Mendocino Coast District Hospital
Policy and Procedure

Section: Patient Accounting
Number 8530.215
Page: 1of 6

Title: Charity Care & Discount Payment Policy

Purpose: To establish the basic procedures needed for the granting of full or partial charity care and discounted payments for financially qualified hospital patients.

The following policy identifies circumstances under which Mendocino Coast District Hospital will extend charity care and discounted payment arrangements to qualified patients.

Policy: To provide healthcare to support the efforts of those who lack financial resources to obtain healthcare. The evaluation of the ability to receive medical care at Mendocino Coast District Hospital, for any patient, will be based primarily upon clinical necessity. However, a consideration of financial status may be necessary under certain circumstances. In cases where there exists an urgent condition (where the patient requires immediate attention for care and treatment) or emergency medical condition (where the patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions) Mendocino Coast District Hospital's evaluation of possible payment alternatives will occur only after such medical evaluation and care have been rendered. In cases of elective (scheduled) services, Mendocino Coast District Hospital evaluation of possible payment alternatives will occur prior to care being rendered. After clinical and/or financial evaluation, Mendocino Coast District Hospital may refer individuals to appropriate alternative programs or services. Charity Care will only be applied to Emergency Care (Definition 1.5). The Discount Payment Policy will be applied to either Emergency Care or Elective Services (Definition 1.6). Cases with exceptional circumstances will be referred to the Chief Financial Officer for evaluation and determination.

Confidentiality of information and the dignity of the individual will be maintained for all who seek and/or are provided assistance. Procedures developed to implement the policies shall not be construed as a means to deny urgent or emergency medical care to anyone on the basis of their ability to pay. It is the patient's or their designated guardian responsibility to provide the necessary information to evaluate the patient's financial circumstance.

Procedure:

1.0 <u>Definitions</u>

1.1 Applicant: Applicant may be the patient, or in the case of a dependent child or adult, a family member, guarantor and/or guardian.

1.2 Bad Debt: Money owed by a patient who demonstrates the ability and unwillingness to pay for services.

1.3 Charity Care Chart of Approval: Mendocino Coast District Hospital policy, which identifies and delineates the limits of governance and administration of fiscal discretion as it relates to charity allowance.

1.4 Mendocino Coast District Hospital Policy: Policy which sets out requirements to provide care to the poor and benefit to the community assuring fulfillment through uniform accountability mechanisms.

1.5 Emergency Care: Condition manifesting itself by acute systems of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, including a pregnant woman or fetus, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, as well as an appropriate medical screening exam, as defined by Emergency Medical Treatment and Active Labor Act (EMTALA).

1.6 Elective Services: Services, which do not meet emergency criteria, listed above and any service that is not life threatening or potentially disabling. Elective Services are not eligible for a charity discount or discount payments.

1.7 Collection Coordinator: An employee empowered by Mendocino Coast District Hospital to accept and evaluate Financial Assistance Applications and to recommend charity-allowance, discount payment eligibility, and submission to outside Collection Agency.

1.8 Medically Necessary: Services provided by a physician or other providers to identify or treat an illness, injury or condition and which in the opinion of the physician or other provider are:

1.8.1 Consistent with the symptom(s), diagnosis and treatment of the condition, disease, ailment, or injury.

1.8.2 Not primarily for the convenience of the patient, the patient family, the physician or other provider.

1.8.3 The most appropriate level of service which can safely be provided to the patient.

1.9 Medicare Co-insurance: Patient's portions of the charges for healthcare services received as a Medicare beneficiary as mandated by the federal government. For inpatient care, this is mandated on a daily basis for designated time periods. For outpatient care, this is mandated per visit.

1.10 Medicare Deductible: Amount mandated as a lump sum by the federal government that is the patient's responsibility for a designated time period for inpatient care, as well as the annual amount mandated by the federal government that is the patient's responsibility for outpatient care.

