.15	CHAPMAN GLOBAL MEDICAL CENTER POLICY AND PROCEDURE		
Title:	**CHARITY CARE/DISCOUNT CARE POLICY**		
Manual:	**BUSINESS OFFICE PROCEDURE MANUAL**	**Policy No.:**	02.06.02
Original Date: 3/08/2005	**Revised Date:** 2/01/2015	**Reviewed Date:** 4/01/2015	

PURPOSE:

The purpose of this Policy is to define the criteria which will be used by KPC Healthcare Inc.'s hospitals – Anaheim Global Medical Center, Chapman Global Medical Center, Orange County Global Medical Center, and South Coast Global medical Center - hereinafter each referred to a "Facility", to comply with the requirements of the California Hospital Fair Pricing Policies Act..

SCOPE:

All KPC facilities' Admitting and Patient Accounting Platforms (Central Business Office)

DEFINITIONS:

Charity Care: Charity care is defined as medically necessary inpatient or outpatient hospital services provided at no cost to a patient who (1) is an Uninsured Patient or a Patient with High Medical Costs, (2) has an income equal to or less that 199% of the current applicable federal poverty guideline (FPG) and (3) has established qualification in accordance with requirements contained in this policy.

Discount Payment: A discount payment is defined as partial financial assistance that results from any medically necessary inpatient or outpatient hospital service provided to a patient who: (1) desires assistance with paying their hospital bill , (2) is Uninsured or is a Patient with High Medical Costs, (3) has an income from 200% to 350% of the applicable FPG; and (4) who has established qualification in accordance with requirements contained in this policy.

Federal Poverty Guidelines ("FPG"): The Federal Poverty Guidelines are guidelines issued and updated periodically by the United States Department of Health and Human Services that establish the gross income eligibility criteria (based on family size) for Charity Care and Discount Payment status as described in this Policy.

Good Faith Estimate: An amount quoted by Facility Registration staff that represents a reasonable approximation of the actual price to be paid for services received by the patient at the Facility. If a Good Faith Estimate is reasonably required, Registration staff

will make their best efforts to develop and quote a Good Faith Estimate, however, registration staff may not be able to fully predict the actual medical services that will subsequently be ordered by the patient's attending, treating or consulting physician(s).

Medically Necessary Services: Financial assistance under this policy shall only apply to medically necessary services which are services or supplies determined to be proper and needed for the diagnosis, direct care or treatment of the medical condition and meet the standards of good medical practice in the medical community. Financial assistance is excluded under this policy for services that are not medically necessary including, but not limited to, unique services where medically efficacious alternative therapies are available. Examples of excluded services include, but are not limited to, the following: cosmetic and/or plastic surgery services, infertility services, or other services that are primarily for patient comfort and/or patient convenience.

Patient with High Medical Costs: A patient is considered to have high medical costs if he or she has (1) a family income equal to or less than 350% of the applicable FPG and (2) annual out of pocket medical expenses aid and/or incurred by the patient or the patient's family in the past 12 months that exceed 10% of the patient's family income, provided the patient provides documentation of the patient's expenses paid by the patient or the patient's family in the prior 12 months

Patient's Family: A Patient's family means the following:

1. For persons 18 years of age and older: spouse, domestic partner, as defined in Section of the California Family Code, and dependent children under 21 years of age, whether living at home or not.

    a. Domestic Partner: A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
    (1) Both persons have a common residence.
    (2) Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
    (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
    (4) Both persons are at least 18 years of age.
    (5) Either of the following:
    (A) Both persons re members of the same sex.
    (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-

age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

(6) Both persons are capable of consenting t the domestic partnership.

2. For persons under 18 years of age: parent, caretaker relatives and other children under 31 years of age of the parent or caretaker relative.

Policy: A reference to "this policy" shall refer to this Charity Care/Discount Payment Policy.

Qualified Payment Plan: A payment plan established for a patient who has qualified for a Discount Payment through this Policy is classified as a Qualified Payment Plan. A Qualified Payment Plan shall have no interest charges applied to any or all balances due from the patient/guarantor. In the event that the Facility and the patient/guarantor cannot reach agreement on terms for a Qualified Payment Plan, the Facility shall use the formula described in Health & Safety Code Section 127400(i) to establish terms for a "reasonable payment plan," as defined in the statute.

