EASTERN PLUMAS HEALTH CARE

SUBJECT: **CHARITY CARE**	POLICY # **BO201**
DEPARTMENT: **BUSINESS SERVICES**	Page 1 of 1
APPROVED BY:	DISTRIBUTION: ☐ Global ☐ Departmental
EFFECTIVE: **7/1998**	REVIEWED: **11/2008 APREL MARTIN** REVISED: **12/2014 APREL MARTIN**

I. POLICY STATEMENT

It is the policy of Eastern Plumas Health Care to identify charity care that is provided to patients according to the guidelines of this policy. Charity care is defined as health care services provided at no charge or at a reduced charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. This is in contrast to a bad debt which is defined as a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by their actions an unwillingness to resolve the bill. Partial and full charity care will be based solely on ability to pay and will not be abridged on the basis of age, sex, race, creed, disability or national origin. Classification of healthcare services as charity care will only be made in those cases when a reasonable effort has been made to seek other financial resources, but classification can occur at any time. Classification of healthcare services as charity care will not be made for non-medically necessary services (i.e. cosmetic surgery, patient convenience hospital days and services, etc.)

II. PURPOSE

The purpose of this policy is to define the eligibility criteria for charity care assistance and provide administrative guidelines for the identification and classification of patient accounts as charity care.

III. ELIGIBILITY

The following categories of patient accounts will be classified for charity care:

Category A – Emergency room patients without a payment source. Individuals in this category have no job, no mailing address/or residence, *and* no insurance. These patients may meet the qualification guidelines for medical assistance such as Medicare, Medi-Cal or Covered California but do not have the inclination to follow through on the necessary eligibility processes. Collection efforts would be fruitless. Approval for write-off usually takes place after the service has been rendered.

Category B – This category includes patients who do not qualify for Medicare, Medi-Cal, Covered California or other assistance programs and are financially unable to pay all or part of the hospital bill.

Typically, individuals and families in this category may be partially covered by health insurance and seek charity care assistance after insurance has paid. Patients in this category must complete the attached application form and their adjusted family income must fall within the financial criteria to receive charity care (see Attachment A). Families whose income exceeds the income

criteria may still qualify for charity care with a cost share (see Attachment B). Charity care approval can take place at any time including prior to service.

Category C – This category includes the following indigent/uncollectible situations that normally occur after service has been rendered.

Current Medicare, Medi-Cal or Covered California recipients who are requesting Charity Care for a prior hospitalization which was not covered by the program. This situation normally occurs in cases where a patient does not meet the financial eligibility criteria for either program for the month of hospital service, but subsequently after discharge (weeks, months) the patient's financial condition deteriorates and therefore becomes eligible for assistance for future hospitalizations. Medicare, Medi-Cal or Covered California will not retroactively qualify applicants for prior periods.

A deceased patient having no estate.

Confirmed "Other County" Medi-Cal/Medicaid patients whose county is not contracted with Eastern Plumas Health Care.
Confirmed "Other County" MIA patients whose county is not contracted with Eastern Plumas Health Care.

IV. PROCEDURAL GUIDELINES

A. The employee who receives a request for charity care or determines a patient's account(s) should be considered for charity care should thoroughly research and document on the financial file folder all relevant facts. Care should be taken that reasonable efforts have been made to seek alternative financial resources. Efforts should be made to secure approval or denial prior to admission.

B. The charity care request (Charity Care Application and/or documentation on the financial file jacket) should be forwarded through the levels of management to the lowest level able to authorize the charity care write-off amount (see write-off matrix below).

C. Authorized employees must sign their approval or denial and reason for determination on the file. Authorized employees must assure that reasonable efforts have been made to assure that alternative resources are not available to cover the cost of the hospitalization.

D. The file should then be returned to the originating employee to process the write-off and send the Eligibility Determination Notice (see Attachment C) to the patient. (Not sent to Category A patients).

E. The patient financial files (approvals only) and eligibility determination (approvals and denials) are to be archived for no less than five years. These records are to be archived in such a manner as to assure easy accessibility.

WRITE-OFF MATRIX

	Estimated or Actual Amount
Hospital Administrator/Chief Executive Officer Chief Financial Officer	Above $5,000
Business Office Manager	To $5,000

(Amounts shown are maximum per account(s) if combined)

ATTACHMENT A

Date of Request: _____ Birthdate: _____

Patient's Name: _____ Telephone No.: _____

Social Security Number: _____

Address: _____ (street)

_____ (city, state, zip code)

Account #: _____ Dates of Service: _____

Marital Status: _____ Name of Spouse: _____

Employer: _____ Last Day Worked: _____

Spouse's Employer: _____ Last Day Worked: _____

Do you have? Medicaid _____ Medicare _____ Other Insurance _____

Gross Annual Family Income: Self: $_____

Spouse: $_____

Other: $_____

Total: $_____

Number of Dependents Supported On Income (Include Self): _____

Provider of Financial Information (If other than patient or guarantor):

Name:_____

Address:_____

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY EASTERN PLUMAS HEALTH CARE AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Requested By: _____

DO NOT COMPLETE (To be completed by Hospital Personnel only).

