

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY

Effective 01/01/2025

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- I. **Purpose:** To establish a framework and guidelines for providing financial assistance to qualifying patients with an effective and consistent method for identifying eligible patients and for administration and allocation; and to establish credit and collection guidelines for Duke Health Lake Norman Hospital (the “Facility”). This policy describes the various points of collection and various collection methods that the Facility employs throughout the patient billing and payment cycle. This policy also outlines steps the Facility will take to mitigate the medical debt of its patients.
- II. **Scope:** This Financial Assistance Policy applies to Duke Health Lake Norman Hospital acute care facility and does not apply to ambulatory care centers, clinics or physician services that may be affiliated with the Facility.
- III. **Policy:** The Facility is committed to treating all patients regardless of their ability to pay and to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for their medical care based on their individual financial situation. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), emergency and Medically Necessary Care will not be delayed or withheld based on a patient’s ability to pay. As a service to our community, we participate in the North Carolina Healthcare Access and Stabilization Program (HASP) program and offer financial assistance and debt mitigation to our patients for care received at our Facilities subject to meeting eligibility criteria established herein and in accordance with our specific policy and state requirements. No patient will be denied financial assistance due to his or her race, religion, national origin or any other basis prohibited by law.
- IV. **Definitions:**
- A. Assets or Liquid Assets – Assets, outside of a patient’s primary residence, that are capable of being converted to cash within one year. These include checking accounts, savings accounts (including flexible spending and health savings accounts), trust funds, certificates of deposit, bonds, marketable securities and other investments (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)).

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Additionally, Assets include the liquidated value of luxury items, equity in recreational vehicles, boats, a second home, etc.

- B. Asset Test – A substantive assessment of a patient’s ability to pay based on eligible liquid or cash Assets in the categories included in the FAP Application.
- C. Catastrophic Claim – An account with a patient responsibility balance of at least \$50,000.00 after applying the Uninsured Discount, or a partial Charity Care Discount.
- D. Charity Care Discount – For Uninsured, a full or partial discount off gross charges for medical services available for eligible patients or patient guarantors with annualized individual or family incomes up to specified percentage of the Federal Poverty Level. For Insured, a full or partial discount off net charges for medical services available for eligible patients or patient guarantors with annualized individual or family incomes up to specified percentage of the Federal Poverty Level.
- E. Emergency Services – Emergency Medical Conditions, as defined by Section 1867 of the Social Security Act (42 U.S.C. 1395dd), provided in an emergency room setting.
- F. Federal Poverty Level – The Federal Poverty Level (“FPL”) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of United States Code, Title 42, Section 9902(2). Current FPL Guidelines can be found at <http://aspe.hhs.gov/poverty-guidelines>. We will update the FPL Guidelines for its Financial Assistance Program on an annual basis.
- G. Financial Assistance – A reduction in the amount that the patient owes for medical services based on the patient’s financial need determined by the provisions of this Policy. This reduction is generally determined as a percentage of gross or net charges.
- H. Financial Assistance Program or “FAP” – As detailed herein, a program developed to identify and measure a patient’s eligibility for either free or discounted Financial Assistance based on financial need and to outline the practice for allocating Financial Assistance in a consistent and efficient manner. Discounts offered under the Financial Assistance Program include the Charity Care Discount, the Uninsured Discount and the Catastrophic Claim Discount.
- I. Financial Assistance Program or “FAP” Application – The application a patient must complete in order to identify whether the patient is eligible for the Charity Care Discount available under our Financial Assistance Program.
- J. Gross Charges – The full, undiscounted price of medical services consistently and uniformly charged to patients before applying any contractual allowances, discounts or deductions.
- K. Insured – Patients with any type of insurance coverage and/or third-party payor program which reimburses for, compensates or discounts medical expenses. For purposes of this Policy, patients are considered to be insured even if their benefits are out-of-network.
- L. Medical Indigency or Medically Indigent - A patient whose “Balance Due” (defined as the patient’s residual account balance after payment by all third party payors for Medically Necessary Care received at our Facility) exceeds a specified percentage of the patient’s annual gross income, determined in accordance with our Charity Care Discount eligibility criteria.

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- M. Medically Necessary Care – As defined by Medicare, services or items reasonable and necessary for the diagnosis or treatment of illness or injury.
- N. Policy – This Financial Assistance Policy.
- O. Uninsured – Patients for whom there is not a third party responsible for all or any portion of their medical expenses.
- P. Uninsured Discount – The flat-rate discount applied to eligible gross charges Uninsured patient accounts.

