

## Financial Assistance Program

### Purpose Statement:

Owensboro Health, Inc. ("OH") is committed to providing emergency and medically necessary care to patients without discrimination and regardless of their ability to pay, ability to qualify for Financial Assistance, or the availability of third-party coverage. Under this Financial Assistance Policy (the "Policy"), OH intends to address the dual interests of providing access to care at no charge to those without the ability to pay, and to offer a discount from billed charges for those who can pay a portion of the costs of their care. This Policy provides the basic framework for the Financial Assistance Program that will apply to Owensboro Health Regional Hospital, Owensboro Health Muhlenberg Community Hospital, Owensboro Health Twin Lakes Medical Center, Owensboro Health Medical Group provider services ("Clinic"), and Home Health services.

This Policy is intended to comply with Section 501(r) of the Internal Revenue Code and the related regulations. This Policy describes: (i) the eligibility criteria for Financial Assistance, and whether such assistance includes free or discounted care; (ii) the basis for calculating amounts charged to patients; (iii) the method for applying for Financial Assistance; and (iv) the Hospital's approach to eligibility determinations and the types of information that the Hospital will use to assess eligibility. A separate policy, available online at [www.owensborohealth.org](http://www.owensborohealth.org) and by asking any Patient Financial Services staff members, addresses what collection actions the Hospital may take in the event of non-payment, including civil collections actions and reporting to consumer credit reporting agencies for patients that qualify for Financial Assistance.

This Policy will be effective upon adoption by the Board of Directors (the "Board"), acting in its capacity as the governing body for each OH Hospital, Clinic, and/or Home Health and will constitute the official financial assistance policy (within the meaning of Section 501(r) of the Internal Revenue Code) for each such hospital. The Board will review this Policy annually on behalf of each of the OH entities.

### Policy Details:

#### Definitions

- A. Amounts Generally Billed [AGB] means the Usual and Customary Charges for Covered Services provided to individuals eligible under the Financial Assistance Program, multiplied by the Hospital-Specific AGB Percentage applicable to such services.
- B. Assets mean cash or cash equivalents (e.g. certificates of deposit) and non-retirement investments.
- C. Billing and Collections Policy means the OH Policy entitled "Billing and Collection Policy," as the same may be amended from time to time.
- D. Covered Services means those inpatient and outpatient services provided by an OH Hospital which are Medically Necessary in accordance with the standards of OH's Medicare fiscal intermediary.
- E. Emergent Condition means a medical condition of an Uninsured Patient that has resulted from the sudden onset of a health condition with acute symptoms which. In the absence of immediate medical attention, are reasonably likely to result in placing the Uninsured Patient's health (or in the case of a pregnant woman, an unborn child) in serious jeopardy, result in serious impairment to bodily functions of the Uninsured Patient or, result in serious dysfunction of any bodily organ or part. A pregnant woman with contractions is considered to have an Emergent Condition.

- F. Emergent Services means the services necessary and appropriate to treat an Emergent Condition.
- G. FAP-Eligible Individual means an individual eligible for financial assistance under this Policy pursuant to Section 111.C of this Policy.
- H. "Financial Assistance" means the free or discounted Covered Services provided to FAP-Eligible Individuals.
- I. Hospital means each state-licensed hospital facility owned or leased by OH or one of its affiliates, including Owensboro Health Regional Hospital, Owensboro Health Muhlenberg Community Hospital, Owensboro Health Twin Lakes Medical Center, and each hospital operated by OH at which the OH Board of Directors has governing authority over the operations of such hospital.
- J. Hospital-Specific AGB Percentage means for each Hospital, a percentage derived by dividing (1) the sum of all payments received for Medically Necessary services provided at such Hospital during the Relevant Period by Medicare fee-for-service, by (2) the Usual and Customary Gross Charges for such Medically Necessary Services. The Hospital-Specific AGB Percentages shall be calculated for the initial Relevant Period no later than September 30, 2016. Thereafter, the Hospital-Specific AGB Percentage shall be calculated no later than September 30 of each year. Each Hospital-Specific AGB Percentage will be effective until the next annual calculation of the Hospital-Specific AGB Percentage based on the most recent Relevant Period. The calculation of each Hospital's AGB Percentage will comply with the "look-back method" described in Treasury Regulation 5 1-501(r)(1)(8). The current year's Hospital-Specific AGB percentage may be obtained by calling 270-685-7501.
- K. Household size means taxable household including any children or family members that can be claimed as dependent for tax purposes.
- L. Income, non-retirement related interest and dividends from stocks and bonds, wages, compensation from other services, tips, pensions (including routine or mandatory withdrawals), fees for earned services, price of goods sold, income from rental property, gains on sale of other property, alimony, adoption subsidy payments, Venmo, Chime, PayPal, and/or royalties.
- M. Medicaid means all State and Federal Programs which include (but are not limited to) Medicaid and Medicaid Managed Care Organizations.
- N. Medically Necessary or Medically Necessary Care means those services required to identify or treat an illness or injury that is either diagnosed or reasonably suspected to be Medically Necessary considering the most appropriate level of care. Depending on a patient's medical condition, the most appropriate setting for the provision of care may be at home, a physician's office, an outpatient facility, or long-term care, rehabilitation or hospital bed. To be Medically Necessary, a service must:
  - 1. Be required to treat an illness or injury;
  - 2. Be consistent with the diagnosis and treatment of the Patient's conditions;
  - 3. Be in accordance with the standards of good medical practice;
  - 4. Not be for the convenience of the Patient or the Patient's physician; and
  - 5. Be that level of care most appropriate for the Patient as determined by the Patient's medical condition and not the Patient's financial or family situation.

