

<b><i>AVANTI HOSPITALS MEMORIAL HOSPITAL OF GARDENA EAST L.A. DOCTORS HOSPITAL COMMUNITY HOSPITAL OF HUNTINGTON PARK COAST PLAZA HOSPITAL</i></b>	Subject: Charity Care	Item No.
	POLICY AND PROCEDURE	Scope: HOSPITALWIDE
Supersedes:	Approved by: CHIEF FINANCIAL OFFICER	
Effective: 5/30/2002	Date last revised: 01-01-2012 By: Rachel Gonzalez (CBO Director)	

**PURPOSE:**

To establish a policy for care that is rendered free of charge to individuals who, because of their financial status are unable to pay for services provided. This policy extends to all patients accepted by Avanti Hospital Systems. This policy is also intended to document MHG, ELA DOCTORS, CHHP & CHP compliance with Health & Safety Code requirements for written policies providing discounts to financially qualified patients, even though the policy obligations exceed such legal obligations and provide for discounts to patients who financially qualify.

**SCOPE & RESPONSIBILITIES:**

It is the responsibility of the CBO Director and the Admitting Managers to ensure that appropriate procedures, as described below, are in place and followed to ensure appropriate action is taken. This includes the handling of patient accounting transactions in a manner that supports the mission and values.

**DETERMINATION/REVOKABILITY:**

Charity Care eligibility can be determined, or revoked, at any point in the pre-admission, billing or collection process should any significant changes occur in the patient's financial status or third party coverage.

**Policy**

***Full Charity Discount and Partial Charity Discount Defined***

Full Charity Care is defined as writing off the bill of any necessary<sup>1</sup> inpatient, ER, UMS or outpatient hospital service provided to a patient who is unable to pay for care and who

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<sup>1</sup> Necessary services are defined as any entity inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

has established qualification in accordance with requirements contained in the Avanti Hospitals Financial Assistance Policy.

Financial assistance by a partial discount is available against hospital charges for any necessary inpatient, ER, UMS or outpatient hospital services provided to a patient who is uninsured or underinsured and 1) who desires assistance with paying their hospital bill; 2) who can demonstrate that the patient has an income at or below 350% of the federal poverty level; and 3) who has established qualification in accordance with requirements contained in Avanti Hospitals Financial Assistance Policy.

Depending upon individual patient eligibility, financial assistance may be granted for full charity write-off or for a partial discount. Financial assistance may be denied when the patient or other responsible family representative does not meet the Avanti Hospitals Financial Assistance Policy requirements.

### ***Full Charity and Partial Charity Discount Reporting***

All Avanti hospitals located within California will report actual charity write-offs and discounts provided in accordance with regulatory requirements of the California Office of Statewide Health Planning and Development (OSHPD) as contained in the *Accounting and Reporting Manual for Hospitals, Second Edition*. To comply with regulation, each hospital will maintain written documentation regarding its criteria and, for individual patients, written documentation regarding all eligibility determinations. As required by OSHPD, charity discounts provided to patients will be recorded on the basis of actual charges for services rendered.

Each hospital will provide OSHPD with a copy of this Financial Assistance Policy which includes the full and partial discount policies within this single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity and partial charity discounts; and 3) the review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

### **Full and Partial Discount Eligibility: General Process and Responsibilities**

Eligibility exists for any patient whose family<sup>2</sup> income is less than 500% of the current federal poverty level, and if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account.

Avanti Hospitals Financial Assistance Program utilizes a single, unified patient application for both Full Charity and Partial Charity Discounts. The process to obtain assistance is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for the hospital to determine patient

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<sup>2</sup> A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

eligibility and such information will be used to qualify the patient or family representative for maximum coverage under the Avanti Hospitals Financial Assistance Program.

Eligible patients may qualify for Avanti Hospitals Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the Financial Assistance Program, but eligibility begins a process of evaluation to determine coverage before full charity or partial charity discounts may be granted.

Access to necessary care shall in no way be affected by whether financial assistance eligibility under this policy exists; medically necessary care will always be provided to the extent the facility can reasonably do so.

The Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate gathering accurate and timely patient financial information, a financial assistance application will be used. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application, and will also be offered information, assistance and referral as appropriate to government sponsored programs for which they may be eligible. Insured patients who are unable to pay the bill remaining after insurance, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be afforded the opportunity to complete a financial assistance application and have it considered.

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.

Completion of a financial assistance application provides:

- a. Information necessary for the hospital to determine if the patient has income sufficient to pay for services;
- b. Documentation useful in determining qualification for financial assistance; and
- c. Documentation of the hospital's commitment to providing financial assistance.

However, a completed financial assistance application is not required if the hospital determines it has sufficient patient financial information from which to make a financial assistance qualification decision; an example of this can be a homeless patient.

#### *Procedures*

#### ***Qualification: Full Charity and Partial Charity Discounts***

Qualification for full or partial financial assistance shall be determined without discrimination based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.

- a. The patient and/or patient family representative who requests or is in need of financial assistance relative to the hospital bill shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination, and direct assistance shall be provided to patients or their family representative as necessary to help complete applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
- b. Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion, consistent with laws and regulations, to establish objective eligibility criteria and determine when a patient demonstrates qualification for financial assistance.
- c. Patients or their family representative who are provided an application for the Financial Assistance Program and who elect to complete it on their own shall be told of the availability of assistance to complete the application, where to turn in the application once complete, and what they can expect in follow-up.
- d. Personnel who have been trained to review financial assistance applications for completeness and accuracy will review completed applications as quickly as possible and provide a timely response.
- e. An affirmative financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:
  - Director of Patient Financial Services: Accounts less than \$100,000.
  - Chief Financial Officer: Accounts over than \$100,000.
- f. Factors to consider when determining whether an individual is qualified for financial assistance pursuant to this policy may include, but are not limited to:
  - Eligibility for insurance under any government coverage program or other third party insurer;
  - Family income (determined based upon tax returns and recent pay stubs);
  - Written verification of wages from employer
  - Copies of unemployment letters
  - Social Security checks
  - Disability Checks
  - EBT income
  - Signed Affidavits
  - Signed attestation stating patient is unemployed, or being supported by someone else.

- Family size
  - Denial of coverage by governmental agency (Medicare, Medi-Cal, Healthy Families, CCS)
- g. Qualification criteria are used in making each individual case determination for coverage under the Avanti Hospitals Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this policy.
- h. Financial assistance may be granted in full or in part depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.
- i. Once qualification has occurred, the hospital may, at its sole discretion, treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of a positive qualification may be eligible for write-off, but will be separately considered and may not be subject to this discount.
- j. Patient obligations for Medi-Cal/Medicaid share of cost payments cannot be waived or discounted in advance under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/Medicaid share of cost patient may be considered for financial assistance.
- k. Patients higher than 100% of the FPL will not be billed for more than the Medicare reimbursement rate tables that have been established by the hospital. This shall apply to all necessary hospital inpatient, outpatient and emergency services provided.

***Full and Partial Charity Discount Income Qualification Levels***

*A charity care patient is a patient whose family income is below or equal to the charity care criteria (see below) and the first ten thousand (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility.*

**The 48 Contiguous States and DC**

<b>Persons in family</b>	<b>Poverty guideline</b>
1	\$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890

For families with more than 8 persons, add \$3,960 for each additional person.

*2012 poverty scale*

*Example of the FA charity calculator is listed as Table 1:*

- a. If the patient's family income is 100% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements ("Qualified at 100% FPL or less"), the entire (100%) patient liability portion of the bill for services will be written off.
- b. Qualified at between 100.01% and 200% FPL, the following will apply:

Patient's care is not covered by a payer. If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's bill will be discounted based on the Charity Care Financial Assistance Calculator (Medicare rate).

Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will not exceed the amounts calculated off the Charity Care Financial Assistance Calculator (Medicare rate).

- c. Qualified at between 201% and 350% FPL, the following will apply:
  - Patient's care is not covered by a payer. If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the total patient payment obligation<sup>3</sup> will be the hospital specific total gross amount based on the average HMO/PPO payment rate (the "Hospital Specific HMO/PPO Rate")<sup>4</sup>.
  - Patient's care is covered by a payer. If the services are covered by a third party payer so that the patient is responsible for only the percentage of the total billed charges that would have been paid at the average Hospital Specific HMO/PPO Rate.

