



## SENECA HEALTHCARE DISTRICT POLICY

<b>DEPARTMENT: FINANCE</b> <b>POLICY TITLE: CHARITY CARE</b> <b>POLICY NUMBER: FIN-006.003</b>  <b>COMPLIANCE REQUIREMENT:</b> CA Health and Safety Code §127400, §127405, §127425; Assembly Bill 774; Assembly Bill 1503; Senate Bill 1276	<b>Page 1 of 16</b>  <b>Date of Origin:</b> 11/15/2007  <b>Revision Date:</b> 03/28/2013, 10/29/2015  <b>Periodic Review</b> <b>By:</b> <b>Date:</b>
<b>AUTHOR: Linda Wagner, RN, CEO</b> <b>REVISED BY: Carlene Slusher, CPA, Director of Finance</b>	<b>Policy Rescinded by</b> <b>Policy #:</b> <b>Effective Date:</b>

**Policy:** Seneca Healthcare District (SHD) shall offer all patients charity care as applicable state and federal regulations dictate. Charity care is a *resource of last resort*.

Patients are expected to cooperate with SHD procedures for obtaining charity, other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. 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. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for protection of their individual assets.

Partial and full charity care applications will be processed without concern for age, gender, race, sexual orientation, religious affiliation, disability, or national origin. SHD will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial or government assistance.

<b>Authorization</b>	<b>Signature</b>	<b>Date</b>
<b>Department Head</b>		
<b>Medical Department Chair</b>	<b>N/A</b>	
<b>Compliance Officer</b>		
<b>Chief Nursing Officer</b>	<b>N/A</b>	
<b>Administration</b>		
<b>Medical Chief of Staff</b>	<b>N/A</b>	
<b>Governing Board</b>		

**POLICY NUMBER REFERENCE: FIN-006.003**

## PROCEDURE

### 1. Charity Care Policy

#### a. Purpose

The purpose of the Charity Care policy is to define the eligibility criteria for charity care assistance and to provide proper guidelines for identifying, qualifying, and applying charity care to patient(s) account(s). Charity Care Application is Attachment B.

#### b. Eligible Services

- i. **Covered:** Emergency medical services, general acute care hospital services and rural health clinic services.
- ii. **Not Covered:** Elective procedures/surgeries/services, cosmetic services, and skilled nursing services.

#### c. Charity Care Criteria

- i. All homeless and/or uninsured patients are referred to SHD's patient financial specialist for assistance with acquiring insurance or applying for charity care.

#### ii. Eligibility

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination (Attachment A).
2. Gross income should fall within established standard for determination of the FPL, considering family size, geographic area and other pertinent factors.
3. Family size will be considered. For this purpose, "Family" is defined, for an adult patient as spouse, domestic partner, and dependent children under the age of 21, whether living at home or not. For patients under the age of 18, "Family" is defined as the patient's parent(s) and/or caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
4. If a dependent child is over the age of 18 and does not appear on a parent or caretaker's most recent tax return, the dependent child must provide a copy of their own most recent tax return.
5. Patients whose family income is at or below 150% of the FPL are eligible to receive charity.
6. Patients whose family income is above 150% but not more than 250% of the FPL are eligible to receive reduced rates, based on a sliding fee scale, on a case-by- case basis.
7. Patients whose family income exceeds 250% of the FPL may be eligible to receive reduced rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of SHD.
8. Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
9. Patients whose out-of-pocket medical expenses exceed 10% of their prior 12 months of income may be eligible for financial assistance at the discretion of SHD.
10. Charity status will be determined by the Director of Finance and CEO, after the time of discharge and after all required documentation is submitted by the patient or responsible party.

11. Once the account is settled, the information used for determination will be kept on file by SHD for at least seven (7) years.
12. Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to SHD may request a payment plan from SHD's patient financial specialist.
13. Patients who are a victim of a crime could be eligible for State of California funding from the Victim of Crime (VOC) program. Patients can apply at the District Attorney's office at the courthouse in Quincy. The patient will not qualify if:
  - a. There is insurance involved;
  - b. He/she initiated the crime;
  - c. He/she expires.

**iii. Patients with Insurance**

1. Medi-Cal Share of Cost recipients do not qualify for Charity Care as their financial responsibility has been predetermined through the Medi-Cal assessment process.
2. Inpatient days denied by Medi-Cal as not medically necessary become eligible for Charity Care if the denial is upheld following SHD appeal. The Medi-Cal denied day(s) will be adjusted for purposes of stating the "uncollectible" as the charity care amount in preference to inflating the Medi-Cal allowance.
3. Patients with Medicare and commercial HMO/PPO coverage are eligible for Charity Care. If these patients have large out of pocket expenses they will be considered and approved for charity care if they meet all financial requirements. No discount will be applied to the remaining portion of the patient's claim until after their primary and any secondary insurance payments and contractual adjustments are applied.

**iv. Presumptive Financial Assistance**

1. A patient financial specialist or admissions representative will assist uninsured patients to apply for Hospital Presumptive Eligibility.
2. For patients aged 65 and over, SHD's patient financial specialist will assist the patient with completing and submitting a Date Preservation form or initial Medi-Cal application.

**d. Specific Procedure:**

**i. Identification**

1. Candidates for Charity Care can be identified at any point along the patient revenue cycle. Every effort shall be made to identify eligibility during the service period.
2. Initial referrals may be directed to the patient financial specialist or the business office.
3. The patient/guarantor is instructed regarding the application process and is provided SHD's Charity Care Application to complete.
4. Notes related to patient conversations/encounters and application information is documented in the appropriate system by SHD staff.

**ii. Pending Applications**

1. The application for charity care and all supporting documentation completed by the patient are thoroughly researched and reviewed.
2. A review of insurance, lack thereof, and identification of any other potential payer source is conducted.