V. Financial Assistance Policy and Procedures

A. Financial Assistance: Charity Care Discount Policy

- i. **Eligible Services.** Emergency Services and Medically Necessary Care may be eligible for a Charity Care Discount, depending on other eligibility criteria set forth below. Services that are non-medically necessary and/or cosmetic services are not generally eligible for the Charity Care Discount at the Facility; however, the Facility CFO or Shared Services Center (“SSC”) may approve application of the Charity Care Discount for such services on a case-by-case basis.
- ii. **Charity Care Discount.** The Facility offers a Charity Care Discount off the entire bill or on a sliding scale basis, as described in **Appendix B**, after evaluation of the FAP Application, attached as **Appendix D**, submitted by a patient or through our presumptive eligibility screening process described below, if applicable, to determine whether the patient has an adjusted individual or household gross income¹ that falls within a specified percentage of the current FPL Guidelines established by the Department of Health and Human Services, attached as **Appendix A**. However, a patient must cooperate with the Facility in providing the information and documentation necessary to determine eligibility. More information on our Charity Care Discount is found in **Appendix B**.
- iii. **Charity Care Discount Program Eligibility and Administration.**
 - 1. Presumptive Eligibility Screening.² We provide presumptive eligibility screening services for patients who are screened for potential Medicaid eligibility as well as coverage by other sources, including other governmental programs, who do not appear to qualify for coverage under any program to evaluate the patient's eligibility to receive a Charity Care Discount under the Facility's Financial Assistance Program (“Presumptive Eligibility”). We screen eligible patients using a health care industry-recognized predictive model based on public record databases to evaluate a patient's adjusted family gross income under current FPL Guidelines. Information from the predictive model is used to satisfy the documentation requirements required in the FAP Application process for a Charity Care Discount.
 - (1) Has financial criteria that falls within a specified percentage of the FPL Guidelines established by the Department of Health and Human Services for the patient's applicable family size, as described by each Facility in **Appendix B**; and
 - (2) Did not agree prior to rendering of healthcare services to pay a specific dollar amount for the services provided as a special arrangement.
 - (3) Patients that meet any of the following criteria will be deemed presumptively eligible for financial assistance. Screening for the criteria will be done using the questionnaire in **Appendix G** and will

¹ Household consists of the patient, spouse and all legal dependents. If the patient is a minor or legal dependent, the family gross income will include parent(s), legal guardian(s) and/or the taxpayer claiming the patient as a dependent for income tax purposes.

² Presumptive Eligibility Screening is not available for patients between the ages of 19-23 as they may be eligible to qualify as a dependent for tax purposes. However, such individuals will still be eligible to apply for Charity Care through the FAP Application process and may be eligible for other discounts offered under this Policy.

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occur prior to or at check in for scheduled services and prior to discharge where feasible for Emergency Services.

- a. Homelessness;
 - b. Mental incapacitation with no one to act on the patient's behalf;
 - c. Enrollment in Medicaid of patient or a child in their household³;
 - d. Enrollment in another means-tested public assistance program.
 - a. Patients will not be required to present documentation to validate any reported criteria, but may be asked to sign the Patient Attestation included in **Appendix G**.
 - b. If a patient does not meet the Presumptive Eligibility criteria, or if the patient presumptively qualifies for a partial discount, the patient will still have an opportunity to qualify for a Charity Care Discount through the FAP Application process or if the patient meets the definition of Medical Indigency.
 - c. **Patients eligible for Medicare must complete and submit a Financial Assistance Application and an Asset Test in order to qualify for a Charity Care Discount for benefits not covered by Medicare.**
3. **FAP Application Process.** A patient who does not meet Presumptive Eligibility will have an opportunity to qualify for a Charity Care Discount through the FAP Application process set forth below. Our FAP Application is found in **Appendix C**. The FAP Application and Asset Test request information from the patient that allows the Facility to evaluate a patient's adjusted family gross income under current FPL Guidelines, attached as **Appendix A**.
- a. Generally, patients may apply for a Charity Care Discount at the time of service or any time after care has been provided during their billing cycle. Patients may obtain FAP Applications, as well as assistance with completing the application, by calling or visiting customer service at the following address:

Duke Health Lake Norman Hospital
171 Fairview Road
Mooresville, NC 28117

(704)660-4000
<https://www.lnrmc.com/>
 - b. All patients who wish to apply for a Charity Care Discount or are identified as a possible candidate for a Charity Care Discount will have a FAP Application made available to them.
 - c. A patient who wishes to apply for a Charity Care Discount must provide adequate documentation, as outlined below, supporting their financial income and expenses to be considered for charity care.

³ For purposes of presumptive eligibility requirements, a child shall be considered part of the patient's household if the child is part of the patient's household for purposes of Medicaid eligibility, as defined under 42 CFR 435.603(f)(3) for non-tax filers. Under this definition, the household includes the following:

- The individual
- Their spouse
- If living with the individual, the individual's children (defined as a natural or biological, adopted, or step child under the age of 19)