Uninsured Patient: An Uninsured Patient is a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance as determined and documented by the Facility.

POLICY:

I. Charity Care/Discount Payment Qualification Requirements. Depending upon Individual patient qualification, financial assistance in the form of Charity Care or a Discount Payment may be granted to the patient. If a person requests charity care or a discount payment and fails to provide information that is reasonable and necessary for the Facility to make a determination, the Facility may consider that failure in making its determination. Financial assistance may be denied when the patient/responsible person does not meet the qualification requirements under this Policy.

II. Patient Cooperation: This Policy relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, the Facility utilizes a Financial assistance Application. All patients unable to demonstrate financial coverage by

third party insurers will be offered an opportunity to complete the Financial Assistance Application.

Patients are required to provide accurate and truthful eligibility documentation reasonably necessary to make a determination of the patient's qualification for financial assistance coverage through any government coverage program or this Policy. Patient should expect and are required to pay any or all amounts due at the time of service. Said amounts due may include, but are not limited to, copayments and deductibles.

III. Process and Procedure.

A. Eligibility. A patient is eligible for financial assistance under this Policy if (1) the patient's family income is equal to or less than 350% of the applicable FPG and (2) the patient is either an Uninsured Patient or a Patient with High Medical Costs.

Eligibility alone is not an entitlement to financial assistance qualification under this Policy. The patient must complete the Financial Assistance Application and provide all required documentation and the Facility must complete a process of applicant evaluation and determine qualification before charity care or a discount payment may be extended to the patient.

B. Other Insurance Options. Uninsured patients will also be (1) offered information, assistance and referral to government-sponsored programs for which they may be eligible and (2) provided information regarding insurance coverage through Covered California. Uninsured patients will also be provided with contact information for local consumer legal assistance center which may assist the uninsured patient with obtaining health benefits coverage.

C. Completion of a Financial Assistance Application.

1. The Financial Assistance Application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

2. The Financial Assistance Application provides:

a. Information necessary for the Facility to determine if the patient has income sufficient to pay for services.
b. Documentation useful in determining qualification for financial assistance; and
c. An audit trail documenting the Facility's commitment to providing financial assistance.

3. In certain circumstances, a completed Financial Assistance Application may not be required if the Facility, in its sole discretion, determines it has sufficient patient financial information from which to make a financial assistance qualification decision.
4. If a patient applies or has a pending application for another health coverage program at the same time he or she applies for financial assistance under this Policy, neither application shall prevent the patient for establishing eligibility under the other program.

D. Determination Based On Ability to Pay. Qualification for charity care or a discount payment shall be determined solely based on the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, gender identity, ethnicity, national origin, veteran status, disability or religion. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the Facility retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

E. Asset/Income Qualification.

1. For Discount Payments: Family size and documentation of family income in the form of federal income tax returns and recent pay stubs.

2. For Charity Care:

a. Family size and documentation of income and assets including information on all monetary assets including, without limitation, federal income tax returns, recent pay stubs, and/or other relevant information, but including statements on retirement or deferrre3d compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. The Facility may require waivers or

releases from the patient or patient's family, authorizing the Facility to obtain account information from financial commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value.

b. A patient's family assets may be evaluated to determine if sufficient patient household resources exist to satisfy the Facility's bill for services rendered. Evaluation of patient assets will consider both the asset value and amounts owed against the asset to determine if potential net worth is available to satisfy the patient payment obligation. Recognizing the need to protect basic household assets, each patient family unit evaluat3d will be allowed the following asset exemptions:

i. Primary residence;
ii. One vehicle per patient or two vehicles per family unit;
iii. The first $10,000 of monetary assets, and 50% of monetary assets after the first $10,00; and
iv. Retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans.

Patients who have assets beyond those specifically exempted will be expected to leverage the assets through independent financing in order to satisfy the patient account.