1.11 Medicare Non-Covered Charges: Charges that are specified by Medicare as non-reimbursable services to the provider but qualify to be billed to the patient. While these charges are the patient's responsibility, he/she may be eligible for charity care consideration.

1.12 Service(s) Rendered: Diagnosis and treatment of a condition, disease, ailment, or injury by a physician or other provider of Mendocino Coast District Hospital. For the purpose of this policy, any reference to services or services rendered are deemed to be medically necessary.

1.13 Urgent Care: Condition that is deemed to be medically necessary by a physician after examination of the patient, usually in the physician office. In the physician's opinion, if admission does not occur, this could develop into a life threatening condition. The patient is sent from the physician's office to be admitted the same day.

2.0 Eligibility Criteria:

2.1 Charity status or Discount Payment status will be determined at the time of Pre-registration/registration, when service is rendered, or as soon as possible thereafter.

2.2 Charity or Discount Payment referrals are primarily initiated by Registration and the Collection Coordinator. Approvals for patient charity care assistance payments will follow the Charity Care Chart of Approval (attachment A).

2.3 All potentially eligible patients may be screened by the Collection Coordinator for assistance through federal, state, county and other social service programs during the charity care review process. Collection Coordinator may work collaboratively with Case Management and Social Services to explore alternative financial resources for the patient. This will be done for every visit.

2.4 Notification of any changes is the responsibility of the patient.

2.5 The purpose of the patient's application for Charity Care or Discount Payment Assistance (attachment B) is to determine a patient's ability to pay for services at Mendocino Coast District Hospital, to determine a patient's possible eligibility for public assistance, or other resources, and to develop an appropriate payment plan.

2.6 Information collected on the Financial Assistance Application will be reviewed for completeness by the Collection Coordinator. The applicant and witness signatures will certify that the information contained in the document is accurate.

2.7 Statistical information, with reference to this policy, will be provided to local and state agency in accordance with legislative guidelines.

2.8 Applicants will be measured against the Mendocino Coast District Hospital standard for charity care, which is 250% above the most current Federal Poverty Guidelines. The results of the financial review will be valid for the date of service initially applied for and any remaining days in that calendar month.

2.7 A patient may request reconsideration of a denial or the amount awarded for charity care assistance or discounted payments. Requests should be in writing to the Collection Coordinator. Requests for reconsideration will be judged individually after review by the Chief Executive Officer.

2.9 Charity Care will only be applied to Emergency Care (Definition 1.5). The Discount Payment Policy will be applied to either Emergency Care or Elective Services (Definition 1.6).

3.0 Eligibility Documentation Verification

3.1 Providing documentation used to determine eligibility for charity care or discount payments is the responsibility of the applicant. The Collection Coordinator will ensure that all requested information is provided and that the application form has been reviewed for completeness. The Collection Coordinator may accept a signed and witnessed statement of income if other documentation required in Section 3.2 is not available.

3.2 Required documentation is in accordance with Mendocino Coast District Hospital guidelines and California Law AB 774 and is listed in detail in the Instructions for Application for Charity Care Assistance or Discount Payment Policy (Attachment C). The application will be used first to determine eligibility for Charity Care under the guidelines applicable. If Charity Care is denied then application will be looked at in accordance with Discount Payment Policy guidelines (see section 4.3).

3.3 When it is determined that an applicant qualifies for other aid, he/she is required to complete and submit application for public assistance programs **within 10 days from the date of service**, including and not limited to Medi-Cal, as a condition for approval for charity care. If the applicant is denied coverage by Medi-Cal or other public assistance program based on income, then the application can be reviewed by Mendocino Coast District Hospital for Charity Care or Discount Payment Policies. If the applicant does not fulfill the applications process for public assistance and is denied coverage, the applicant will not be eligible for Mendocino Coast District Hospital's Charity Care or Discount Payment Policies.