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- d. For Uninsured patients, a patient is deemed eligible for a Charity Care Discount after Facility evaluation of the FAP Application if the patient:
 - (1) Received or is scheduled to receive Medically Necessary Care;
 - (2) Has financial criteria that falls within a specified percentage of the FPL Guidelines, as described in **Appendix B**; *and*
 - (3) Financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to our patient Asset Test.
 - e. For Insured patients, a patient is deemed eligible for a Charity Care Discount applied to the Balance Due after Presumptive and/or Facility evaluation of the FAP Application (as applicable) if the patient:
 - (1) Received Emergency Services;
 - (2) Has financial criteria that falls within a specified percentage of the FPL Guidelines, as described in Facility's **Appendix B**; *and*
 - (3) Financial status is validated using financial scoring or documentation provided by the patient to verify patient's assets, pursuant to our patient Asset Test.
 - f. **Medical Indigency.** Patients who are not deemed eligible for a Charity Discount based on the above criteria may still be eligible to receive a Charity Care Discount if the patient meets the definition of Medical Indigency with a Balance Due that exceeds a specified percentage of the patient's annual gross income determined through the application process, as described in **Appendix B**.
 - g. The FAP Application must be provided to the patient or responsible party, completed and returned prior to any write-off transaction being applied to the account.
4. A patient that is deemed not eligible for a Charity Care Discount may be considered for other assistance under the Financial Assistance program, as set forth below, or may qualify for discounts available at the Facility that are not part of the Financial Assistance Program on a case-by-case basis. Financial counselors at our Facility are available for additional information.
5. Criteria for Evaluating FAP Applications.
- a. The FAP Application will request for the following financial information related to the patient:
 - (1) A copy of the last four pay checks stubs;
 - (2) Prior year Federal 1040 tax return;
 - (3) Unemployment benefits (check stubs);
 - (4) Social Security benefits (copy of check or letter from Social Security);
 - (5) Department of Social Services grants and/or amount of food stamps;
 - (6) List of personal expenses, including but not limited to rent, house payment, utilities, car payment, insurance, food, etc.; and/or
 - (7) Other documents needed to verify Assets to determine eligibility.
 - b. Even if a patient FAP Application evaluation determines that the patient's FPL score exceeds the specified percentage identified in **Appendix B**, a patient may also qualify for a Charity Care Discount after Facility evaluation of the FAP Application if,
 - (1) The patient is Medically Indigent;
 - (2) The patient's account balance from the Facility for Medically Necessary Care exceeds a specified percentage of the patient's annual gross income (after payment by third party payors and excluding patient's cost-sharing amounts), as described by the Facility in **Appendix B**; and
 - (3) The patient's financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to the Facility's patient Asset Test.

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- c. **Tax Filings.** Where the patient/guarantor indicates they do not file federal tax returns, the Facility will request that the patient/guarantor complete IRS Form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the Facility has completed lines 6-9. The Facility will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, the Facility will enter prior year and prior 3 years. A copy of the IRS Form 4506-T is attached hereto as **Appendix D**.
 - d. **Asset Test.** Applying the Asset Test, a patient with Assets that exceed 400% of the FPL or have \$100,000 or more in eligible or liquid Assets (i.e. cash, bonds, certificates of deposit), for the guarantor or patient may not be eligible for the Charity Care Discount. The Facility Chief Financial Officer and Patient Access Director along with the Shared Service Center (SSC) will determine the amount due if the patient's liquid assets exceed \$100,000.
 - e. Patients will initially be given thirty (30) days to complete and return the FAP Application and all necessary documentation to the Facility or the SSC. The FAP Application will be sent to the Facility financial counselor or SSC designated director for final determination.
- 6. **Information Not Available.**
 - a. A patient who is unable to provide the above-mentioned documentation to support a charity care eligibility determination must contact the Facility or the SSC to discuss other available evidence that may demonstrate eligibility. Notarized letters from family members, neighbors, etc. stating or certifying the patient has no income or other financial resources are not considered adequate documentation.
 - b. Accounts for which complete documentation is not received will be returned to the normal self-pay collections workflow.
- 7. **Incomplete Information.**
 - a. A patient should be notified in-person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within thirty (30) days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.
 - b. Applications that remain incomplete after thirty (30) days from the date the notice was mailed may result in denial of application and will return to the normal self-pay collections workflow.
 - c. The application may be reopened and reconsidered once the required information is received.
- 8. **Denial.**
 - a. A patient or guarantor who applied for a Charity Care Discount but was denied may be informed in writing that their request for a Charity Care Discount was denied.
 - b. The patient or guarantor may appeal the determination of eligibility for financial assistance by providing additional information or verification that you believe will impact this decision within thirty (30) days receipt of notification of denial. Following this evaluation, written notification of the determination from that reconsideration will be provided to the patient/ guarantor.
- 9. **Notification of Approval.** We will send every patient that has been approved for a Charity Care Discount via the Presumptive Eligibility process a written notice of their approval prior to billing for services.
- 10. **Length of Eligibility.**

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- a. The patient's account status will never be permanently designated as eligible for a Charity Care Discount; rather the patient's status will be reviewed every three (3) months. This means that a patient's eligibility determination remains effective for three (3) months, during which other accounts belonging to the same patient may be added to the previous approval, if requested by the patient. We may require a new FAP Application or presumptive qualifications evaluation once the three (3) month period of eligibility expires, measured from the date of approval. We may also require a new FAP Application or presumptive qualifications evaluation within the three (3) month period, if a patient's financial situation appears to or is suspected to have changed.
- b. A patient's Charity Care Discount may be revoked, rescinded or amended if,
 - (1) A patient received the discount due to circumstances which undermines the Financial Assistance Program;
 - (2) Other payment sources are identified after receiving the Charity Care Discount; or
 - (3) A change in healthcare insurance coverage is identified after receiving the Charity Care Discount.