F. Catastrophic Medical Event. Any patient who experiences a catastrophic medical event may be deemed eligible for financial assistance as determined in the Facility's sole discretion. The determination of a catastrophic medical event shall be based upon the amount of the patient's family income and assets as reported at the time of occurrence. As a general guideline, any account with a patient liability for services rendered that exceeds $100,00 may be considered for eligibility as a catastrophic medical event.

G. Pricing Guidelines. If a patient qualifies for a Discount Payment, the Facility shall limit the expected payment for medically necessary services rendered to the amount the Facility would expect, in good faith, to receive for providing the services from Medicare, Medi-Cal or any other government –sponsored health program of health benefits in which the Facility participates, whichever is greater. If the Facility provides a service for which there is not established payment by a government-sponsored program, the Facility shall establish an appropriate discount payment. Generally, the following rates shall apply:

California Fair Pricing Rates-Reference Sheet

Services	Rates
Emergency Room	Medicare guidelines
Outpatient Ancillary services	Medicare guidelines
Outpatient surgery/invasive services	*Greater of: Medicare guidelines or CalOptima Direct Adult Expansion guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*
Inpatient Services:	
OB Delivery	*Greater of: Medicare guidelines or CalOptima Direct Adult Expansion guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*
Outpatient OB observation	*Greater of: Medicare guidelines or CalOptima Direct Adult Expansion guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*
NICU	*Greater of: Medicare guidelines or CalOptima Direct Adult Expansion guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*
Trauma	*Greater of: Medicare guidelines or CalOptima Direct Adult Expansion guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*
Burn	*Greater of: Medicare guidelines or CalOptima Direct guidelines; and the cost for implants (if applicable) is equal to or greater than $3K cost*

H. Qualified Payment Plans.

1. When the Facility has determined a patient is qualified for a discount payment, the patient shall have the option to pay any or all outstanding amounts due in one lump sum payment or through a scheduled term Qualified Payment Plan. The Facility will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 36 months.

2. Reasonable Payment Plan. KPC Healthcare shall negotiate in good faith with the patient; however the Facility is not obligated to accept the payment terms offered by the patient. In the event that the Facility and an individual patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, he Facility will use the "reasonable payment plan" formula as defined in Health & Safety Code Section 127400(i) as the basis for a payment plan. A "reasonable payment plan" means monthly payments that are not more than 10% of patient's family income for a

month, excluding deductions for essential living expenses as such expenses are defined in the statute.

In order to apply the "reasonable payment plan" formula, the Facility shall collect patient family information on income and "essential living expenses" in accordance with the statute. The Facility shall use a standardized form to collect such information. Each patient or guarantor seeking to establish a payment plan by applying the "reasonable payment plan" formula shall submit the family income and expense information as requested, unless the information request is waived by the Facility.

3. No Interest. No interest will be charged to Qualified Payment Plan accounts for the duration of any plan arranged under the provisions of the Policy.

4. Payment Default. Once a Qualified Payment Plan has been approved by the Facility, any failure to pay all consecutive payments due may constitute a payment plan default. It is the patient or guarantor's responsibility to contact the Facility's Central Business Office if circumstances change and payment plan terms cannot be met. However, in the event of payment plan default, the Facility will make a reasonable attempt to contact the patient or their family representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the extended Qualified Payment Plan and may do so by contacting the Central Business Office within twenty-one (21) days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the Qualified Payment Plan within twenty-one (21) days, the payment plan will be deemed inoperative and the account may become subject to collection actions as permitted by law.

IV. Emergency Physician. An emergency physician, as defined in Health and Safety Code Section 127450, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to Uninsured Patients or Patients with High Medical Costs who are at or below 350% of the applicable FPG. This statement shall not be construed to impose any additional responsibilities upon the Facility.

V. Public Notice. The Facility shall post notices informing the public of this Policy.

Such notices shall be posted in high volume inpatient, and outpatient service areas, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas in the Facility. Notices shall also be posted at any location where a patient may pay his or her bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where apply for such assistance.

Exhibit A – Financial Assistance Referral Form/Instructions

HOSPITAL NAME

HOSPITAL ADDRESS

FINANCIAL ASSISTANCE

(For Medi-Cal, Victims of Crime, California Children's Services Program, Charity Care or Discount Program.)

