EXHIBIT A

ST. VINCENT'S CHILTON
FINANCIAL ASSISTANCE POLICY

Effective October 1, 2016

POLICY/PRINCIPLES

It is the policy of St. Vincent's Chilton (the "Organization") to ensure a socially just practice for providing emergency or other medically necessary care at the Organization's facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.

3. The List of Providers Covered by the Financial Assistance Policy, attached, provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means the St. Vincent's Health System eight county service area of Blount, Cullman, Jefferson, Shelby, St. Clair, Talladega, Walker and Chilton Counties.
- "**Emergency Care**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in either: placing the health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment/dysfunction to body functions or organs, with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another Hospital before deliver or that the transfer may pose a threat to the health or safety of the pregnant woman or the unborn child.
- "**Medically Necessary Care**" means care that is determined to be medically necessary

following a determination of clinical merit by a licensed provider. In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.

- "**Organization**" means St. Vincent's Chilton.
- "**Patient**" means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Patients with income less than or equal to 250% of the Federal Poverty Level ("FPL"), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. At a minimum, Patients with incomes above 250% of the FPL, but not exceeding 327% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any. A Patient eligible for the sliding scale discount will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

FINANCIAL ASSISTANCE (FAP) CHARITY GUIDELINES SLIDING SCALE	
Adjustment of Charges	Sliding Scale based on Federal Poverty Guidelines (FPL)
100%	250% or Greater of FPL Base
93%	251% - 289% of FPL Base
85%	290% - 327% of FPL Base

3. Patients with demonstrated financial needs with income greater than 327% of the FPL may be eligible for consideration under a "Means Test" for some discount of their charges for services from the Organization based on a substantive assessment of their ability to pay. A Patient who is not eligible for FAP under presumptive eligibility will be able to complete a FAP application for consideration of qualifying for Charity under the "Means Test". The Means Test shall be applied in individual cases of hardship under particular circumstances of patients with income greater than the FPL base. A Patient eligible for the "Means Test" discount will not be charged more than the calculated AGB charges for the care provided.
4. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.
5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant's failure to complete a financial assistance application ("FAP Application").

6. Eligibility for financial assistance must be determined for any balance for which the patient with financial need is responsible.
7. The process for Patients and families to appeal an Organization's decisions regarding eligibility for financial assistance is as follows:

    a. Once, a Determination Letter has been received by the patient. A Letter of Appeal can be submitted to:

Senior Manager Patient Access
St Vincent's Health System
c/o Carol L Jones
810 St Vincent's Drive
Birmingham, AL 35205

No particular form for the Letter of Appeal is required. The patient may submit such additional information, or make such additional arguments, as the patient deems appropriate for consideration.

    b. All appeals will be considered by the Organization's 100% charity care and financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to

the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by submitting a letter of request for AGB calculations to:

Senior Manager Patient Access
St Vincent's Health System
c/o Carol Jones
810 St Vincent's Drive
Birmingham, AL 35205.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process. The FAP Application and FAP Application Instructions are available by contacting the following:

- A St. Vincent's Health System facility Business Office
- A St. Vincent's Health System facility Cashier Office,
- Customer Service @ 877-202-0356;
- Email at (mailto:stvhsfinancialassistance@stvhs.com) or
- Information may be obtained at any registration point in A St. Vincent's Health System facility.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained by submitting a letter of request to:

Senior Manager Patient Access,
St Vincent's Health System
c/o Carol Jones
810 St Vincent's Drive
Birmingham, AL 35205.

Interpretation

This policy is intended to comply with 501(r), except where specifically indicated. This policy, together with all applicable procedures, shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

ST. VINCENT'S CHILTON
LIST OF PROVIDERS COVERED BY THE FINANCIAL ASSISTANCE POLICY
October 1, 2016

Per Reg. Sec. 1.504(r)-4(b)(1)(iii)(F) and Notice 2015-46, this list specifies which providers of emergency and medically necessary care delivered in the hospital facility are covered by the Financial Assistance Policy (FAP). Elective procedures and other care that is not emergency care or otherwise medically necessary are not covered by the FAP for any providers.