11. Out-of-State Medicaid Recipient.

- a. Patients covered by out-of-state Medicaid where we are not an authorized provider will be eligible for charity care upon verification of Medicaid coverage for the service dates since they will be considered uninsured. No other documents will be required in order to approve the patient for financial assistance. The patient will not be required to make a formal FAP Application. We may submit the application and verification of Medicaid coverage as proof of qualification.

iv. **Collection Efforts.**

1. All collection efforts should be suspended if the patient has submitted a complete FAP Application and all accompanying documentation. Collection efforts should be suspended until a final eligibility determination is made. However, if the FAP and / or accompanying documentation are incomplete, collection efforts and statement processing will continue until all the required documentation is received.
2. If a patient is awarded a 100% balance adjustment under the Policy, collections efforts will cease. However, if the patient is awarded a sliding scale adjustment that is less than 100%, collections efforts and statement processing may resume for the remaining balance not adjusted under the Policy.
3. If a patient is awarded a Charity Care Discount, any deposits or payments received from the patient for that care must be refunded if the payments exceed any balance remaining after application of the all Financial Assistance discounts.

v. **Publicity of Charity Care.**

1. At the time of service, all patients should be notified of the possibility of a Charity Care Discount under our Financial Assistance Program.
2. An opportunity to complete a FAP Application should be given to all patients that wish to apply for a Charity Care Discount or have been recommended by practice staff, a physician or a financial counselor for a Charity Care Discount.
3. A patient may request a FAP Application in-person, by phone, by mail, or by accessing the electronic version on our website. Copies of the policy, application forms, and instructions will be made available free of charge.

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4. Patients should be provided a written notice with their bill that contains information regarding the Charity Care Discount including information about applying for charity care and contact information for the Business Office where the patient may obtain further information about this and other Financial Assistance available under this policy.
5. Information about the Charity Care Discount should be posted in languages representative of the Facility's patient demographics and in conspicuous places, including but not limited to posting notices in the emergency rooms, urgent care centers, admitting and registration departments, business offices and patient financial services offices that are located at the Facility. Facilities must consult state law to determine additional notice and publication requirements.
6. Any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with EMTALA and all applicable state and federal regulations.

B. Financial Assistance: Uninsured Discount Policy

- i. Patients who are not eligible for or who have not been identified as eligible for a Charity Care Discount may receive an Uninsured Discount. More information on the Facility's Uninsured Discount percentages is found in **Appendix E**.
- ii. **Eligibility.** The Uninsured Discount applies to Uninsured patients.
 1. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:
 - a. The patient's insurance does not cover a portion or all of the services and treatment rendered during a patient visit; or
 - b. The patient's applicable benefits have been exhausted.
- iii. The Uninsured Discount will be applied at the time when the Facility is able to identify and classify a patient as Self-Pay/Uninsured and will be reflected on a patient's final bill.
- iv. If, after the Uninsured Discount is applied to a patient account, the Facility determines that the patient has adequate insurance within timely filing limitations, the patient's insurance will be billed for the account, and the Uninsured Discount will be reversed if the patient's benefits cover the billed services.

C. Financial Assistance: Catastrophic Claim Discount Policy

- i. Uninsured patients with certain high balances for medical treatment may receive a Catastrophic Claim Discount in addition to an Uninsured Discount. More information on the Facility's Catastrophic Claim percentages is found in **Appendix F**.
- ii. **Eligibility.**
 1. The Catastrophic Claim Discount will apply to claims with a patient balance of at least \$50,000.00 after applying the Uninsured Discount to the claim.
 2. The Catastrophic Claim Discount only applies to Uninsured patients. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:

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- a. The patient's insurance does not cover the patient visit through no fault of the patient; or
- b. The patient's applicable benefits have been exhausted.

VI. Mitigation of Problematic Debt Collection Practices

1. Medical Debt Interest Rate Cap
 - a. The interest rate for all medical debt held directly by Duke Health Lake Norman Hospital shall be capped at 3%.
2. Sale of Medical Debt
 - a. Medical Debt of Duke Health Lake Norman Hospital will not be sold to a third party.
3. Medical creditors/debt collectors (including third party collection agencies retained by, or on behalf of, Duke Health Lake Norman Hospital) will not take any of the following actions to collect medical debt:
 - a. Causing an individual's arrest
 - b. Causing an individual to be held in civil contempt or imprisoned.
 - c. Foreclosing on an individual's real property.
 - d. Garnishing wages or State income tax refunds.
4. Medical creditors/debt collectors will not engage in any permissible extraordinary collection actions until 180 days after the first bill for a medical debt has been sent.⁴
5. Medical creditors/debt collectors will provide patients with 30 days notices of any extraordinary collection actions.
6. Any extraordinary debt collection actions will be reversed if the patient is subsequently found to be eligible for financial assistance using the criteria above.
7. Patient debt will not be reported to credit reporting agencies.
8. No individual—except for spouses—will be held liable for medical debt of any other person age 18 or over, although individuals may voluntarily assume liability for medical debt.
 - a. A spouse held liable for a patient's medical debt will be eligible for the same medical debt mitigation policies offered to the patient.
9. No legal action will be initiated against a patient/guarantor for any claims where an insurance appeal or review is pending and will not be initiated until at least 60 days after the insurance appeal/review has concluded. These accounts will not be referred to an external debt collector if insurance appeal/review was pending in the prior 60 days.