### ***Payment Plans***

A patient qualified for a partial discount shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.

Payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient to the individual Avanti hospital and the patient's or patient

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<sup>3</sup> In the case of patient liability for co-payments or deductibles, this provision shall apply only when not expressly prohibited by any agreement between the Avanti hospitals and the patient's third party insurer.

<sup>4</sup> The average Hospital Specific Medicare/HMO/PPO payment is determined annually by the hospital, based upon all hospital Medicare/HMO/PPO payment rate amounts for inpatients and outpatients. Any patient liability amount due will be based upon calculation of the total gross payment obligation using the above methods.

family representative's financial circumstances. Payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan term shall not exceed (12) months. Payment plans are free of any interest charges or set-up fees. Some situations may necessitate special payment plan arrangements based on negotiation between the hospital and patient or their representative. Payment plans may be arranged by contacting a Business Office representative or an outside agency that the hospitals have contracted with. Once a payment plan has been agreed upon, changes to it require the agreement of both parties. It is the patient's or guarantor's responsibility to contact the Business Office if circumstances change and payment plan terms cannot be met.

### ***Special Circumstances***

The following requirements must be satisfied to treat a patient as medically indigent for purposes of claiming Medicare bad debt pursuant to Medicare Provider Reimbursement Manual (PRM) § 310.

1. The patient's indigence must be determined by the provider, not by the patient. A patient's signed declaration of his inability to pay his medical is not proof of indigency.
2. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses.
3. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill.
4. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

### ***Other Eligible Circumstances***

At any given time a patient's financial status changes, they can be re-reviewed for financial assistance as long as all required documentation is received validating their financial status has changed. The hospital will make final determination of status upon new documentation submitted.

Those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal/Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income program) are deemed to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and CCS) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under the hospital's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off. Specifically included as eligible are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are eligible for financial assistance.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be eligible for financial assistance if:

1. The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or
2. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient who experiences a catastrophic medical event may be eligible for financial assistance. Patients who have high incomes do not qualify for routine full charity care or discount partial charity care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's 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 \$75,000 may be considered for eligibility as a catastrophic medical event.

Any services primarily designed to expand access to care for the medically poor may be considered eligible for financial assistance when the following conditions are met:

1. the services are identified in the hospital community benefit plan;
2. the services are targeted at populations which would qualify for financial assistance as identified within the community benefit plan;
3. the services are recorded at full established hospital rates as gross patient revenue;
4. the services are provided by a licensed healthcare professional; and
5. the services are those medical diagnostic or therapeutic services for which a medical record is maintained

Minimum payments may be accepted from patients to assist funding of access to care programs. Any or all self-pay patients may be offered a financial assistance screening form. However, any patient served through an access to care program shall be deemed as



qualified without absolute requirement for submission of a financial assistance application.

Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, will be considered for financial assistance. Documentation of the patient or family representative's inability to pay for services will be maintained

### ***Criteria for Re-Assignment from Bad Debt to Charity Care***

All outside collection agencies contracted with Avanti Hospitals to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to charity care:

1. Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers).
2. The patient or family representative must have a credit score rating within the lowest 25<sup>th</sup> percentile of credit scores for any credit evaluation method used; and
3. The patient or family representative has not made a payment within 150 days of assignment to the collection agency; and
4. The collection agency has determined that the patient/family representative is unable to pay; and/or
5. The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

### ***Dispute Resolution***

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with a complete explanation of the patient's dispute and rationale for reconsideration.

All appeals will be initially reviewed by the hospital director of patient financial services. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the Centralized Business Office Director, the patient may request in writing, a review by the hospitals Administration Department. Administration shall review the patient's written appeal and documentation, as well as the findings of the CBO Director. The Administrative officer shall make a determination and provide a written explanation of findings to the patient. The internal dispute resolution process concludes with a final decision by the Administration Dept.

### ***Public Notice***

Each of the Avanti hospitals shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area.

A copy of this Financial Assistance Policy will be made available to the public upon request, or on a reasonable basis.