Below illustrates the list of covered and non-covered providers by FAP. Full lists will be available on line and in paper form upon request as indicated

Providers covered by FAP	Providers not covered by FAP
A COMPLETE LIST MAY BE OBTAINED BY SUBMITTING A LETTER OF REQUEST TO: Senior Manager Patient Access, St Vincent's Health System c/o Carol Jones 810 St Vincent's Drive Birmingham, AL 35205. Or at: • http://www.stvhs.com/financialpolicy.asp • Email at stvhsfinancialassistance@stvhs.com	Physicians – Last First Middle Abraham, Jacob C., M.D. Aldana, Alvaro A., M.D. Allen, Andrew M., M.D. Arjona, Jose L., M.D. Arora, Vikram, M.D. Bailey, Michael S., M.D. Baker, Allyson C., M.D. Baker, Theodore D., M.D. Bansal, Vinod K., M.D. Bennett, Matthew P., M.D. Beretta, James P., D.O. Bernal, Juan M., M.D. Boogaerts, James R., M.D. Bowen, Kathleen P., M.D. Boyken, Scott C., M.D. Branscomb, Elizabeth E., M.D. Brian, Christopher A., M.D. Brown, John O., M.D. Bundy, Lisa M., M.D. Cavender, J. B., M.D. Chaicharncheep, Beatrice, M.D. Chen, Pei Y., M.D. Chitty, Marc J., M.D. Christen, Neil L., M.D. Clement, Kevin B., M.D. Clingan III, Warren J., M.D. Cochran, Joseph L., M.D. Cockrell, Joshua N., M.D. Collins, Barry G., M.D. Colon, Percy J., M.D. Crawford, John R., M.D. Crowe, Amanda E., M.D.

	Curtis, John D., M.D. Davis, Jonathan D., D.O. Devos, William T., M.D. Dier, Gary L., M.D. DiLeo, Steven J., M.D. Doyle, Jennifer L., M.D. Druhan, Julian P., M.D. D'sa, Peter A., M.D. Dupre, Michael D., M.D. Dyer-Smith, Jeffrey W., M.D. Edmond, Davisson J., M.D. Edmunds Jr., Hayward S., M.D. Endfinger, Christopher G., M.D. Ferraro, Francis A., M.D. Firouztale, Pejman A., M.D. Flanagan, Brian D., M.D. Fleisher, Isadore K., M.D. Flowers, Brian A., M.D. Fortson, Stephen B., M.D. Foster, Robert E., M.D. Frey, E. Shields, M.D. Frye, Timothy A., M.D. Fulmer, Benjamin B., M.D. Gerth, Justin B., M.D. Gong, Stephanie H., M.D. Gordon, Donald G., M.D. Gorman, Kimberly C., M.D. Greene, Dale M., M.D. Harris, Adam S., M.D. Harrison, Daniel K., M.D. Harrison, William R., M.D. Heinzman, Stephen E., M.D. Helms Jr., Ronald W., M.D. Hill, Richard S., M.D. Hofammann, Karl E., M.D. Honan, Michael B., M.D. Horne-Ballard, Gaylyn M., M.D. Hunt III, Lewis A., M.D. Jabcuga, Christine E., M.D. Jackson Jr, William H., M.D. Jariwala, Hasmukh N., M.D. Johannson, Joshua B., M.D. Jones, Byron D., M.D. Jotani, Rutwij "Rick" K., M.D. Judge, David A., M.D. Judson III, Paul F., M.D. Kassamali, Rahim, M.D. Kelley, Weddington B., M.D. Kelly, D. Shane, M.D. Kennedy, Kevin M., M.D.

	King, Christopher A., M.D. Kloss, Kurt K., M.D. Lee, James D., M.D. Lee, Timothy C., M.D. Lindley, Jeremy E., D.O. Long, Jay C., M.D. Lopez, William C., M.D. MacLean, William A., M.D. Malik, Rohit, M.D. Mallah, Radwan, M.D. Mallampati, Gautham K., M.D. Margolies, Scott S., M.D. McAllister, Ashford S., M.D. McClanahan Jr., William H., M.D. McLean, Owen R., M.D. McMullan, Daniel T., M.D. Meadows, Cornelius R., M.D. Mehra, Mohit, M.D. Mehra, Mukul, M.D. Miller, Andrew P., M.D. Milner, Jeffrey D., M.D. Morros, Demetrius K., M.D. Nguyen, Vinh, M.D. Nicholson, Joseph E., M.D., Ph.D O'Loughlin, Terence J., M.D. Peilen, Kathryn C., M.D. Phillips, Elizabeth L., M.D. Phillips, Jonathan G., M.D. Pickett, Michael J., M.D. Pretorius, E. S., M.D. Prisacaru, Ilinca C., M.D. Rahim, Fazal, M.D. Rahim, Irfan U., M.D. Rajendra, Anil B., M.D. Ramsey, Angelyn L., M.D. Rana, Zulfiqar I., M.D. Ray, Clinton M., M.D. Reeder, Van C., M.D. Riddle, Nicole D., M.D. Rivas, Daniel L., D.O. Shah, Dishant G., M.D. Shanker, Pradheep J., M.D. Siddiqui, Rubina, M.D. Simmons, Donald R., M.D. Simmons, Paula R., CRNA Simpson, Michael T., M.D. Simpson, Nicole S., M.D. Slappey Jr., Donald H., M.D. Snoddy, Brian D., M.D.