3.4 Charity care correspondence from Mendocino Coast District Hospital to applicant will include:

3.4.1 Acknowledgement of application pending review (Attachment D)

3.4.2 Confirmation of acceptance/approval (Attachment E)

3.4.3 Denial of application/request for consideration (Attachment F)

3.4.4 Information request letter (Attachment G)

3.5 Timely application to public assistance and Mendocino Coast District Hospital must be met in order for the applicant to be considered for the Charity Care or Discount Payment Policies. Timeliness guidelines for public assistance: application must be submitted within the month the services were rendered. Timeliness guidelines for MCDH Charity Care and Discount Payment Policies: application must be submitted to MCDH within 30 days from the date of service or 10 days from income denial from Medi-Cal or other public assistance.

4.0 Methodology for Calculating the Amount of Charity Care/Discount Payments

4.1 The income and assets identified in the application for Charity Care Assistance (Attachment B) will be used in the Charity Care Determination Worksheet (Attachment H) to determine a patient's eligibility for charity care under the Federal Poverty Guidelines and Mendocino Coast District Hospital Guidelines.

4.2 The total gross annual income and monetary assets calculated in the Charity Care Determination Worksheet will be applied to the Formula for Charity Care Assistance (Attachment I), which will be used to determine the amount of the applicant's share of charges.

4.3 For the purpose of determining eligibility for Discount Payments, documentation will be limited to the recent pay stubs or income tax returns.

4.4 Once eligibility for Discount Payments has been determined MCDH will extend a payment plan for no longer than twelve (12) months.

4.4.1 If the applicant is meeting payment obligations, the interest will be waived. If at any time the payment obligations are not met the entire balance left on the account and the accrued interest will be turned over to an outside collection agency.

REVISED: 12/06

Reviewed and Approved:

_____

Business Office Manager Date

_____

Chief Financial Officer Date

_____

Chief Executive Officer Date

_____

President, Board of Directors Date

Attachment B
Mendocino Coast District Hospital
Application for Charity Care Assistance

Date _____

Section A

1. Patient's Name_____
Last First Middle

2. Home Address_____
_____
City State Zip

3. Phone Number _____SS# _____Date of Birth_____

4. Employer_____
_____
Name Address

5. Employer Phone Number (____)_____How Long? _____Occupation_____
Yrs/Mon

6. Other Employment_____
_____
Name Address Phone

Section B Spouse, Parent or Guarantor Information (If Applicable)

1. Spouse, Parent or Guarantor Name_____

Last First Middle

2. Home Address_____ _____
City State Zip

3. Phone Number _____SS# _____Date of Birth_____

4. Employer_____ _____
Name Address

5. Phone Number _____How Long _____Occupation _____

6. Other Employment_____ _____
Name Address Phone

Section C **Other Parent Information (If Applicable)**

1. Spouse, Parent or Guarantor Name_____
Last First Middle

2. Home Address_____ _____
City State Zip

3. Phone Number _____SS# _____Date of Birth_____

4.
Employer_____
_____
Name Address

5. Phone Number _____How Long
_____Occupation _____

6. Other
Employment_____
_____
Name Address
Phone

Section D **Dependent Information**

Full Name	Date of Birth	Social Security Number	Dependent Lives in Household Yes or No

_____
_____

Section E **Income Information**

Source Of Income	Gross Amount	Monthly or Weekly
1. Employment Patient	$	

2. Employment Spouse, Parent or Guarantor	$
3. Alimony Received	$
4. Child Support Received	$
5.	$
5. Disability SSI/AFDC (Medi-Cal)	$
6. Food Stamps Received	$
7. Interest and Dividend Income	$
9.	$
8. Regular Income from Operation of Business or Profession	$
9. Other Income-----Specify Source	$

