FIRST MILE CARE™

IMPORTANT BILLING INFORMATION FOR PATIENTS

Thank you for choosing First Mile Care. This handout is designed to help our patients understand the financial assistance that is available to eligible patients, the application process for financial assistance, and your payment options. Please contact Patient Financial Services (contact information below) for any questions regarding First Mile Care's financial assistance.

Payment Options: First Mile Care has many options to assist you with payment of your First Mile Care bill.

Payment Plans: Patient account balances are due upon receipt. Patients may elect to make payment arrangements for their First Mile Care bill. A Financial Agreement must be signed before Patient Financial Services can accept payment arrangements that allow patients to pay their First Mile Care bills over time.

Medicare & Government Program Eligibility: You may be eligible for a government-sponsored health benefit program.

Summary of Financial Assistance: First Mile Care is committed to providing financial assistance to qualified low-income patients and patients who have insurance that requires the patient to pay for a significant portion of their care. The following is a summary of the eligibility requirements for financial assistance and the application process for patients who wish to seek financial assistance. The following are categories of patients who are eligible for financial assistance:

- Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level.
- Patients who are covered by insurance but have (i) family income at or below 400% of the federal poverty level; **and** (ii) medical expenses for themselves or their family (incurred during the program or paid to other providers in the past 12 months) that exceed 10% of the patient's family income.
- Patients who are covered by insurance but exhausted their benefits either before or during the program and have a family income at or below 400% of the federal poverty level.

You may apply for financial Assistance using the application form, which can be obtained by calling Patient Financial Services or on the First Mile Care website (www.firstmilecare.com). You may also submit an application by speaking with a representative from Patient Financial Services, who will assist you with completing the application.

During the application process you will be asked to provide information regarding the number of people in your family, your monthly income, and other information that will assist First Mile Care with determining your eligibility for financial assistance. You may be asked to provide a pay stub or tax records to assist First Mile Care with verifying your income.

After you submit the application, First Mile Care will review the information and notify you in writing regarding your eligibility. If you have any questions during the application process, you may contact Patient Financial Services. If you disagree with First Mile Care's decision, you may submit a dispute to the Patient Financial Services office.

Notice of Availability of Financial Estimates: You are entitled to a written estimate of your financial responsibility for First Mile Care services. Requests for estimates must be made during business hours. We will provide you with an estimate of the amount First Mile Care will require you to pay for First Mile Care services.

If you have any questions, please contact Patient Financial Services at **650-656-9856**.

FIRST MILE CARE
FINANCIAL ASSISTANCE POLICY

Policy:
First Mile Care ("FMC") provides financial assistance, including free or discounted Services for income-based eligible patients that are unable to provide payment for all or a portion of their Services ("Financial Assistance"). This Financial Assistance Policy (the "Policy") provides guidance on FMC's Financial Assistance eligibility requirements, application procedures, and implementation.

The Chief Commercial Officer (CCO) shall be responsible for reviewing and approving this Policy.

Purpose:
To establish a procedure for income-based eligible patients to receive Financial Assistance.

Procedure/General Instructions:

1. FMC will provide financial assistance to patients based on the following eligibility criteria for Financial Assistance:
   - **Self-Pay Patients**: A patient without third party coverage ("Uninsured Patient") or for patients receiving Services that are not covered ("Non-Covered Services") are eligible if the patient's family income is at or below 400% of the most recent Federal Poverty Level ("FPL") (see Attachment B) as annually published by the United States Department of Human Services. Patients may receive up to a full write off of all charges for Services, subject to the patient's ability to pay.
   - **Balance Billing for Out-of-Network Patients:** A patient with third party coverage, including government insurance such as Medicare and Medicaid ("Insured Patient") with a family income at or below 400% of the most recent FPL and with medical expenses for themselves or their family (incurred at FMC or paid to other providers) in the past twelve (12) months that exceed 10% of the family income may receive up to a full a write off of the amount the patient is responsible to pay out-of-pocket after the patient's third party coverage has determined the amount of the patient's benefits ("Patient Responsibility"), subject to the patient's ability to pay.