	Sowder, Joseph T., M.D. Stanford, Michael J., M.D. Sulzer, Jana L., M.D. Taggar, Amit K., M.D. Taylor, Julie T., M.D. Thompson, Jason B., M.D. Thompson, Scott B., M.D. Thomson, Thomas O., M.D. Townsend, Jacob C., M.D. Trammell Jr., Dale E., M.D. Trimm, James R., M.D. Tuck, James M., M.D. Turner, Jordan L., D.O. Turner, Timothy S., M.D. Umphrey, Gregory W., M.D. Varnell Jr., William D., M.D. Vest, Richard N., M.D. Vrocher III, Diamond, M.D. Wade, Larry W., M.D. Walker, Benjamin H., M.D. Warner, Jeffrey C., M.D. West, James E., M.D. White, James T., M.D. Whitmore, Robert L., M.D. Williams, Jane N., M.D. Wood III, William C., M.D. Worthen, James V., M.D. Yoe, Robert H., M.D. Zenooz, Navid A., M.D. **A COMPLETE LIST MAY BE OBTAINED BY SUBMITTING A LETTER OF REQUEST TO:** Senior Manager Patient Access, St Vincent's Health System c/o Carol Jones 810 St Vincent's Drive Birmingham, AL 35205 Or at: • http://www.stvhs.com/financialpolicy.asp • Email: stvhsfinancialassistance@stvhs.com

Covered Provider Listings will be updated at least quarterly to assure accurate identification of care providers covered and not covered by the Financial Assistance Program.

ST. VINCENT'S ST. CHILTON
AMOUNT GENERALLY BILLED CALCULATION
July 1, 2016

The Organization calculates one AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of that calculation and AGB percentage are described below.

The AGB percentage for St. Vincent's Chilton is as follows:

AGB: **Unable to calculate at this time, new facility**.

This AGB percentage will be calculated by dividing the sum of the amounts of all St. Vincent's Chilton claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12 month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

ST. VINCENT'S CHILTON
BILLING AND COLLECTION POLICY
October 1, 2016

POLICY/PRINCIPLES

It is the policy of St. Vincent's Chilton (the "Organization") to ensure a socially just practice for providing emergency or medically necessary care at the Organization pursuant to its Financial Assistance Policy (or FAP). This Billing and Collection Policy is specifically designed to address the billing and collection practices for Patients who are in need of financial assistance and receive care at the Organization.

All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. The Organization's employees and agents shall behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating Patients and their families with dignity, respect and compassion.

This Billing and Collection Policy applies to all emergency and other medically necessary services provided in the Organization, including employed physician services and behavioral health. This Billing and Collection Policy does not apply to payment arrangements for elective procedures.

DEFINITIONS

1. "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

2. "**Application Period**" means the period during which a FAP Application may be submitted to the Organization. The Application Period begins on the earlier of the date the FAP Application is submitted or the date care is provided and ends on the date specified in an Application Period Termination Notice.

3. "**Application Period Termination Notice**" means a written notice stating the deadline after which the Organization will no longer accept and process a FAP Application submitted (or, if applicable, completed) by the Patient for the previously provided care at issue, with the deadline specified in the written notice being no earlier than the later of (a) thirty (30) days after the date that the written notice is provided, (b) 240 days after the date that the first post-discharge billing statement was provided for the previously provided care, or (c) in the case of a Patient who has been deemed presumptively eligible for Financial Assistance less than 100%, then end of a reasonable time to apply for Financial Assistance as described herein. The Application Period Termination Notice may be a separate written document or may be language included within another written notice sent to Patient.

4. "**Extraordinary Collections Actions**" **or** "**ECAs**" means any of the following collection activities that are subject to restrictions under 501(r):

a. Selling a Patient's debt to another party, unless the purchaser is subjected to certain restrictions as described below. (NOTE: the Organization does not sell a Patient's debt.)
b. Reporting adverse information about the Patient to consumer credit reporting agencies or credit bureaus.
c. Deferring or denying, or requiring a payment before providing, medically necessary care because of a Patient's nonpayment of one or more bills for previously provided care covered under the FAP.
d. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding. These actions include, but are not limited to,
    i. placing a lien on the Patient's property,
    ii. foreclosing on a Patient's property,
    iii. placing a levy against or otherwise attaching or seizing a Patient's bank account or other personal property,
    iv. commencing a civil action against a Patient, and
    v. garnishing a Patient's wages.