### ***Confidentiality***

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by Avanti Hospitals values and strive for such interactions to be sacred encounters.

### ***Good Faith Requirements***

Avanti Hospitals makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, Avanti hospitals reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for Avanti's Financial Assistance Programs.

Table 1 – Example of FA Charity Calculator

**East Los Angeles Doctors Hospital**  
**Calculator for Financial Assistance/Charity Care**      Account # [REDACTED]  
 LAST, FIRST

**Current Balance Due:** [REDACTED]  
**Total Household Member:** [REDACTED] Allowance  
**Total Annual Household Income:** [REDACTED] \$10,000.00

Reimb %	Medicare	PPO/HMO
Inpatient	24%	35%
Outpatient	15%	20%
ER Visit	12%	15%

<u>Range</u>	<u>From</u>	<u>To</u>	<u>Sliding Scale</u>	<u>Inpatient</u>	<u>Outpatient</u>	<u>ER Visit</u>
	<u>FPL%</u>	<u>FPL %</u>		<u>Amt Owed</u>	<u>Amt Owed</u>	<u>Amt Owed</u>
	0.00	100.00	N/A	0.00	0.00	0.00
	100.01	200.00	N/A	0.00	0.00	0.00
	200.01	350.00	N/A	0.00	0.00	0.00

Table 2 – Example of FA Charity Application



**EXHIBIT C**

Patient Name _____		Facility: _____		DOS: _____	
Patient Number _____		<b>Confidential Financial Statement (Application)</b>			
<b>RESPONSIBLE PARTY</b>					
Name _____		Marital Status _____		Social Security Number _____	
Street Address, City, State, Zip _____		How long at this address _____		Home Phone _____	
Employers Name and Address (If Unemployed –How Long) _____				Business Phone _____	
Position / Title _____	Monthly income – Gross _____	Monthly income - Net _____	Length of current employment _____		
<b>SPOUSE</b>					
Name _____				Social Security Number _____	
Employer Name and Address _____				Business Phone _____	
Position / Title _____	Monthly income – Gross _____	Monthly income – Net _____	Length of current employment _____		
<b>DEPENDENTS</b>					
Name & Year of Birth of all dependents in household _____		Total Number of Dependents in household _____		Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount _____	
<b>INCOME PER MONTH &amp; ASSETS</b>					
Dividends, Interest _____	\$ _____	Child Support / Alimony _____	\$ _____		
Public Assistance / Food Stamps _____	\$ _____	Rental Income _____	\$ _____		
Social Security _____	\$ _____	Grants _____	\$ _____		
Unemployment Compensation _____	\$ _____	IRA _____	\$ _____		
Workers' Compensation _____	\$ _____	Other _____	\$ _____		
Savings _____	\$ _____				
<b>EXPENSES PER MONTH</b>					
Mortgage / Rent Payment: _____	\$ _____	Balance: _____	\$ _____	Medical / Dental _____	\$ _____
Own Home? (Yes/No) _____			Doctor – Name _____	\$ _____	
Food _____	\$ _____			Doctor – Name _____	\$ _____
Utilities: _____	\$ _____			Doctor – Name _____	\$ _____
Electric _____	\$ _____			Credit Cards: _____	\$ _____
Gas _____	\$ _____			Visa           Limit	\$ _____
Water / Sewer _____	\$ _____			Mastercard   Limit	\$ _____
Trash _____	\$ _____			Discover       Limit	\$ _____
Phone _____	\$ _____			Other           Limit	\$ _____
Cable _____	\$ _____			Installment Loans _____	\$ _____
Auto Payments _____	\$ _____			Child Support _____	\$ _____
Auto Expenses _____	\$ _____			Miscellaneous Expenses _____	\$ _____
Insurance: _____					
Auto Premium _____	\$ _____				
Life Insurance _____	\$ _____				
Health Insurance _____	\$ _____				
<b>OFFICE USE ONLY</b>			To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.		
Gross income _____			_____		
Net income _____			_____		
Total Expenses _____			_____		
Total Net income (loss) _____			_____		
				PATIENT/GUARANTOR SIGNATURE _____	
				DATE _____	