Medically Necessary does **NOT** include the following:

1. Elective cosmetic surgery (but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity);
2. All bariatric program related services (including but not limited to surgical weight loss procedures);
3. Experimental procedures, including non-FDA approved procedures and devices or implants;
4. Services for which prior authorization is denied by the Patient's insurance carrier;
5. Cost of specialty replacement lenses;
6. Hearing aids and hearing aid repair;
7. Retail pharmacy
8. Fertility and/or Sterilization treatment; and
9. Services or procedures for which there is a reasonable substitute or if the Patient's insurance company will provide a service or procedure that is a covered service or procedure.

- O. Out-of-Network (PON)- means a physician, hospital or other healthcare provider who does not participate in an insurer's network. Claims processed and/or denied as OON are not eligible for Financial Assistance.
- P. Patient means the person receiving or registered to receive medical treatment or the person who is financially responsible for the person receiving those services, such as in the case of guarantors, minors or the mentally impaired.
- Q. PFE means Patient Financial Services, the operating unit of OH responsible for billing and collecting self-pay accounts for hospital/clinic services.
- R. Plain Language Summary means a Hospital-specific plain language summary that notifies an individual that OH offers financial assistance under the Financial Assistance Program. The Plain Language Summary is attached in Exhibit C to this policy.
- S. Relevant Period means the 12-month period from June 1 to May 31.
- T. Uninsured Patient means a Patient without benefit of health insurance or government programs that may be billed for Covered Services provided to them for physician services, hospital services, and/or Home Health Services, and who is not otherwise excluded from this policy under Section III.A Below.
- U. Usual and Customary Charges means the rates for Covered Services as set forth in the chargemaster for that Hospital at the time the Covered Services are rendered. The chargemaster is available by appointment by calling 270-685-7184.

## Procedure

Overview. OH is dedicated to providing quality healthcare to all Patients regardless of age, sex, sexual orientation, race, color, religion, disability, veteran status, national origin and/or ability to pay. This policy establishes the Financial Assistance Program that is available to Uninsured Patients and Patients with a balance due after insurance and copays if applicable if such Patient meets the eligibility criteria set out in Section III.C below. All Patients identified as Uninsured Patients will be referred to a representative of OH who will screen the Uninsured Patient for Financial Assistance Program eligibility. If the Uninsured Patient is eligible for Medicaid or other state or Federal programs, the Patient will be asked to apply for these programs. Should the Patient not be a candidate for any such federal or state program, the OH Financial Assistance Program application will be given to the Patient.

- A. Exclusions. This policy and the Financial Assistance Program hereunder do not apply to the Retail Pharmacy, special wellness screens, and/or Long-Term Care resident related services. Furthermore, this policy does not apply to charges for services from other providers whose services are coincident to those provided by OH. For a list of providers who follow this Financial Assistance Policy, please see Exhibit A. Providers not listed on Exhibit A do not follow this Policy. OH will update Exhibit A's provider list by adding new or missing information, correcting erroneous information, and deleting obsolete information at least quarterly.