An ECA does not include any of the following (even if the criteria for an ECA as set forth above are otherwise generally met):

a. the sale of a Patient's debt if, prior to the sale, a legally binding written agreement exists with the purchaser of the debt pursuant to which
    i. the purchaser is prohibited from engaging in any ECAs to obtain payment for the care;
    ii. the purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) of the Internal Revenue Code at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
    iii. the debt is returnable to or recallable by the Organization upon a determination by the Organization or the purchaser that the Patient is eligible for Financial Assistance; and
    iv. the purchaser is required to adhere to procedures specified in the agreement that ensure that the Patient does not pay, and has no obligation to pay, the purchaser and the Organization together more than he or she is personally responsible for paying pursuant to the FAP if the Patient is determined to be eligible for Financial Assistance and the debt is not returned to or recalled by the Organization;
b. any lien that the Organization is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to a Patient as a result of personal injuries for which the Organization provided care; or
c. the filing of a claim in any bankruptcy proceeding.

5. "**FAP**" means the Organization's Financial Assistance Policy, which is a policy to provide Financial Assistance to eligible Patients in furtherance of the Organization's and Ascension Health's mission and in compliance with 501(r).

6. "**FAP Application**" means the application for Financial Assistance.

7. "**Financial Assistance**" means the assistance the Organization may provide to a Patient pursuant to the Organization's FAP.

8. "**Organization**" means St. Vincent's Chilton, which is part of Ascension Health. To request additional information, submit questions or comments, or submit an appeal, you may contact the office listed below or as listed in any applicable notice or communication you receive from the Organization:

Senior Manager Patient Access,
St Vincent's Health System
c/o Carol Jones
810 St Vincent's Drive
Birmingham, AL 35205

9. "**Patient**" means an individual receiving care (or who has received care) from the Organization and any other person financially responsible for such care (including family members and guardians).

BILLING AND COLLECTION PRACTICES

The Organization maintains an orderly process for regularly issuing billing statements to Patients for services rendered and for communicating with Patients. In the event of nonpayment by a Patient for services provided by the Organization, the Organization may engage in actions to obtain payment, including, but not limited to, attempts to communicate by telephone, email, and in-person, and one (1) or more ECAs, subject to the provisions and restrictions contained in this Billing and Collection Policy.

Pursuant to 501(r), this Billing and Collection Policy identifies the reasonable efforts the Organization must undertake to determine whether a Patient is eligible under its FAP for Financial Assistance before it engages in an extraordinary collection action, or ECA. Once a determination is made, the Organization may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. Except as provided below, a Patient may submit a FAP Application at any time during the Application Period. The Organization will not be obligated to accept a FAP Application after the Application Period unless otherwise specifically required by 501(r). Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

a. Complete FAP Applications. In the case of a Patient who submits a complete FAP Application during the Application Period, the Organization shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

b. Presumptive Eligibility Determinations. If a Patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application submitted with respect to prior care), the Organization will notify the Patient of the basis for the determination and give the Patient a reasonable period of time to apply for more generous assistance before initiating an ECA.

c. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, the Organization will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement for the care is sent to the Patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one (1) or more ECA(s) to obtain payment for care from a Patient who has not submitted a FAP Application, the Organization shall take the following actions:

   i. Provide the Patient with a written notice that indicates Financial Assistance is available for eligible Patients, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;
   ii. Provide the Patient with the plain language summary of the FAP; and
   iii. Make a reasonable effort to orally notify the Patient about the FAP and the FAP Application process.

d. Incomplete FAP Applications. In the case of a Patient who submits an incomplete FAP Application during the Application Period, the Organization shall notify the Patient in writing about how to complete the FAP Application and give the Patient thirty (30) calendar days to do so. Any pending ECAs shall be suspended during this time, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.

e. Termination of the FAP Application Period. The Application Period may be terminated by the Organization by delivering a written Application Period Termination Notice to the Patient.

2. Restrictions on Deferring or Denying Care. In a situation where the Organization intends to defer or deny, or require a payment before providing, medically necessary care, as defined in the FAP, because of a Patient's nonpayment of one or more bills for previously

provided care covered under the FAP, the Patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible Patients. Patient may also be given an Application Period Termination Notice.

3. Determination Notification.

   a. Determinations. Once a completed FAP Application is received on a Patient's account, the Organization will evaluate the FAP Application to determine eligibility and notify the Patient in writing of the final determination within forty-five (45) calendar days. The notification will include a determination of the amount for which the Patient will be financially responsible to pay. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

   b. Refunds. The Organization will provide a refund for the amount a Patient has paid for care that exceeds the amount the Patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

   c. Reversal of ECA(s). To the extent a Patient is determined to be eligible for Financial Assistance under the FAP, the Organization will take all reasonably available measures to reverse any ECA taken against the Patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

4. Appeals. The Patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. An appeal does not otherwise extend or reset the application process provided in this Billing and Collection Policy.

5. Collections. Upon conclusion of the above procedures, the Organization may proceed with ECAs against uninsured and underinsured Patients with delinquent accounts, as determined in the Organization's procedures for establishing, processing, and monitoring Patient bills and payment plans. Subject to the restrictions identified herein, the Organization may utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts, and such agencies or service providers shall comply with the provisions of 501(r) applicable to third parties.