Section I **Asset Information**

Description	What is Current Value	What is Owed
1. Cash, Savings, Checking Accounts	$	$
2. Certificate of Deposits (CD's)	$	$
3. U.S. Savings Bonds, US Treasury Bonds/Bills	$	$
4. Stocks Mutual Funds (Name, Number of Shares)	$	$
	$	$
	$	$
5. Corporate/Municipal Bonds	$	$
6. Life Insurance Policies (Cash Value)	$	$
7. Collectibles (Stamps, Coins, Jewelry, Art)	$	$
8. Real Estate (Other than Primary Residence)	$	$
9. Business	$	$
10. Farm	$	$
11. Vehicles (Year, Make and Model)	$	$
Auto, Motorcycles, Recreational Vehicles, Boats	$	$
12. Other Assets (Be Specific)	$	$
13. Does anyone owe you money?	$	$

Section J **Attestation Statement**

I hereby certify that the information provided is true and correct to the best of my knowledge. I understand that providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree. I authorize Mendocino Coast District Hospital to contact my creditors, former and present employers, in order to verify this information.

_____

_____

Date Applicant's Signature

_____

_____

Date Witness Signature

Section F **Banking Information**

1. Name of Bank/Credit Union/Other Financial Institute_____

2. Checking Account Yes or No Savings Account Yes or No Other Yes or No

Section G **Housing Information**

1. Do you own your own home? Yes or No Mortgage Payment_____ Amount Owed_____

2. What is the estimated value? _____Do you rent? Yes or No Monthly Rent _____

Section H **Paid Medical Expenses**

1. Out-of-pocket medical expenses for the past 12 months____ Amount Paid_____

SUPPORTING DOCUMENTATION REQUIRED

ATTACHMENT C

MENDOCINO COAST DISTRICT HOSPITAL
INSTRUCTIONS FOR
APPLICATION FOR CHARITY CARE ASSISTANCE
OR DISCOUNT PAYMENT

Before you begin to fill out the form, lay it alongside the instructions so that you can check for additional instructions as you go along.

Some questions on the form are self-explanatory. For these questions no additional instructions are provided. Where additional information is necessary, you will find it in this instruction sheet.

Records You Will Need

- Current U.S. income tax return (IRS Form 1040, 1040A, or 1040EZ).
- Current state and local income tax returns (if applicable).
- W-2 Forms and other records of money earned in the current year.
- Paycheck stubs.
- Written verification of wages from employer.
- Forms of approving or denying unemployment compensation or workers' compensation.
- Records of untaxed income, such as welfare, AFDC, or veterans benefits.
- Current bank statements.
- Current mortgage information.
- Business and farm records.
- Records of stocks, bonds, and other investments.
- Driver's license and social security card.
- Supporting documentation of out-of-pocket medical expenses paid in the last 12 months.

When You Fill Out This Form

- Print carefully, so that your form will be easy to read.

Sections A-C

These sections provide demographic, employment and other information about the patient, spouse or guardian, if applicable.

- Section A: This section pertains to the patient information. Complete all areas that are applicable to the patient. If not applicable, please indicate N/A for those questions.

- Section B: This section pertains to the spouse, parent (if the patient is a dependent) or guarantor (person other than patient who accepts financial responsibility). Complete all areas that are applicable and if not applicable, please indicate N/A for those questions.
- Section C: This section pertains to the other parent. Complete all areas that are applicable and if not applicable, please indicate N/A for those questions.

Section D

List all persons dependent upon the patient, spouse, parents(s), guarantor and guardian. Dependents are generally children 18 years of age or younger. It could also include full-time students for whom the guarantor has financial responsibility. Dependents may also be adults who are listed as dependents on the IRS form 1040, i.e., spouse, grandparent or parent, disabled adult or child.

Section E

This section identifies the various sources of income for the patient, spouse, parent, and/or guarantor. Several possible sources have been listed. Complete all areas that are applicable. Please indicate N/A for those areas which do not apply.

Column 1-Source of Income, identifies the various sources of income. Column 2-Gross Amount represents the total amount of income before taking any deductions. Column 3-Monthly or Weekly, indicates how often income is received. Please circle the appropriate response. If payment period differs from those provided, please write in correct payment period.