- B. Methods for Applying for Financial Assistance. Patients may apply for the Financial Assistance Program by any of the following means:
1. Advising PFS personnel at or prior to the time of registration that they are an Uninsured Patient.
    - a) PFS personnel will offer the Patient the application for Financial Assistance.
    - b) PFS personnel will offer to assist the Patient in applying for Medicaid or to make an appointment with a Patient Financial Advocate to assist the Uninsured Patient in completing the Medicaid application.
  2. Download and print the application form from the Owensboro Health Website ([www.owensborohealth.org](http://www.owensborohealth.org)) and mailing it to the Patient Financial Advocates at the address on the application form.
  3. Requesting an application form by phone: 270-685-7501. Financial Assistance Program application and Plain Language Summary will be mailed to the requestor, free of charge.
- C. Eligibility Criteria and Determination. Patients receiving Financial Assistance and who require medically necessary care (but not emergency care services) will be screened for Medicaid eligibility or health insurance exchange coverage and, if found eligible, the patient must fully cooperate with enrollment requirements before the procedure being scheduled and/or services rendered. Eligible patients who fail or refuse to enroll in Medicaid or other state or federal programs (excluding Kentucky Health patients in lockout period) will be ineligible for Financial Assistance. Except as otherwise provided herein, an Uninsured Patient or a Patient with a balance due after insurance will ordinarily qualify for the Financial Assistance Program if he or she meets each of the following requirements:
1. Completes the Financial Assistance Program application attached as Exhibit B of this Policy
  2. Has an annual household income (including Assets) equal to or less than 450% of the Federal Poverty Level;
  3. If requested by OH to apply for Medicaid or other state or federal programs, fully cooperates in the application and eligibility determination process (excluding Kentucky Health patients in lockout period). Patient Financial Advocates are available to assist with Medicaid and health insurance exchange registration process;
  4. Is denied Medicaid Coverage; and
  5. Complies with the Patient Responsibilities listed in Section III.E.

Under the Financial Assistance Program, Uninsured Patients and Patients with a balance due after insurance that have a household income (including Assets such as checking or savings accounts) at or below 400% of the Federal Poverty Guidelines are eligible for 100% assistance.

If a patient seeking care (other than on an emergency basis) is covered by a plan with which OHI is not an in-network provider, then the Patient will be informed that OHI is out of network for their plan and as such will not be eligible for Financial Assistance.

When a determination of eligibility for Financial Assistance has been made, all the Patient's accounts will be handled in the same manner for six months following the date of such determination, without the need to complete a new application for Financial Assistance. In addition, OHI will consider Patients eligible for Financial Assistance discounts on all open balances looking back 240 days from the eligibility determination date. A new application will be required for services provided six months or more after the initial (or other prior) determination or if indications are received that the Patient's financial status has significantly changed from the initial evaluation period.

A sliding scale of discounted charges is available for those Uninsured Patients and Patients with a balance due after insurance that have a household income of up to 450% of the Federal Poverty Guidelines in accordance with the table in Exhibit D. The discounts set forth in the sliding scale below are calculated by multiplying the sliding scale percentage discount by the gross charges associated with the emergency and medically necessary care provided.

A FAP-Eligible Individual will not be charged for Emergent Services or other Medically Necessary Care in an amount greater than the Amount Generally Billed to individuals who have insurance coverage for such care. For all other medical care provided to FAP-Eligible Individuals, OH will limit its charges to less than gross charges.

OH agrees to accept the sliding fee discount program policy for patients that are referred to OH through the Audubon Area Community Care Clinic. The appropriate supporting documentation of approval for this discount program will be sent during the referral process in order to identify these patients. This policy and the sliding scale income guidelines are available upon request to authorized individuals.

For Patients who are "Plain People" (i.e. Amish, Old Order Mennonite, and Conservative Mennonites), a separate procedure is provided as their belief system prohibits them from receiving any assistance from the government or from OH. Because they will not apply for Financial Assistance, they are ineligible for Financial Assistance under this Policy. Nonetheless, such Patients desire to pay something for the care they receive, and accordingly, they will be offered a discount. In order to receive this discount, the individual must be able to provide valid proof that he/she is part of these communities. This Policy excludes any special package pricing that has been agreed upon with these communities.

D. Asset Test- if all responsible individuals' combined Assets are equal to or less than \$10,000, then this Policy's Assets Test will not apply. If all responsible individuals' combined Assets exceed \$10,000, then those Assets exceeding \$10,000 will be considered by OH in determining a responsible individual's income and eligibility for Financial Assistance.