This document was received on: _____

By: _____ Title: _____

Eastern Plumas Health Care
"People Helping People"

Size of Family Unit	2014 Federal Poverty Guideline	EPHC Poverty Guideline
1	$11,670	$23,340
2	$15,730	$31,460
3	$19,790	$39,580
4	$23,850	$47,700
5	$27,910	$55,820
6	$31,970	$63,940
7	$36,030	$72,060
8	$40,090	$80,180

For family units over 8 members, add $8,040 (EPHC Poverty Guideline) for each additional member.

ATTACHMENT B

Eastern Plumas Health Care
"People Helping People"

Date: _____

Patient Name: _____

Account Number(s): _____

Amounts(s): _____

Gross Annual Family Income: $_____

Less EPHC Poverty Guideline: $_____ **(A)**

Adjusted Gross Annual Family Income: $ _____ **(B)**

Cost Share Scale Percentage: _____ **(B divided by A)**
(From Column A below)

Percentage Discount Applicable _____ **(C)**
(From Column B below)

Account Amount(s) Due: $_____ **(D)**

Cost Share to Be Bore by Patient: $_____ **(D times C)**

COST SHARE SCALE

COLUMN A: ***COLUMN B:***

PERCENTAGE OF ADJUSTED GROSS ANNUAL INCOME TO EPHC POVERTY GUIDELINES	PERCENTAGE DISCOUNT
One to thirty-three (1%-33%)	Seventy-five percent (75%)
Thirty-four to Sixty-six (34%-66%)	Fifty percent (50%)
Sixty-seven to one hundred (67%-100%)	Twenty-five percent (25%)

ATTACHMENT C

Eastern Plumas Health Care
"People Helping People"

ELIGIBILITY DETERMINATION FOR CHARITY CARE PROGRAM

Eastern Plumas Health Care has conducted an eligibility determination for EPHC Charity Care Program for:

_____	_____	_____
Patient's Name	Account Number	Date(s) of Service

The request of Charity Care Program assistance was made by the patient or on behalf of the patient on _____. This determination was completed on: _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for Charity Care has been approved for services rendered on _____ with a balance on account of $_____. If a balance is due, our office will need to be informed as to how your account balance will be satisfied. Please contact one of the principals appearing at the bottom of this letter to make arrangements.

_____ Your request for Charity Care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____

_____

_____

_____ Your request for Charity Care has been denied because:

_____

_____

_____

If you have any question on this determination, please contact:

_____

Aprel Martin Business Office Manager Eastern Plumas Health Care (530) 832-6569	or	Sarah Skeels Pt. Financial Advocate Eastern Plumas Health Care (530) 832-6568

Eastern Plumas Health Care
"People Helping People"

500 East First Ave.
Portola, CA 96122
Phone: (530) 832-6568
Fax: (530) 832-Z1105

Date: _____

Re: Account # _____

Dear _____

We have received your request for a possible charity care write off. In order for us to process your request we will need the enclosed form completed and returned to our business office within 10 business days along with the accompanying information:

a) Copies of your prior three months bank statements.
b) Copy of your last Federal Income Tax return filed.
c) Copies of your prior three months paycheck stubs.
d) Copy of denial letter from Medi-Cal.

Upon receipt of the above information, you will be notified of our decision. Should you require further clarification or have any questions, please contact me at (530) 832-6568.

Sincerely,

Sarah Skeels
Patient Financial Advocate
Eastern Plumas Health Care

Attachments

ATTACHMENT A

Eastern Plumas Health Care
"People Helping People"

FINANCIAL STATEMENT
for
Charity Care

Date of Request: _____ Birth date: _____

Patient's Name: _____ Telephone No.: _____

Social Security Number: _____

Address: _____ (street)

_____ (city, state, zip code)

Account #: _____ Dates of Service: _____

Name of Spouse: _____

Employer: _____ Last day worked: _____

Spouse's Employer: _____ Last day worked: _____

Do you have? Medicaid _____ Medicare _____ Other Insurance _____

Gross Annual Family Income: Self: $_____

Spouse: $_____

Other: $_____

Total: $_____

Number of Dependents Supported On Income (Include Self): _____

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY EASTERN PLUMAS HEALTH CARE AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES. I CERTIFY THAT I HAVE MADE REASONABLE EFFORTS TO OBTAIN MEDICAL ASSISTANCE BY APPLYING FOR HEALTH COVERAGE THROUGH COVERED CALIFORNIA AND THE ABOVE INFORMATION IS TRUE AND CORRECT.

Requested By: _____

DO NOT COMPLETE (To be completed by Hospital Personnel only).

This document was received on: _____

By: _____ Title: _____

Eastern Plumas Health Care
"People Helping People"

500 East First Ave.
Portola, CA 96122
Phone: (530) 832-6564
Fax: (530) 832-1105

APPROVAL FOR CHARITY CARE

Patient Name: _____

Account Number(s): _____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

Total $ _____

ACCOUNT REPRESENTATIVE CHECK LIST:

1.	Does patient meet income criteria?	Yes _____	No _____
2.	Is proof of income Attached? (bank statements, prior year's tax return, paycheck stubs)	Yes _____	No _____
3.	Account attached?	Yes _____	No _____
4.	Notes in computer system?	Yes _____	No _____
5.	Write off sheet attached?	Yes _____	No _____

_____ _____

Account Representative Signature Date

Adjustment: Approved _____ Denied _____ By: _____

Business Office Manager