- Lines 1-3: Provide gross income (before taxes and other deductions) on the appropriate line.
- .
- Line 6:Income received from Supplemental Security Income for disabilities (SSI) and Aid For Dependent Children (AFDC) received in conjunction with Medi-Cal.
- Line 7:Interest earnings from bonds, certificate of deposits, bank accounts or loans to others. Dividend earnings from stocks.
- Line 8: Income not included in lines 1-3 from business, service, or farm operations.
- Line 9: Any income from a source, which is not included in the list, provided. Please be specific.

Section F

This section identifies the banking information for the patient, spouse, parent, and/or guarantor.

Section G

This section identifies the housing information for the patient, spouse, parent, and/or guarantor. Please note that homesteaded property cannot be liquidated involuntarily to pay bills.

Section H

This section identifies the total amount of out-of-pocket medical expenses paid in the last 12 (twelve) months. Supporting documentation is required to show the total paid and needs to be presented by the applicant.

Section I

This section pertains to the various assets of the patient, spouse, parent, and/or guarantor. Several possible types of assets have been listed. Complete all areas that are in excess of $100.00. Please indicate N/A for those areas which do not exceed $100.00.

Column 1-Description identifies the various types of assets owned or controlled by the patient, spouse, parent, and/or guarantor. Column 2- What is the Current Value? represents the dollar value of the asset(s) if cashed in or sold today. Column 3- What is Owed? represents the current balance owed to a creditor for the purchase of the asset. "N/A" (Not Applicable) in this column indicates that no response is required.

- Lines 3-5: To obtain current value, use most current newspaper listing, or use most recent statement from the brokerage house(s).
- Line 6: Contact agent or insurance company directly to obtain current cash value of the policy(s).
- Line 7: Describe and estimate the value of any collectibles owned. Use back page if necessary.
- Line 8: Today's market value of any real estate, excluding the primary residence.
- Line 9: The net worth of any ongoing business concerns in which the patient, spouse, parent, and/or guarantor has an interest.
- Line 10: The net worth of any farming concerns in which patient, spouse, parent, and/or guarantor has an interest.
- Line 11: Include year, make and model and estimate current value of each.

Section J

This section requires the signatures of the applicant and a witness.

ATTACHMENT D
ACKNOWLEDGEMENT OF RECEIPT OF APPLICATION

Date

Jane Doe
360 S Maple
Fort Bragg, California 95437

Dear Ms. Doe,

We have received your application for charity care assistance for Mendocino Coast District Hospital Charity Care program. Consideration of your need is very important and once we have thoroughly reviewed your application, we will contact you with a decision by _____(date).

If you have any questions or concerns, please do not hesitate to contact us at any time.

Thank You,

Collections Coordinator
Mendocino Coast District Hospital
707-961-4684

ATTACHMENT E
CONFIRMATION OF ACCEPTANCE/APPROVAL

Date

Account Number: V00000000

Jane Doe
360 S Maple
Fort Bragg, California 95437

Dear Ms. Doe,

We are please to inform you that your application for charity care assistance for Mendocino Coast District Hospital has been approved. The amount due from you will be $_____. We will contact you to make payment arrangements to satisfy your account balance.

This determination of assistance was based on the information you provided on you application. Should any funds be realized by you from future insurance payments, litigation settlements, or any other type of settlement related to services rendered on the above referenced account, the Collections Coordinator will adjust your account accordingly.

We hope this information and assistance will help ease concerns you may have regarding your account. If you have any questions or concerns, please do not hesitate to contact us at any time.