E. Patient Responsibilities. To be eligible for Financial Assistance, Patients must complete the required application form truthfully and submit all applicable documentation. Patients must respond to an OH Hospital's requests for information or documentation in a timely manner. A Patient who is requested to apply for Medicaid or other state or federal programs but does not cooperate fully with the application and eligibility determination process (excluding Kentucky Health patients in lockout period) may not be eligible for participation in the Financial Assistance Program. Patients must notify the Hospital promptly of any change in financial situation so that the Hospital can assess the change's impact on that individual's eligibility for Financial Assistance or a payment plan. If a patient knowingly provides untrue information, he or she will be ineligible for financial assistance, any financial assistance that has been granted may be reversed, and the individual may become responsible for paying his or her entire bill.

F. Discounts and Adjustments. Covered Services will be eligible for discounts, in whole or part, if:

1. A FAP-Eligible Individual qualifies for Medicaid after services have been provided by OH (100% discount). This includes any bills for services that predate coverage where Medicaid will not backdate coverage.
2. A FAP-Eligible Individual qualifies for Medicaid and Medicaid denies coverage for particular covered services (100% discount).
3. A FAP-Eligible Individual is approved for participation in the Financial Assistance Program with successful completion of Financial Assistance Program application and necessary documents.

Upon approval, discounts and adjustments will be processed promptly in accordance with PFS procedures.

G. Signature Authority for Discounts. Financial Assistance Program discounts will be granted subject to the following approval limits:

1. Up to \$2,500 -Patient Financial Advocate Supervisor
2. Up to \$25,000 - Business Office Manager
3. Up to \$50,000 - Director of Revenue Cycle
4. Up to \$100,000 - Vice President of Financial Services
5. Over \$100,000-Chief Financial Officer

- H. Payment Plans. OH offers interest free payment plans for patients for the amounts that they are personally responsible for paying, after applying any insurance reimbursements or discounts under this Policy. To participate in OH's payment plans, the Patient's remaining balance must be a minimum of \$25 a month and/or paid off in 36 months. Example: Remaining balance on account or group of accounts total \$1,000. The monthly minimum payment of \$27.78 would meet the criteria of being more than \$25 a month and being paid off within 36 months. Under certain circumstances, payment plans can be extended to longer terms with the approval of a Business Office Manager or above.
- I. Medical indigent. An individual is considered medically indigent if they do not qualify for the Financial Assistance Program due to income being over the FAP guidelines under Section III.C. The individual must have OH medical bills that are equal to or more than 50% of his/her yearly income (including Assets). If this criteria is met, then the individual would be responsible for 25% of their yearly income (including Assets) and the rest would be written off.
- J. Collection of Balances Owed by Patients; Patient Financial Services Billing and Collections Policy. OH Hospitals may take certain actions, including collections actions and reporting to credit agencies, against patients, including FAP- Eligible Individuals, if they do not pay the amounts for which they are responsible to pay as described in a separate Billing and Collections Policy. Under the Billing and Collections Policy, OH will not engage in certain collection actions until it has taken reasonable efforts to determine whether a Patient who has an unpaid balance is eligible for Financial Assistance under this Policy. The Billing and Collections Policy is available on OH's website at [www.owensborohealth.org](http://www.owensborohealth.org). In addition, a free copy of the Billing and Collections Policy can be obtained by any member of the public upon request to the Business Office or by calling 270-685-7501.
- K. Prompt Pay Discount Policy. OH offers a prompt pay discount of 10% to Patients first post-discharge billing statement if the balance is paid in full within 30 days of the statement's date (Prompt Pay Discount does not apply to any OH Medical Group co-pays, balances over 30 days, collection balances, sports physicals, immunizations, cosmetic procedures, bariatric services, or services performed at any walk-in clinic, including but not limited to OH Medical Group Urgent Care locations.)
- L. Refunds. Consistent with the Billing and Collection Policy, OH will refund amounts previously paid by a Patient if the amount exceeds what OH has determined the Patient should have been personally responsible for paying after applying the FAP, unless the amount is less than \$10 (indexed for inflation). OH can apply refunds, if any, to a Patient's debts from prior care that did not qualify for Financial Assistance.

**Publicizing the Policy:**

Each OH Hospital will widely publicize this program within the community it serves. To that end, OH will take the following steps to ensure that members of the communities to be served by its Hospitals are aware of the Policy and have access to the Policy.