2. To determine a patient's eligibility for Financial Assistance, FMC will request financial information regarding the patient's family income. Family income is the annual earnings of all members of the patient's family from the prior 12 months or prior tax year as shown by the recent pay stubs or income tax returns, less payments made for alimony and child support ("Family Income"). The income for this calculation includes every form of income (e.g., salaries and wages, workers' compensation, retirement income, and investment gains). FMC will require the patient provide either the last three (3) months of pay stubs or the previous year's tax return for wage and salary verification, and/or social security benefits statement, workers' compensation, etc., and three (3) months of most recent bank statements unless the patient is currently on Medicaid in a state that does not

cover the services provided by FMC (FMC care will require a limited amount of information to verify their Medicaid coverage and grant financial assistance). Annual income may be determined by annualizing year-to-date Family Income. FMC may validate income by using external presumptive eligibility service providers, provided that such service only determines eligibility using only information permitted by this Policy.

3. A patient's family includes: (a) for patients 18 years of age or older, the patient's family includes the patient and their spouse, domestic partner, and dependent children less than 21 years of age, whether living at home or not, or (b) for patients under 18 years of age, the patient's family includes their parent(s), caretaker relatives, and other children less than 21 years of age of the parent(s) or caretaker relatives.

4. Expired patients, with no surviving spouse, may be deemed to have no income for the purposes of calculating Family Income, "deemed to have no income" and documentation of income is not required for expired patients, however the documentation of the estate or probated proceeding may be required. If an expired patient has a surviving spouse, the surviving spouse may apply for Financial Assistance.

5. If a patient fails to provide documentation and information that is reasonable and necessary for FMC to make its determination of the patient's Financial Assistance eligibility, FMC may consider that a failure in its determination.

6. After determining Family Income, FMC will calculate the Family Income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the FPL for a family of three is $20,000, and a patient's Family Income is $60,000, FMC will calculate the patient's Family Income to be 300% of the FPL. FMC will use this calculation during the application process to determine whether a patient meets the income criteria for Financial Assistance.

7. When an Insured Patient's third-party coverage pays only a portion of the expected reimbursement for the patient's Services because the patient exhausted his or her benefits, FMC should collect from the patient the balance of the expected reimbursement that would have been due from the third-party coverage if the benefits were not exhausted. FMC will not pursue from the patient any amount in excess of the amount that would have been due from the third-party coverage if the benefits were not exhausted, plus the patient's share of cost or co-insurance. A patient who exceeded their benefit cap is eligible to apply for Financial Assistance. If the patient is eligible for Financial Assistance, FMC may write off up to all charges for Services that FMC provided after the patient exceeded the benefit cap.

8. Financial Assistance is not available when: (a) an Insured Patient refuses to pay for services because the patient failed to provide information to the third party payor necessary to determine the third party payor's liability, (b) a patient receives payment for services directly from an indemnity, government payor or supplement, or other payor, (c) a patient falsifies information regarding Family Income, household size or other information in his or her eligibility application, and (d) a patient or FMC receives a

settlement or judgment amount from a third-party tortfeasor related to the patient's treatment by FMC, that satisfies any account balances.

9. In order to qualify as an Uninsured Patient, the patient or the patient's guarantor must attest in writing that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill, and that all of the information being furnished to FMC is accurate. If FMC believes the patient is eligible for Medicaid, the patient will be encouraged to apply for Medicaid before any financial assistance will be granted.

10. Patients who wish to apply for Financial Assistance will use the FMC standardized application form, The Application for Financial Assistance (*see* **Attachment A**). Patients should complete the application for Financial Assistance as soon as possible, prior to or once Services have been provided. Failure to complete and return the application within 240 days of the patient's initial billing statement may result in the denial of Financial Assistance. Patients may request assistance with completing the application for Financial Assistance, over the phone by contacting Patient Financial Services at **650-656-9856** or via the FMC website (www.firstmilecare.com).

11. FMC will consider each patient's application for Financial Assistance and grant Financial Assistance when the patient meets the Financial Assistance eligibility criteria and has received or will receive FMC Services. Once a determination has been made regarding Financial Assistance, patients will receive correspondence from FMC advising them of FMC's decision.

12. If a patient applies, or has a pending application, for another health coverage program while they apply for Financial Assistance, the application for coverage under another health coverage program may preclude the patient's eligibility for Financial Assistance.

13. A patient may seek review of any decision by FMC to deny Financial Assistance by notifying Patient Financial Services, of the basis of the dispute and the desired relief within thirty (30) days of the patient receiving notice of the circumstances giving rise to the dispute. Patients must submit the dispute in writing. The individual responsible for finance at FMC or their designee will review the patient's dispute as soon as possible and inform the patient of any decision in writing.