VII. Medical Debt Donation

1. Duke Health Lake Norman Hospital shall relieve/donate all unpaid patient medical debt dating back to January 1, 2014 for North Carolina residents who are currently enrolled in Medicaid (including in limited benefit family planning coverage).
2. Duke Health Lake Norman Hospital shall evaluate patient accounts with outstanding balances for current Medicaid enrollment, and reclassify debt for such individuals dating back to January 1, 2014 as charity care. For purposes of this requirement, debts reclassified as charity care will be considered relieved.
 - a. This requirement shall apply to any debts subject to a payment plan previously agreed to by the patient.
 - b. Beginning no later than July 1, 2025 and thereafter, Duke Health Lake Norman Hospital shall evaluate all patients who are North Carolina residents and enrolled in Medicaid for past medical

⁴ An extraordinary collection action includes any of the following: reporting adverse information about the patient to a consumer reporting agency; actions that require a legal or judicial process (e.g., placing a lien on an individual's real property, commencing a civil action).

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debt within 60 days of the patient's inpatient discharge or outpatient encounter from the hospital, and must reclassify any past debt as charity care.

- c. Duke Health Lake Norman Hospital shall not advertise about the policy but must inform the Medicaid enrolled patient about the policy during the patient's encounter at the hospital.
- d. In addition, all past debt of Medicaid-enrolled patients that proactively contact the hospital to inquire about medical debt relief will be reclassified as charity care.
 - i. The patient's Medicaid enrollment will be confirmed prior to reclassifying past debt as charity care.

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Appendix A

The 2025 poverty guidelines are in effect as of January 17, 2025, as published by the Department of Health and Human Services on its website: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>.

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	Poverty guideline
1	\$15,650
2	\$21,150
3	\$26,650
4	\$32,150
5	\$37,650
6	\$43,150
7	\$48,650
8	\$54,1508
For families/households with more than 8 persons, add \$5,500 for each additional person.	
2025 Poverty Guidelines for Alaska	
Persons in family/household	Poverty guideline
1	\$19,550
2	\$26,430
3	\$33,310
4	\$40,190
5	\$47,070
6	\$53,950
7	\$60,830
8	\$67,710
For families/households with more than 8 persons, add \$6,880 for each additional person.	

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Appendix B

Duke Health Lake Norman Hospital's Charity Care Discount

As a service to our community, we offer a Charity Care Discount that applies a discount of the entire bill or on a sliding scale basis to patients eligible under our Financial Assistance Program ("FAP") who receive or are scheduled to receive emergency and Medically Necessary services at our facility. The level of discount provided to eligible patients under our Charity Care Discount policy will depend on several criteria, including (a) whether the patient meets the eligibility criteria for the Charity Care Discount under the FAP, (b) whether the patient has other funding sources that can be applied to the patient account, (c) validation of the patient's gross family household income through the FAP Application and Asset Test, and (d) whether the patient's income falls within a certain percentage of the current Federal Poverty Level ("FPL") Guidelines published by the Department of Health and Human Services at the time of evaluation, as further described below. The FAP Application and Asset Test request information from the patient that allows us to evaluate a patient's adjusted individual or family gross income under current FPL Guidelines and determine whether the patient qualifies for a Charity Care Discount.

Uninsured Patients

An Uninsured patient who has received or is scheduled to receive Medically Necessary Care may apply for a Charity Care Discount by submitting a complete FAP Application and all accompanying documentation requested on the FAP Application as part of our Asset Test to determine whether the patient's income falls within one of the below percentages of the current FPL, as validated through the FAP Application process and Asset Test under our FAP. However, we recognize that not all patients and guarantors are able to complete the FAP Application or provide requisite documentation. Accordingly, we also provide certain screening services using a health care industry-recognized predictive model based on public record databases to evaluate a patient's adjusted individual or family gross income under current FPL Guidelines, as part of our eligibility screening services offered to Uninsured patients at our facility ("Presumptive Eligibility"). We use the information from the predictive model to satisfy the documentation requirements required in the FAP Application process for a Charity Care Discount.

- Eligible patients with an adjusted individual or family gross income of under 200% of the FPL may receive a balance adjustment of the entire bill, if their financial status is validated via the Presumptive Eligibility Process.
- Eligible Patients with an adjusted individual or family gross income of 201%-300% of the FPL may receive a balance adjustment of 85% of their bill via the Presumptive Eligibility Process.
- Patients with an adjusted individual or family gross income of 301%-400% will receive a balance adjustment of 80% of their bill via the Presumptive Eligibility Process.

If an Uninsured patient qualifies for a partial discount based on gross family income validated through the Presumptive Eligibility process, the patient will still have an opportunity to qualify for a greater discount under the Charity Care Discount through the FAP Application process.

For non-emergency, scheduled services, the patient will be screened prior to or at check-in and will be notified of the results prior to check-out. No bill will be issued to the patient before this screening has occurred.

For emergency services, the patient will be screened as soon as possible (before discharge if possible) and will be notified of the results prior to issuance of a bill.

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Insured Patients

We recognize that some patients may have public or private insurance coverage that fails to fully cover their medical expenses for whom it would be a financial hardship to fully pay the out-of-pocket expenses for the care received. Accordingly, we have expanded our Charity Care Discount policy to apply to accounts for which other payment or funding sources exist, including Medicare benefits, if the Insured patient received medically necessary services and our screening services (using a health care industry-recognized predictive model based on public record databases to evaluate a patient's adjusted individual or family gross income under current FPL Guidelines) indicate that the patient meets criteria for assistance.