1. OH will make a copy of its current Policy available to the community by posting the Plain Language Summary on its webpage along with downloadable copies of this Policy, the Billing and Collections Policy, and the Financial Assistance Application form and instructions. There will be no fee for accessing these materials. The OH website ([www.owensborohealth.org](http://www.owensborohealth.org)) will either include conspicuous links to these materials or have a conspicuous link to another webpage with links to these materials.
2. OH will provide copies of the Plain Language Summary in locations throughout its Hospitals where the Plain Language Summary will be available to patients and their families.
3. OH will make available, in both print and online, this Policy, the Plain Language Summary, the Application Form and the Billing and Collections Policy in English and Spanish.
4. Each billing statement for self-pay accounts shall include information regarding the Financial Assistance Program.
5. Each Hospital will include information on the availability of financial assistance in discharge packets provided to patients.
6. OH will make information regarding this Policy available to appropriate governmental agencies and nonprofit organizations dealing with public health in OH's service areas.

|                                             |
|---------------------------------------------|
| <b>Director of Revenue Cycle</b>            |
| <b>Vice President of Financial Services</b> |
| <b>Chief Financial Officer</b>              |
| <b>Compliance Officer</b>                   |
| <b>Chair, Board of Directors</b>            |
| <b>Chief Executive Officer</b>              |

## **EXHIBIT A**

### **List of Providers Who Follow OH's Financial Assistance Policy-**

All Owensboro Health Medical Group providers

### **Non-employed Pay for Call groups (in connection with providing emergency call services):**

#### **o Cardiology**

- Kishor Vora

#### **o Nephrology**

- Dhiren Haria
- Hamza Arif
- Hassaan Iftikar
- Maryam Saleem

#### **o Neurosurgical**

- Harold Cannon
- Eric Goebel
- Neil Troffkin
- David Weaver
- Kutluay Uluc

#### **o Oral Surgery**

- Steven Ledford
- Chase Andreason
- Bradley Storrs

#### **o Orthopedics**

- S. Boles
- Geoffrey Hulse
- Charles Milem
- Robert Moore
- Joseph Polio
- Joseph A. Polio
- William Polio

#### **o Pediatrics**

- Andrea Johnston
- Lynette Martin
- Jeremiah Mason
- Amy Ray
- Michael Yeiser
- Sara Medsker
- Heather Johnson

**o Interventional Radiology**

- Bryan Glaenzer, MD

**o Radiology – Rad Partners**

**o OB/GYN**

- Suzanne Rashidian, MD
- Richard Good, MD

\*The Pay for Call Providers follow OH Policy for self-pay patients only. Providers not listed on this Exhibit are not covered by OH's Financial Assistance Policy.

Last Updated: January 6, 2026

**EXHIBIT B****FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS**

1. Complete the financial assistance application.
2. Include all monthly income and expenses in the spaces provided.
3. Provide proof of income, including:
  - a) Last 2 pay stubs AND most recent filed W-2;
  - b) Most Recent Tax Returns;
  - c) Attestation Letter;
  - d) Current Benefit awards letters showing Social Security, Disability, Worker's Compensation, or Veteran's Administration benefits;
  - e) Copies of current benefit award letters or 1099 forms showing Unemployment, Retirement\*, or Pension benefits;
  - f) Proof of Assets which may include, but not limited to complete copies of monthly checking, savings, investments, Venmo, Chime, PayPal, holdings, and retirement accounts for most recent three months;
  - g) Verification of self-employment status and income received:  
Receipts from clients.  
Signed Federal income taxes from the most recent filing year which include the appropriate schedule showing income from self-employment, S-corp, or other such entity.
4. Sign the financial assistance application.

If you have no income, you will need to provide an explanation for how you meet your daily living expenses.

•If you have questions or need assistance completing this application, please call (270) 685-7501 Monday through Friday, 8:00 a.m. to 4:30 p.m. Or you can email us at [financialassistance@owensborohealth.org](mailto:financialassistance@owensborohealth.org).

**Fax the completed application and documents to:  
270-685-7560**

**Mail the completed application to:  
Owensboro Health  
PO Box 20007  
Owensboro, KY 42304  
Attn: Patient Financial Advocate**

Once we have received all the information and documentation requested, we will make and notify you by mail of your eligibility for participation in the Financial Assistance Program within 30 days.