INSTRUCTION **Visit/Invoice #:** _____

1. Please complete all areas on the attached application. If any area does not apply to you, write N/A in the space provided.

2. Attach an additional page if you need more space to answer any question.

3. You must provide proof of income when you submit this application. The following documents are accepted as proof of income:

   If you filed a federal income tax return, you must submit a copy:

   a. Federal income tax return (Form 1040) from the most recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;
   b. Federal W-2 Form showing wages and earnings;

   If you did not file a federal income tax return, please provide the following:

   a. Two (2) most recent paycheck stubs;
   b. Two (2) most recent check stubs from any Social Security, child support, unemployment, disability, alimony or other payments;
   c. Two (2) consecutive bank statements;
   d. If you are paid only by cash, please provide a written statement explaining your income sources. If you have no income, please provide a letter explaining how you support yourself/family.

4. Your application cannot be processed until all required information is provided.

5. It is important that you complete, sign and submit the financial assistance application along with all required attachments within fourteen (14) days.

6. You must sign and date the application. If the patient/guarantor and spouse provide information, both must sign the application.

7. If you have any questions, please call your representative.

   Account Representative: _____

   Phone number: _____

   Send your completed application to:

   HOSPITAL NAME
   C/O MEP Dept.
   HOSPITAL ADDRESS

Exhibit B – Confidential Medical and Financial Assistance Application

Facility:	Visit/Invoice #:	Patient Name:	SSN:	DOB:
Patient Address:				
Patient Home Phone:		Patient Work Phone:		

SECTION A

MEDICAL ASSISTANCE SCREENING– *Please check answers "Y" for yes to "N" for no.*

	Y / N		Y / N
1. Is the patient under age 21 or over age 65?	☐ / ☐	*5. Is the patient pregnant, or was the admission pregnancy related?*	☐ / ☐
2. Is the patient a single parent of a child under age 21?	☐ / ☐	*6 Will the patient potentially be disabled for 12 months?*	☐ / ☐
3. Is the patient a caretaker or guardian of a child under 21?	☐ / ☐	*7. Is the patient a Victim of Crime?*	☐ / ☐
4. Is the patient a married parent of a minor child? *If yes, does the patient have a 30-day incapacitation?*	☐ / ☐	*8. Does the patient have a "COBRA" or insurance policy that the premium has lapsed?*	☐ / ☐

SECTION B

In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:			Relationship to patient:
SSN:	DOB:		
Home Address:			Phone #:
Work Address:			Phone #:
Gross Income**: $**	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly		
	Hours Per Week:		
Responsibility Party:			
SSN:			
Home Address:	DOB:		
Work Address:			Phone #:
Gross Income**: $**			Phone #:
Hours Per Week:	Circle One - ☐ Hourly ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly		

SECTION C

HOMELESS AFFIDAVIT

I, _____, herby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others.

Patient/Guarantor Initials_____

ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided herein is true and correct. I understand that providing false information will result in the denial of this Application. Additionally, depending upon local or state statutes, providing false information to defraud a hospital for obtaining goods or services may be considered an unlawful act. I also acknowledge and consent that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that **KPC** Charity Care program(s) is a "Payer of Last Resort" and hereby confirm all prior assignments of benefits and rights, which may include liability actions, personal injury claims, settlements, and any and all insurance benefits which may become payable, for fitness or injury, for which KPC or its' subsidiaries provided care.

_____ _____

PATIENT/GUARANTOR SIGNATURE **DATE**

with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance atue, may be punishable

by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify ation provided herein. I fully

understand that KPC Charity Care programs is a "Payer of Last Resort" and hereby assign all benefits due from any liability action, nal injury claims, forth

settlements, and any and all insurance benefits which may become payable or fitness or injury for **which KPC** provided care.

PATIENT/GUARANTOR SIGNATURE **DATE**

Exhibit C – Financial Assistance Worksheet

FINANCIAL ASSISTANCE WORKSHEET

Determine if case is catastrophic or non-catastrophic. if the hospital gross charges are more than annual income, the case may be considered catastrophic.