- Eligible patients with an adjusted individual or family gross income of under 200% of the FPL may receive a balance adjustment of the entire bill, if their financial status is validated via the Presumptive Eligibility Process.
- Eligible Patients with an adjusted individual or family gross income of 201%-300% of the FPL may receive a balance adjustment of 85% of their bill via the Presumptive Eligibility Process.
- Patients with an adjusted individual or family gross income of 301%-400% will receive a balance adjustment of 80% of their bill via the Presumptive Eligibility Process.
- Eligible patients with an adjusted individual or family gross income of 301%-400% of the FPL will receive a balance adjustment of 20% of the Balance Due on the patient's account that is greater than \$1,500.

For non-emergency, scheduled services, the patient will be screened prior to or at check-in and will be notified of the results prior to check-out. No bill will be issued to the patient before this screening has occurred.

For emergency services, the patient will be screened as soon as possible (before discharge if possible) and will be notified of the results prior to issuance of a bill.

Medical Indigency

Additionally, we have expanded our Charity Care Discount to patients who may exceed 400% of the FPL who meet our Medical Indigency criteria. Patients for whom the Balance Due on the patient's account exceeds 25% of the patient's annual gross income (after payment by third party payors) may receive a balance adjustment of 80% of the Balance Due.

Payment Plans

Patients with household incomes between 200-300% of FPL may be enrolled in a payment plan in the event that they are unable to pay the portion of their bill that is due after all applicable discounts are applied. The plan must not last longer than 36 months and the monthly payment may not be more than 5% of the patient's monthly household income. At the discretion of the facility or SSC CFO only, an alternative payment plan that lasts longer than 36 months may be offered to the patient, but the aggregate amount collected from the patient may not be higher than what would have been collected had the patient paid 5% of household income for 36 months.⁵⁶⁷

No interest will be charged for patient payment plans.

⁵ "Household" is defined in 42 CFR 435.603(f)(3), as outlined in footnote 4.

⁶ A Household's gross income may be determined using the FAP Application or through the Presumptive Eligibility evaluation process.

⁷ A payment plan that exceeds 36 months in duration may be arranged at the discretion of the Lake Norman Regional Medical Center CFO and/or the SSC VP/COO, but the aggregate amount collected from the patient—inclusive of principal and interest will not exceed what would have been collected during a 36-month/5% income plan.

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY
Effective 01/01/2025

Appendix C

Form 4506-T (June 2023) Department of the Treasury Internal Revenue Service	Request for Transcript of Tax Return ▶ Do not sign this form unless all applicable lines have been completed. ▶ Request may be rejected if the form is incomplete or illegible. ▶ For more information about Form 4506-T, visit www.irs.gov/form4506t .	OMB No. 1545-1872														
<p>Tip: Get faster service: Online at www.irs.gov, Get Your Tax Record (Get Transcript) or by calling 1-800-908-9946 for specialized assistance. We have teams available to assist. Note: Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: Tax Return Transcript (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), Tax Account Transcript (shows basic data such as return type, marital status, AGI, taxable income and all payment types), Record of Account Transcript (combines the tax return and tax account transcripts into one complete transcript), Wage and Income Transcript (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and Verification of Non-filing Letter (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).</p>																
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">1a Name shown on tax return. If a joint return, enter the name shown first.</td><td style="width: 50%; padding: 5px;">1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)</td></tr><tr><td style="width: 50%; padding: 5px;">2a If a joint return, enter spouse's name shown on tax return.</td><td style="width: 50%; padding: 5px;">2b Second social security number or individual taxpayer identification number if joint tax return</td></tr><tr><td colspan="2" style="padding: 5px;">3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)</td></tr><tr><td colspan="2" style="padding: 5px;">4 Previous address shown on the last return filed if different from line 3 (see instructions)</td></tr><tr><td colspan="2" style="padding: 5px;">5 Customer file number (if applicable) (see instructions)</td></tr></table>			1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)	2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return	3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)		4 Previous address shown on the last return filed if different from line 3 (see instructions)		5 Customer file number (if applicable) (see instructions)					
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4 Previous address shown on the last return filed if different from line 3 (see instructions)																
5 Customer file number (if applicable) (see instructions)																
<p>Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See What's New under Future Developments on Page 2 for additional information.</p>																
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶</td><td style="width: 50%; padding: 5px;"></td></tr><tr><td style="width: 50%; padding: 5px;">a Return Transcript, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days</td><td style="width: 50%; padding: 5px; text-align: right;"><input type="checkbox"/></td></tr><tr><td style="width: 50%; padding: 5px;">b Account Transcript, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days</td><td style="width: 50%; padding: 5px; text-align: right;"><input type="checkbox"/></td></tr><tr><td style="width: 50%; padding: 5px;">c Record of Account, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days</td><td style="width: 50%; padding: 5px; text-align: right;"><input type="checkbox"/></td></tr><tr><td colspan="2" style="padding: 5px;">7 Verification of Nonfiling, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days</td><td style="width: 50%; padding: 5px; text-align: right;"><input type="checkbox"/></td></tr><tr><td colspan="2" style="padding: 5px;">8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days</td><td style="width: 50%; padding: 5px; text-align: right;"><input type="checkbox"/></td></tr></table>			6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶		a Return Transcript , which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. 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<p>Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.</p>																
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 50%; padding: 5px;">9 Year or period requested. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.</td><td style="width: 50%; padding: 5px;"></td></tr><tr><td style="width: 50%; padding: 5px;">/ / / /</td><td style="width: 50%; padding: 5px;">/ / / /</td></tr></table>			9 Year or period requested. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.		/ / / /	/ / / /										
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/ / / /	/ / / /															
<p>Caution: Do not sign this form unless all applicable lines have been completed.</p>																
<p>Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. Note: This form must be received by IRS within 120 days of the signature date.</p>																
<table border="1" style="width: 100%; border-collapse: collapse;"><tr><td style="width: 60%; padding: 5px;"><input type="checkbox"/> Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.</td><td style="width: 40%; padding: 5px; text-align: right;">Phone number of taxpayer on line 1a or 2a</td></tr><tr><td style="width: 60%; padding: 5px;"><div style="display: flex; justify-content: space-between;"><div>Signature (see instructions)</div><div>Date</div></div></td><td style="width: 40%; padding: 5px;"></td></tr><tr><td style="width: 60%; padding: 5px;"><div style="display: flex; justify-content: space-between;"><div>Title (if line 1a above is a corporation, partnership, estate, or trust)</div><div></div></div></td><td style="width: 40%; padding: 5px;"></td></tr><tr><td style="width: 60%; padding: 5px;"><div style="display: flex; justify-content: space-between;"><div>Spouse's signature</div><div>Date</div></div></td><td style="width: 40%; padding: 5px;"></td></tr></table>			<input type="checkbox"/> Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.	Phone number of taxpayer on line 1a or 2a	<div style="display: flex; justify-content: space-between;"><div>Signature (see instructions)</div><div>Date</div></div>		<div style="display: flex; justify-content: space-between;"><div>Title (if line 1a above is a corporation, partnership, estate, or trust)</div><div></div></div>		<div style="display: flex; justify-content: space-between;"><div>Spouse's signature</div><div>Date</div></div>							
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DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY

Effective 01/01/2025

Form 4506-T (Rev. 6-2023)

Page **2**

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to www.irs.gov/form4506t. Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

The filing location for the Form 4506-T has changed. Please see **Chart for individual transcripts or Chart for all other transcripts** for the correct mailing location.

What's New. As part of its ongoing efforts to protect taxpayer data, the Internal Revenue Service announced that in July 2019, it will stop all third-party mailings of requested transcripts. After this date, masked Tax Transcripts will only be mailed to the taxpayer's address of record.

If a third-party is unable to accept a Tax Transcript mailed to the taxpayer, they may either contract with an existing IVES participant or become an IVES participant themselves. For additional information about the IVES program, go to www.irs.gov and search IVES.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506-T to request tax return information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Customer File Number. The transcripts provided by the IRS have been modified to protect taxpayers' privacy. Transcripts only display partial personal information, such as the last four digits of the taxpayer's Social Security Number. Full financial and tax information, such as wages and taxable income, are shown on the transcript.

An optional Customer File Number field is available to use when requesting a transcript. This number will print on the transcript. See Line 5 instructions for specific requirements. The customer file number is an optional field and not required.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart shows two different addresses, send your request to the address based on the address of your most recent return.

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 5. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number **should not** contain an SSN. Completion of this line is not required.

Note. If you use an SSN, name or combination of both, we will not input the information and the customer file number will reflect a generic entry of "999999999" on the transcript.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form**, 10 min.; **Preparing the form**, 12 min.; and **Copying, assembling, and sending the form to the IRS**, 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526

Washington, DC 20224

Do not send the form to this address. Instead, see **Where to file** on this page.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 855-587-9604
Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094



You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY

Effective 01/01/2025

Appendix D

Duke Health Lake Norman Hospital's FAP Application

Financial Assistance Program Application



Financial Assistance Program Application

Our hospital is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for Financial Assistance. Please complete and return the following form with requested documents to the Facility Registration Department or Financial Counselor to be evaluated for Financial Assistance.

Patient Account(s) #: _____

Date of Application: _____

of Qualified Household Members: _____

Dependent of Another: ☐ Yes ☐ No

(A Qualified Household Member includes any additional adult(s) and dependent(s) based on the tax filing status of the patient.)

PATIENT INFORMATION

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State/Zip: _____

State/Zip: _____

SSN (last 4 digits): ____ _

SSN (last 4 digits): ____ _

DOB: _____

DOB: _____

Employer: _____

Employer: _____

Address: _____

Address: _____

City: _____

City: _____

State/Zip: _____

State/Zip: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Length of Employment: _____

Length of Employment: _____

Supervisor: _____

Supervisor: _____

RESOURCES

Checking: ☐ Yes ☐ No Amount: \$ _____

Savings (including flexible spending and health savings accounts): ☐ Yes ☐ No Amount: \$ _____

Bonds: \$ _____

Cash on Hand: \$ _____

Certificate of Deposit(s): \$ _____

IRA Account(s): \$ _____

Roth Account(s): \$ _____

Stock/Other Financial Investment Account(s) (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)): \$ _____

Trust Fund Account(s): \$ _____

Vehicle 1: Yr: _____ Make: _____ Model: _____

Vehicle 2: Yr: _____ Make: _____ Model: _____

Vehicle 3: Yr: _____ Make: _____ Model: _____

Vehicle 4: Yr: _____ Make: _____ Model: _____

Vehicle 5: Yr: _____ Make: _____ Model: _____

(This includes recreational vehicles such as: boats, campers, etc.)