## System Policy

Responsible Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Marital Status per Federal Tax Return: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_ Spouse SSN: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Insured Person: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Insured Person: \_\_\_\_\_

| Household (Dependent) Member's Name | Date of Birth / Relationship | SSN | Age |
|-------------------------------------|------------------------------|-----|-----|
|-------------------------------------|------------------------------|-----|-----|

(Use back of page for additional Household Member's) Number of people in the household (including patient) \_\_\_\_

### EMPLOYMENT:

Employer \_\_\_\_\_ Length of Employment or Hire Date: \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ Spouse Length of Employment or Hire Date: \_\_\_\_\_

### GROSS INCOME:

|                                                                      | Monthly (\$) |
|----------------------------------------------------------------------|--------------|
| Responsible party or patient's gross wages from paychecks/W2s.....   | _____        |
| Spouse's and any children's gross wages from paychecks/W2s.....      | _____        |
| Alimony.....                                                         | _____        |
| Social Security: .....                                               | _____        |
| SSI/Disability/K-Tap.....                                            | _____        |
| Unemployment.....                                                    | _____        |
| Pension: .....                                                       | _____        |
| Food Stamps: .....                                                   | _____        |
| Other Income (e.g., Investment, Workers' Comp.): Yes/No (circle one) | _____        |
| If yes, list: .....                                                  | _____        |
| TOTAL MONTHLY INCOME: .....                                          | \$ _____     |

### EXPENSES:

|                                                                   |          |
|-------------------------------------------------------------------|----------|
| Rent/Mortgage: .....                                              | \$ _____ |
| Food and Supplies.....                                            | _____    |
| Utilities.....                                                    | _____    |
| Telephone.....                                                    | _____    |
| Childcare: .....                                                  | _____    |
| Insurance Premiums (auto, health, dental, life, home, etc.) ..... | _____    |
| Prescribed Medications.....                                       | _____    |
| Other Expenses? Yes/No (circle one)                               | _____    |
| If yes, list: .....                                               | _____    |
| TOTAL MONTHLY EXPENSES: .....                                     | \$ _____ |

### RESOURCES:

|                                                                          |          |
|--------------------------------------------------------------------------|----------|
| Total # of Checking Accounts _____ Saving Accounts _____                 | \$ _____ |
| Stocks and Bond Values.....                                              | \$ _____ |
| Real Estate other than primary residence: Value _____ Balance Owed _____ | _____    |
| Other resources? Yes/No (circle one) If yes, list: .....                 | _____    |
| TOTAL RESOURCES: .....                                                   | \$ _____ |

I certify that the information provided by me in this application is correct and true to the best of my knowledge and belief. I understand that if I give false information or withhold information in applying for assistance, my application may be denied and Owensboro Health may pursue collection of any outstanding balance due. In that instance, I may also be subject to prosecution for fraud. I agree to notify OH of any changes to the information provided in this form including address, telephone number, and income.

\_\_\_\_\_  
(RESPONSIBLE PARTY SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(SPOUSE SIGNATURE)

\_\_\_\_\_  
(DATE)

#### OFFICE USE ONLY

Discount % Approved \_\_\_\_\_  
Date Submitted \_\_\_\_\_  
FC Signature \_\_\_\_\_  
Approval Signature \_\_\_\_\_  
Date Approved \_\_\_\_\_

## EXHIBIT C

### PLAIN LANGUAGE SUMMARY

Owensboro Health (“OH”) offers financial assistance to patients with no health insurance, or those who have out-of-pocket responsibilities that they cannot afford even after insurance has paid for a portion of their care. Patients must submit an application for financial assistance and all required supporting documentation, demonstrating financial need and must otherwise comply with the requirements of the hospital’s Financial Assistance Policy.

The Financial Assistance Program application, policy, and Plain Language Summary may be found on the Hospital’s website. Alternatively, printed copies of the Hospital’s Financial Assistance Policy, the Plain Language Summary, or the application form can be obtained for free by visiting or calling the Hospital’s Patient Financial Services. You may contact the Patient Financial Services office to discuss any questions you might have. This Plain Language Summary will be made available in both English and Spanish. If additional documents are needed, we will contact you by phone or mail to let you know what else is required.

If you are uninsured, you will generally qualify for free Emergency and other Medically Necessary Care under OH’s Financial Assistance Program (1) if you have an annual household income equal to or less than 450% of the Federal Poverty Level, (2) lack any other assets to pay for your charges and (3) if requested to do so by OH, you apply for Medicaid or other state or Federal programs and fully cooperate in the application and determination process.

