible open balances.
 - ii. Coverage is effective for 12 months upon approval unless otherwise determined by PC procedures or a change of circumstances.
- G. Changed Circumstances: Patients or guarantor/responsible party may reapply for Financial Assistance if there is a change in their income, assets, or Family size responsibility. Excess payments made prior to determination of qualification for Financial Assistance may be refunded if the patient is later determined to qualify for Financial Assistance. In addition, the discount may be reversed if subsequent findings indicate the information relied upon was in error.
4. **Billing and Collections Process** - If Financial Assistance is denied, PC will follow the standard credit and collections process.
- A. Reasonable Inquiry: PC will make reasonable efforts to determine whether an individual is eligible for Financial Assistance before referring the patient to a collection agency. PC will not pursue legal action for non-payment of bills against Financial Assistance patients/responsible parties who have clearly demonstrated that they have neither sufficient income nor assets to meet their financial obligations.
- B. Collection Methods: PC will not execute a lien by forcing the sale or foreclosure of a Financial Assistance patient or guarantor/responsible party primary residence to pay for an outstanding medical bill. PC will not use body attachment to require the Financial Assistance patient or responsible party to appear in court. PC may report Financial Assistance patients to credit rating

agencies when they fail to honor their reduced payment plans and there is evidence that the Financial Assistance patient has sufficient income or assets to satisfy his or her obligation. The patient or guarantor/responsible party are responsible for communicating changes in income that may affect their ability to pay to PC. PC will ensure that the guidelines outlined above are followed by any external collection agency engaged to assist in obtaining payment on outstanding bills from Financial Assistance patients.

- C. Collections from Third Party Payers: Nothing in this policy shall preclude PC from pursuing reimbursement from third party payers, third party liability settlements or other legally responsible third parties. Communication of Financial Assistance Policy

5. **Confidentiality and Data Handling**

- A. PC will maintain all information received from applicants seeking Financial Assistance as confidential information. Information regarding Monetary Assets obtained as part of the application process will be kept in the patient's medical records. All information will not be available to the personnel involved in debt collection. However, there is no item in this policy that prevents the use of information obtained by PC or its collection agencies in the debt collection process. PC will communicate the availability of Financial Assistance to all patients or guarantor/responsible party using languages that are appropriate for PC's service areas, including, but not limited to the following methods:
- B. Signage, information, and brochures in appropriate areas of PC;
- i. Plain Language Summary, posted conspicuously in English and Spanish in Registration areas and provided to patients during the billing process;
 - ii. Supplying Financial Counselors/Interpreters who are assigned to explain the Financial Assistance policy;
 - iii. Notating patient statements with Financial Assistance availability and a phone number to call for information; and
 - iv. Supplying information regarding the availability of Financial Assistance is also posted on PC's website.

KEYNOTES / ADDITIONAL INFORMATION

RELATED FORMS

1. [Financial Assistance Policy \(Spanish\)](#)
2. [Financial Assistance Application Cover Letter](#) (English)
3. [Financial Assistance Application](#) (English)
4. [Financial Assistance Application Cover Letter](#) (Spanish)
5. [Financial Assistance Application \(Spanish\)](#)
6. [Financial Assistance Policy – Provider List](#)
7. [Financial Assistance Policy – Plain Language \(English\)](#)
8. [Financial Assistance Policy – Plain Language \(Spanish\)](#)
9. [Price Estimation Tool](#)

REFERENCE(S)

1. Patient Protection & Affordable Care Act
2. Internal Revenue Code section 501(r)
3. A.R.S. § 36-437 – Health Care Facilities; Charges; Public Availability; Direct Payment; Notice
4. A.R.S. § 36-425.09 – Hospital Price Transparency; Verification; Annual Report
5. Arizona Revised Statutes, Title 36 – Public Health and Safety
6. Arizona Administrative Code, Title 9 – Health Services

7. Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd

Information/History:	
Date Written:	<i>December 2023</i>
Date Revised:	<i>6/07, 2/08, 5/09, 12/10, 4/13, 1/14, 2/15, 12/15, 2/16, 2/17, 12/16, 7/17, 8/17, 3/18, 4/19, 4/20, 10/20, 1/23, 3/23, 2/24, 1/25, 4/25</i>
Date Reviewed:	
Review Cadence:	<i>Annual</i>
Owner:	<i>VP, Revenue Cycle</i>
Approval (in order)	<i>Karen Sanchez, Director, Family Finance Glen Reiner, VP, Revenue Cycle Michelle Bruhn, EVP, CFO PCH Board of Directors</i>

A. **ADDENDUM 1**

Financial Assistance Chart for Emergency or other Medically Necessary Care

Below is a matrix of the Financial Assistance write-off percentages based on gross charges available for the corresponding income levels (Federal Poverty Level – all states except Alaska and Hawaii). The FPL calculations below will be updated annually when the poverty guidelines are published by Health and Human Services in the Federal Register.

Persons in Family	225% of FPL	400% of FPL
1	\$ 35,910.00	\$63,840.00
2	\$ 48,690.00	\$ 86,560.00
3	\$ 61,470.00	\$ 109,280.00
4	\$ 74,250.00	\$ 132,000.00
5	\$ 87,030.00	\$ 154,720.00
6	\$ 99,810.00	\$ 177,440.00
7	\$ 112,590.00	\$ 200,160.00
8	\$ 125,370.00	\$ 222,880.00
For each additional person add	\$ 5,680.00	\$ 5,680.00

FPL	Discount Rate
Up to 225%	100% Discount Rate
226-400%	Current AGB Rate

B. ADDENDUM 2

Services not eligible for Financial Assistance

- Contact lenses
- Orthodontic treatment
- Elective procedures including but not limited to the following:
 - Cosmetic procedures
 - Genetic testing
- Non-medical services such as social, educational or vocational services