For Charity recommendation, patient must meet at least 100% of FPG or higher. All others not meeting charity will follow current AR collection effort and may access Dept's prompt payment discount and/or flat rate policy.

Current Gross (annual) income					$ -
Account Gross Charges					$ -
		Annual FPG	**Fmly Size**	**% FPG**	
$ -	Divided by	$ -	0	#DIV/0!	

**Remember: - When calculating income, be consistent - use annual in all your calculations.

FEDERAL POVERTY GUIDELINES (eff. 4/1/15)

Size of Fmly	48 States Gross Annually			
	100% FPG	199% FPG	200% FPG	350% FPG
1	$ 11,770.00	$ 23,422.30	$ 23,540.00	$ 40,989.03
2	$ 15,930.00	$ 31,700.70	$ 31,860.00	$ 55,476.23
3	$ 20,090.00	$ 39,979.10	$ 40,180.00	$ 69,963.43
4	$ 24,250.00	$ 48,257.50	$ 48,500.00	$ 84,450.63
5	$ 28,410.00	$ 56,535.90	$ 56,820.00	$ 98,937.83
6	$ 32,570.00	$ 64,814.30	$ 65,140.00	$ 113,425.03
7	$ 36,730.00	$ 73,092.70	$ 73,460.00	$ 127,912.23
8	$ 40,890.00	$ 81,371.10	$ 81,780.00	$ 142,399.43
9	$ 45,050.00	$ 89,649.50	$ 90,100.00	$ 156,886.63
10	$ 49,210.00	$ 97,927.90	$ 98,420.00	$ 171,373.83
Each addtl person, add	$ 4,160.00	$ 8,278.40	$ 8,320.00	$ 14,560.00

Recommendation:

Family Size:	0	Account No(s)	Balance	Pt Type (inpt,OP, ER)
Gross Annual Family Income:	$0.00			
FPG Based on Family Size:	$0.00			
Current Hospital Charges:	$0.00			
Income/FPG:	0%			
Income X2:	$0.00			

Recommendation:

Prepared by Date

Approved/Denied by Date Title

> $10K CFO Approved/Denied Date

Reason of Denial:

Adjmnt code: **W/O recommendation:** **$ -**

Exhibit D – Approval Letter

Central Business Office
1301 N. Tustin Avenue
Santa Ana, CA 92705

Full Financial Assistance Determination- Approval

Notice date

Patient/Guarantor Name
Guarantor's address 1
Guarantor's address 2

Hospital:
Account Number:
Patient Name:
Admit/Service Date:
Balance:

Dear Sir / Madame

We have completed our review of your request for financial assistance. Based on the guidelines established by the hospital it has been determined that you meet the minimum requirements for financial assistance. *The entire balance of your account has been approved for full financial assistance and closed.* You will receive no further bill from the hospital regarding this account.

Please note, this financial assistance only applies to the above hospital account and it does not apply to Physician, Lab, ambulance or any other medical bills.

Should you have any questions regarding the above, please call *(714) XXX-XXXX* between 10:00AM - 4:00PM Monday through Friday.

Thank you for choosing *Hospital name* for your healthcare needs.

Sincerely

Exhibit D – Approval Letter

Central Business Office
1301 N. Tustin Avenue
Santa Ana, CA 92705

Full Financial Assistance Determination- Approval

Notice date

Patient/Guarantor Name
Guarantor's address 1
Guarantor's address 2

Hospital:
Account Number:
Patient Name:
Admit/Service Date:
Balance:

Dear Sir / Madame

We have completed our review of your request for financial assistance. Based on the guidelines established by the hospital it has been determined that you meet the minimum requirements for financial assistance. *The entire balance of your account has been approved for full financial assistance and closed.* You will receive no further bill from the hospital regarding this account.

Please note, this financial assistance only applies to the above hospital account and it does not apply to Physician, Lab, ambulance or any other medical bills.

Should you have any questions regarding the above, please call *(714) XXX-XXXX* between 10:00AM - 4:00PM Monday through Friday.

Thank you for choosing *Hospital name* for your healthcare needs.

Sincerely