If you are uninsured or have a balance remaining after insurance, you will generally qualify for discounted Emergency and other Medically Necessary Care under OH’s Financial Assistance Program (1) if you have household income of up to 450% of the Federal Poverty Level, (2) lack any other assets to pay for the amounts for which you become personally responsible for paying, and (3) if requested to do so by OH, apply for Medicaid or other state or Federal programs and fully cooperate in the application and determination process.

If OH determines that you are eligible for financial assistance, you will not be personally responsible for paying more than the amount we generally bill patients having insurance coverage for the same care. In addition, you will never be required to make advance payments or other payment arrangements to receive emergency services. However, you may be required in most situations to make a substantial advance deposit or agree to other payment arrangements before receiving non-emergency services.

Free copies of this summary, the Financial Assistance Policy, the Billing and Collections Policy, and the Financial Assistance Program application, including Spanish translations, are available on OH’s website at [www.owensborohealth.org](http://www.owensborohealth.org). Copies are also available at the Hospital in the Admitting areas located near the main entrances or Patient Financial Advocate area. This information is also available by mail by contacting OH Patient Financial Advocates at 270-685-7501.

OH’s Patient Financial Advocate staff is available to answer questions and provide information about the Financial Assistance Program and assistance with the application process. Our Patient Financial Advocate staff is located throughout our clinics, Hospitals, and the Business Center (located at 2511 Frederica Street, Owensboro, Kentucky 42301). They can also be reached by phone at 270-685-7501 or via email [financialassistance@owensborohealth.org](mailto:financialassistance@owensborohealth.org).

**EXHIBIT D**  
Owensboro Health Regional Hospital  
Owensboro Health Medical Group  
Owensboro Health Muhlenberg Community Hospital  
Owensboro Health Twin Lakes Medical Center



**2026 Financial Assistance Eligibility Grid**

| Federal Poverty Guidelines |                       | All Financial Classes<br>If the patient would qualify for hospital billing or professional billing assistance, refer him/her to a Patient Financial Advocate or give a financial evaluation to complete. |           |                           |           |                       |           |
|----------------------------|-----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------|-----------|-----------------------|-----------|
| Household Size             | Federal Poverty Limit | 100% (400% of FPL)                                                                                                                                                                                       |           | 90% (401% to 425% of FPL) |           | 80% (426% to 450%FPL) |           |
|                            |                       | Low                                                                                                                                                                                                      | High      | Low                       | High      | Low                   | High      |
| 1                          | \$15,650              | \$0                                                                                                                                                                                                      | \$62,600  | \$62,601                  | \$66,513  | \$66,514              | \$70,425  |
| 2                          | \$21,150              | \$0                                                                                                                                                                                                      | \$84,600  | \$84,601                  | \$89,888  | \$89,889              | \$95,175  |
| 3                          | \$26,650              | \$0                                                                                                                                                                                                      | \$106,600 | \$106,601                 | \$113,263 | \$113,264             | \$119,925 |
| 4                          | \$32,150              | \$0                                                                                                                                                                                                      | \$128,600 | \$128,601                 | \$136,638 | \$136,639             | \$144,675 |
| 5                          | \$37,650              | \$0                                                                                                                                                                                                      | \$150,600 | \$150,601                 | \$160,013 | \$160,014             | \$169,425 |
| 6                          | \$43,150              | \$0                                                                                                                                                                                                      | \$172,600 | \$172,601                 | \$183,388 | \$183,389             | \$194,175 |
| 7                          | \$48,650              | \$0                                                                                                                                                                                                      | \$194,600 | \$194,601                 | \$206,763 | \$206,764             | \$218,925 |
| 8                          | \$54,150              | \$0                                                                                                                                                                                                      | \$216,600 | \$216,601                 | \$230,138 | \$230,139             | \$243,675 |

Effective 2/1/2026

For more than eight in the family, add \$5,500 for each additional member.

Hospital Financial Assistance is based upon 400% of Federal Poverty Guidelines for eligibility of 100% assistance with a sliding scale up to 450% of Federal Poverty Guidelines for eligibility of 80% financial assistance.

The Low and High dollar amounts represent annual income limits for the household size within the chart. The percentage above represents the discount applied to patients meeting the criteria of annual income range and household size.