14. During a patient's registration with FMC (or as soon thereafter as practicable) FMC will provide all patients with a copy of **Attachment C** which includes a plain language summary of this Policy and contains information regarding the patient's right to receive an estimate of his or her Financial Responsibility for Services. FMC will identify the department that patients can visit to receive information about, and assistance with applying for, Financial Assistance. Billing statements will refer patients where to find information regarding financial assistance.

15. Patients may be eligible for a payment plan. Payment plans will be offered and negotiated per FMC's customary billing and collections practices.

16. FMC may employ reasonable collection efforts to obtain payments from patients.

Attachments:

Attachment A – Application for Financial Assistance
Attachment B - Financial Assistance Calculation Worksheet including FPL
Attachment C – Important Billing Information for Patients

Audits:

The CCO, or an FMC delegate will annually (or more frequently as deemed necessary) review this Policy, and the administration of this Policy will be subject to internal and external audits.

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Attachment A

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME_________________________SPOUSE______________________________

ADDRESS____ PHONE ___________________

ACCOUNT#__________________SSN(PATIENT)__________SSN(SPOUSE)_____________

FAMILY STATUS: List any spouse, domestic partner, or children under the age of 21. If patient is a minor, list all parents, caretaker relatives, and siblings under 21

Name	Age	Relationship

Does the patient have active Medicaid/Medicaid MCO coverage? If so, please list policy information below:

Member ID: _____________________________ MCO Plan Name: ____________________

****Stop here if the patient is covered by Medicaid in Texas or Michigan.**

EMPLOYMENT AND OCCUPATION

Patient Employer: ____________________________________ Position: __________________

Contact Person & Telephone: ____

If Self-Employed, Name of Business: ____

Spouse Employer: _____________________________________Position: __________________

Contact Person & Telephone: ____

If Self-Employed, Name of Business: ____

CURRENT MONTHLY INCOME		Patient	Other Family
	Gross Pay (before deductions)		
add:	Income from Operating Business (if self-employed)		
add:	Other Income		
	Interest and Dividends from		
	Real Estate or Personal Property		
	Social Security		
	Other (e.g. alimony, support payments; specify)		
Subtract:	Alimony, Support Payments Paid		
Equals:	Current Monthly Income		
	Total Currently Monthly Income (add patient + Spouse)		
	Income from above		

Family Size

Total Family Members: _________________________

(Add patient, parents (for minor patients), spouse and children from above)

FIRST MILE CARE™

Question	Yes	No
Do you have health insurance?		
Do you have other insurance that may apply (such as an auto policy)?		

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that First Mile Care will use these statements to determine my eligibility for financial assistance. If any information changes, it is my responsibility to report such changes to First Mile Care. I further understand that any false representations or false claims, statements or documents or concealments of any material fact may result in an immediate termination of any financial assistance granted to me or my family and that I will be liable to repay all amounts of financial assistance previously provided to me.

I certify that the information given on this application and any attached supporting document is accurate and complete to the best of my ability.

Patient Signature or Guarantor: ____ Date: ________

Signature of Spouse: ____Date: ________

Return this application with proof of income, bank statements, and proof of medical expenses if applicable, to:

First Mile Care
Patient Financial Services
3000 Sand Hill Road
Suite 3-210
Menlo Park, CA 94025

For Office Use Only

Date Received ___________ Date Reviewed __________ Approved or Denied

Attachment B

FINANCIAL ASSSISTANCE CALCULATION WORKSHEET

Annualize the patient's income by multiplying the total monthly income by 12. Compare the annual income to the scale below based on the family/household size. If the annual income is at or below 400% of the Federal Poverty Guidelines the patient qualifies for financial assistance.

2023 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family/Household	Federal Poverty Guideline	400% of Federal Poverty Guideline
1	$13,590	$54,360
2	$18,310	$73,240
3	$23,030	$92,120
4	$27,750	$111,000
5	$32,470	$129,880
6	$37,190	$148,760
7	$41,910	$167,640
8	$46,630	$186,520

For families/households with more than 8 persons, add $4,720 for each family member to the Federal Poverty Guideline and multiply by 4 to get 400% of the Federal Poverty Level.

Out-of-Pocket Medical Expenses

Add together all the reported out-of-pocket medical expenses for the family/household. Next multiply the annual family/house income by 0.10. If the total of out-of-pocket medical expenses is more than 0.10 of the total annual income, and the patient falls within the income guidelines noted above, the patient qualifies for financial assistance.

Attachment C

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