**Note:** The Financial Statement (Application) is available in Spanish

Table 3 – Example of FA Charity Affidavit



4060 E. Whittier Blvd.  
Los Angeles, CA 90023



2623 E. Slauson Avenue  
Huntington Park, CA 90255



Memorial Hospital  
of Gardena  
1145 W. Redondo Beach Blvd.  
Gardena, CA 90247



COAST PLAZA  
HOSPITAL  
13100 Studebaker Road  
Norwalk, CA 90650

AFFIDAVIT

State of California  
County of Los Angeles

I \_\_\_\_\_, living at  
\_\_\_\_\_, Los Angeles County  
California, certify through my signature that the statement given below is true and correct to the best of

My knowledge and belief: \_\_\_\_\_  
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SIGNATURE \_\_\_\_\_

ANY PERSON WHO SIGNS THIS STATEMENT AND WHO WILFULLY STATES IT AS TRUE AND MATERIAL MATTERS WHICH HE KNOWS TO BE FALSE IS SUBJECT TO THE PENALTIES PRESCRIBED FOR PERJURY IN THE PENAL CODE BY THE STATE OF CALIFORNIA; SEC.11054 OF THE W & J CODE.

\_\_\_\_\_  
WITNESSED AND VERIFIED BY TITLE DATE

East Los Angeles Doctors Hospital Campus  
Centralized Business Office  
4036 E. Whittier Blvd. Suite #100  
Los Angeles, CA 90023  
Office: (323) 318-8200 Fax: (323) 318-8239

Isi J. Russ M.D, Inc.  
(East Los Angeles Emergency Associates)  
P O Box 11600  
Westminster, CA 92685

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**Charity Discount Policy**

- ER physicians will extend discounts upon request to financially qualifying patients whose income is below 350% of the federal poverty line, as required by CA Health & Safety Code § 127452.
- Patients approved for Charity are offered a 50% discount of billed charges.
- Payment plans may be offered in connection with discounts; however payments must be received by the 20th each month to be in compliance with the terms of payment plans. Minimum payments for payment plans is \$25.00.

<b>AVANTI HOSPITALS: MEMORIAL HOSPITAL OF GARDENA EAST L.A. DOCTORS HOSPITAL COMMUNITY HOSPITAL OF HUNTINGTON PARK COAST PLAZA DOCTORS HOSPITAL</b>	Subject: Self pay Discount Policy	Item No.
	POLICY AND PROCEDURE	Scope: HOSPITALWIDE
Supersedes:	Approved by: Chief Financial Officer	
Effective: 01/01/2007	Date last revised: 01-01-2012	

**Purpose:**

Memorial Hospital of Gardena and East Los Angeles Doctors Hospital shall maintain a policy for Uninsured, Self-Pay patients to allow a 45% discount of Total Billed Charges.

**Procedure:**

**1. Guidelines**

- Patient must be uninsured.
- Account must be paid within 30 days for Final Bill date for total charges less 45% discount.  
Example: Total charges \$100.00 – patient pays \$55.00. Discount is \$45.00.
- If patient is insured, patient must submit insurance information to the Centralized Business Office (CBO) department within 30 days from the discharge date. Billing after 30 days will be submitted to the payor(s) as a courtesy to the patient. The self-pay discount does will no longer apply, unless approved by CBO Director or Administraiton.
- If patient has an out-of pocket co-insurance or deductible, due to contractual Language restraints, Avanti Hospitals is not allowed to further discount unless patient qualifies for a Charity Care Adjustment. (See Financial Evaluation Guidelines Policy and Procedure).
- Any statement being generated to the patient may notate a 45% discount message will be given if paid in full within 30 days. If patient has insurance, patient is responsible to submit copy of front & back of their insurance card for billing within 30 days from discharge date.
- Centralized Business Office (CBO) will allow the Patient thirty (30) days from the Final Billed date to be approved for the discount. If payment is not received within this time frame, patient is responsible for total charges.

2. Control and Reporting Mechanisms:

- The Chief Financial Officer and/or CBO Director will denote specific financial or departmental criteria for which concurrent audits will be conducted.
- The CBO Director shall supervise the auditing, reporting and billing process involving appropriateness of self pay discounts.
- The CBO Director will review this policy annually for repeal or amendment.