Financial Assistance Program Application

Not Part of the Medical Record

100-ADM-1202

03/21 (Rev. 08/21, 06/23)

Page 1 of 3

Patient Label

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY

Effective 01/01/2025

INCOME

Patient/Guarantor Wages
(monthly): \$ _____

Spouse/Second Parent Wages
(monthly): \$ _____

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers Comp: \$ _____

SSI: \$ _____

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers Comp: \$ _____

SSI: \$ _____

LIVING ARRANGEMENTS

Primary Residence:

☐ Rent: \$ _____ ☐ Own: \$ _____ ☐ Other (explain): \$ _____

Landlord/Mortgage Holder: _____

Phone Number: _____ Monthly Payment: \$ _____

Second Home/Other Property: ☐ Rent: _____ ☐ Own: _____ (check one)

Value: \$ _____ Loan Amount: \$ _____ Payment: \$ _____

House Rent/Mortgage Payment: \$ _____

Other Property Payment: \$ _____

Utilities: \$ _____

Gas: \$ _____

Auto: \$ _____

Loans: \$ _____

Medical Bills: \$ _____

Food: \$ _____

Child Support: \$ _____

Other: \$ _____

REQUESTED AVAILABLE DOCUMENTS

Proof of Income:

- ☐ Last 4 paystubs
- ☐ Letter from employer
- ☐ Social Security benefits (if applicable)
- ☐ Last 3 months bank statements
- ☐ Previous year's Federal Tax Return

Proof of Expenses:

- ☐ Copy of mortgage payment OR
- ☐ Copy of rental agreement
- ☐ Other documents requested
- ☐ Copies of monthly bills

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in the denial of any financial assistance by the hospital.

Signature of Applicant: _____

Hospital Representative completing the application: _____

Financial Assistance Program Application

Not Part of the Medical Record

100-ADM-1202

03/21 (Rev. 08/21, 06/23)

Page 2 of 3

Patient Label

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY
Effective 01/01/2025

Financial Assistance Approval Worksheet											
Hospital Name:	Date Submitted:										
Patient Name:	Account Number(s):										
# in Household:	Balance Due:										
Total Yearly Income:	Service: OP/IP/ER										
Comments:											
<p>Check box the appropriate financial assistance being offered by the hospital.</p> <p><input type="checkbox"/> YES Approved for 100% financial assistance</p> <p><input type="checkbox"/> YES Approved for partial financial assistance _____ % assistance</p> <p><input type="checkbox"/> NO Patient does not qualify for financial assistance</p> <p>Hospital Representative completing this review: _____</p> <p>Approved by:</p> <table style="width: 100%;"><tr><td style="width: 50%; border-bottom: 1px solid black; text-align: center;">SSC Director</td><td style="width: 50%; border-bottom: 1px solid black; text-align: center;">SSC CFO/VP</td></tr><tr><td style="text-align: center;">Date</td><td style="text-align: center;">Date</td></tr><tr><td colspan="2" style="height: 50px;"></td></tr><tr><td style="border-bottom: 1px solid black; text-align: center;">CFO</td><td style="border-bottom: 1px solid black; text-align: center;">CEO</td></tr><tr><td style="text-align: center;">Date</td><td style="text-align: center;">Date</td></tr></table>		SSC Director	SSC CFO/VP	Date	Date			CFO	CEO	Date	Date
SSC Director	SSC CFO/VP										
Date	Date										
CFO	CEO										
Date	Date										

Appendix E

Duke Health Lake Norman Hospital's Uninsured Discount

Duke Health Lake Norman Hospital offers a discount of 65% from gross charges for all Uninsured patients that are not found to be presumptively eligible or eligible via application for the facility's Charity Care discounts.

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY Effective
01/01/2025

Appendix F

Duke Health Lake Norman Hospital's Catastrophic Claim Discount

Duke Health Lake Norman Hospital offers a discount for patient accounts that meet the eligibility requirements for the Catastrophic Care Discount under this Policy. For eligible Uninsured patient accounts with balances of at least \$50,000.00 after applying Duke Health Lake Norman Hospital's Uninsured Discount or a partial charity discount, the patient balance for a Catastrophic Claim will be reduced to a maximum patient responsibility of \$50,000.

DUKE HEALTH LAKE NORMAN HOSPITAL FINANCIAL ASSISTANCE AND DEBT MITIGATION POLICY
Effective 01/01/2025

Appendix G

Patient Screening Questionnaire

(to be completed by Patient Access or ESS personnel and documented in patient account)

1. Is the patient experiencing Homelessness? (*circle one*) Yes No
2. Is the patient mentally incapacitated? (*circle one*) Yes No
 - a. If yes, does the patient have a guardian or other advocate that is able to make financial decisions on the patient's behalf? (*circle one*) Yes No
3. Is the patient or a child in the patient's household enrolled in Medicaid? (*circle one*) Yes No
4. Is the patient enrolled in any programs like SNAP (Food Stamps) or WIC (Women, Infants and Children Nutritional Program), TANF (Temporary Assistance for Needy Families), LIEAP (Low Income Energy Assistance Program), etc.? (*circle one*) Yes No

Patient Attestation

I, _____ [print patient name] attest that all answers provided above are truthful to the best of my knowledge.

Patient/Representative Signature

Date