Thank You,

Collections Coordinator
Mendocino Coast District Hospital
707-961-4684

ATTACHMENT F
DENIAL LETTER

Date

Account Number: V00000000

Jane Doe
360 S Maple
Fort Bragg, California 95437

Dear Ms. Doe,

After a very thorough and personal review of your application and the financial information you or your representative provided, we are unable to offer you charity care assistance from Mendocino Coast District Hospital. However, if your financial or family situation changes, or has changed from the date you submitted your application, please do not hesitate to contact us within 15 days with any information that will help us reconsider your needs or those of your family.

Thank You,

Collections Coordinator
Mendocino Coast District Hospital
707-961-4684

ATTACHMENT G
REQUEST FOR ADDITIONAL INFORMATION

Date

Account Number: V00000000

Jane Doe
360 S Maple
Fort Bragg, California 95437

Dear Ms. Doe,

In an effort to thoroughly consider your application so that it addresses your needs and satisfies the guidelines of Mendocino Coast District Hospital Charity Care Assistance program, we are requesting that you provide some additional information. Please complete the areas of your application that we have highlighted then return your application to us within 15 days.

If you have any questions or concerns, please do not hesitate to contact us at any time.

Thank You,

Collections Coordinator
Mendocino Coast District Hospital
707-961-4684

Attachment I
Charity Care Assistance

MCDH GUIDELINES 2007

Charity Care is determined by the ability to pay, not the amount owed.

FAMILY SIZE	FEDERAL POVERTY LEVEL*	250% OVER POVERTY LEVEL
1	$ 10,210	$25,525
2	13,690	34,225
3	17,170	42,925
4	20,650	51,625
5	24,130	60,325
6	27,610	69,025
7	31,090	77,725
8	34,570	86,425

PAYMENT LEVELS	*COLLECTION COORDINATOR*	*MANAGER OF BUSINESS SERVICES*	*CHIEF FINANCIAL OFFICER*	*CHIEF EXECUTIVE OFFICER*	*BOARD OF DIRECTORS*
UP TO $1,999	APPROVAL				
$2,000 TO $9,999	MAKE RECOMMENDATION	APPROVAL			
$10,000 TO $49,999	MAKE RECOMMENDATION	MAKE RECOMMENDATION	APPROVAL		
$50,000 TO $99,999	MAKE RECOMMENDATION	MAKE RECOMMENDATION	MAKE RECOMMENDATION	APPROVAL	
$100,000 OR MORE	MAKE RECOMMENDATION	MAKE RECOMMENDATION	MAKE RECOMMENDATION	APPROVAL	NOTIFICATION

ATTACHMENT H
MENDOCINO COAST DISTRICT HOSPITAL
CHARITY CARE DETERMINATION WORKSHEET

Charity Care Determination

Gross Annual Income _____
Section E (Attachment B)

Personal Monetary Assets _____
Section H (Attachment B)

Asset Percentage _____
Under $10,000 = 0%
over $10,000 = 50%

Adjusted Assets to Apply _____

Total Adjusted Income _____

Poverty Level Rate _____

Does Patient Qualify Yes No

Amount of Write Off _____

Justification for exceptions/extenuating circumstances:

_____

_____

_____

_____

	Approval	Denial	Signature	Date
Collection Coordinator	_____	_____	_____	_____
Manager of Business Services	_____	_____	_____	_____
Chief Financial Officer	_____	_____	_____	_____
Chief Executive Officer	_____	_____	_____	_____

ATTACHMENT H
MENDOCINO COAST DISTRICT HOSPITAL
DISCOUNT PAYMENT DETERMINATION WORKSHEET

Discount Payment Care Determination

Gross Annual Income _____
Section E (Attachment B)

Family Size _____

Out-of-Pocket Medical Expenses Paid _____

Total Adjusted Amount Due _____

Justification for exceptions/extenuating circumstances:

_____

_____

_____

_____

	Approval	Denial	Signature	Date
Collection Coordinator	_____	_____	_____	_____
Manager of Business Services	_____	_____	_____	_____

Chief Financial Officer	_____	_____	_____	_____
Chief Executive Officer	_____	_____	_____	_____