3. Pages 5 and 6 of the application are completed by a SHD representative in the finance department.
4. The patient financial counselor follows up to obtain any additional information needed by phone or by sending letters requesting documentation. If, after three (3) documented contacts have been attempted and the 150<sup>th</sup> day from application is exceeded without receipt of the requested information, the application is documented as denied in the Electronic Medical Record system, closed, and the account released from hold status to resume processing as a Self-Pay receivable per protocol.
5. Charity care applications are reviewed by the patient financial specialist or appropriate SHD personnel per the approved Write Off Matrix (Attachment C).
6. Authorized employees must sign their approval or denial and reason for determination on the application. Authorized employees must assure that reasonable efforts have been made to assure that alternative resources are not available to cover the cost of services.
7. The file will then be returned to the patient financial specialist to process any authorized write-offs and send the Eligibility Determination Notice (Attachment E) to the patient.
8. The patient financial record with eligibility determination will be archived for no less than 7 years.

**iii. Denied Applications**

1. An Eligibility Determination Notice (Attachment E) is mailed to the address submitted during the application.
2. A request for appeal of a final determination must be made in writing to the SHD Compliance Committee within 30 days of the final determination. An independent review of the patient or guarantor's financial information will be performed and the patient/guarantor will be notified of the review outcome within 30 days.
3. The patient's financial class reverts to Self-Pay and the account is processed as a Self-Pay receivable per protocol. Patients may request a payment plan from the patient financial specialist (Attachment D.)

**2. Enforcement**

Violation of this policy may result in disciplinary action, up to and including termination as outlined in the Sanctions policy, ADMIN28.

**Reference:**

California Hospital Association. (2015.) *Hospital Financial Assistance Policies and Community Benefit Laws; Second Ed.* California Hospital Association; Sacramento CA  
 Eastern Plumas Healthcare. (December 2014.) *Charity Care Policy.*  
 Iacino, J. (December 4, 2014.) *SB 1276: Hospital Fair Billing Practices (Charity Care and Discount Payment Plans.)* California Department of Public Health.  
 Plumas District Hospital. (December 2014.) *Charity Care Policy.*  
 Rowert, K. (November 19, 2014.) *AB 774 Reporting Requirement Changes.* Office of the Statewide Health Planning and Development; Accounting and Reporting Systems Section.

**Charity Care Application – Spanish** (*FIN-FORM-002, not attached*)

**Attachments:**

**Attachment A: Federal Poverty Limit Guidelines** (*1 page*) *\*updated annually*

**Attachment B: Charity Care Application** (*FIN-FORM-001, 6 pages*)

**Attachment C: Write-Off Matrix** (*1 page*)

**Attachment D: Financial Policy Handout** (*1 page*)

**Attachment E: Eligibility Determination Notice** (*1 page*)

## Attachment A: Federal Poverty Limit Guidelines

*\*This attachment updated annually*

### 2016 POVERTY GUIDELINES ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

#### ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE										
	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	11,770.00	14,124.00	15,654.10	15,889.50	16,478.00	17,066.50	17,655.00	20,597.50	21,774.50	23,540.00	29,425.00
2	15,930.00	19,116.00	21,186.90	21,505.50	22,302.00	23,098.50	23,895.00	27,877.50	29,470.50	31,860.00	39,825.00
3	20,090.00	24,108.00	26,719.70	27,121.50	28,126.00	29,130.50	30,135.00	35,157.50	37,166.50	40,180.00	50,225.00
4	24,250.00	29,100.00	32,252.50	32,737.50	33,950.00	35,162.50	36,375.00	42,437.50	44,862.50	48,500.00	60,625.00
5	28,410.00	34,092.00	37,785.30	38,353.50	39,774.00	41,194.50	42,615.00	49,717.50	52,558.50	56,820.00	71,025.00
6	32,570.00	39,084.00	43,318.10	43,969.50	45,598.00	47,226.50	48,855.00	56,997.50	60,254.50	65,140.00	81,425.00
7	36,730.00	44,076.00	48,850.90	49,585.50	51,422.00	53,258.50	55,095.00	64,277.50	67,950.50	73,460.00	91,825.00
8	40,890.00	49,068.00	54,383.70	55,201.50	57,246.00	59,290.50	61,335.00	71,557.50	75,646.50	81,780.00	102,225.00

For family units of more than 8 members, add \$4,160 for each additional member.

#### MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE										
	100%	120%	133%	135%	140%	145%	150%	175%	185%	200%	250%
1	980.83	1,177.00	1,304.51	1,324.13	1,373.17	1,422.21	1,471.25	1,716.46	1,814.54	1,961.67	2,452.08
2	1,327.50	1,593.00	1,765.58	1,792.13	1,858.50	1,924.88	1,991.25	2,323.13	2,455.88	2,655.00	3,318.75
3	1,674.17	2,009.00	2,226.64	2,260.13	2,343.83	2,427.54	2,511.25	2,929.79	3,097.21	3,348.33	4,185.42
4	2,020.83	2,425.00	2,687.71	2,728.13	2,829.17	2,930.21	3,031.25	3,536.46	3,738.54	4,041.67	5,052.08
5	2,367.50	2,841.00	3,148.78	3,196.13	3,314.50	3,432.88	3,551.25	4,143.13	4,379.88	4,735.00	5,918.75
6	2,714.17	3,257.00	3,609.84	3,664.13	3,799.83	3,935.54	4,071.25	4,749.79	5,021.21	5,428.33	6,785.42
7	3,060.83	3,673.00	4,070.91	4,132.13	4,285.17	4,438.21	4,591.25	5,356.46	5,662.54	6,121.67	7,652.08
8	3,407.50	4,089.00	4,531.98	4,600.13	4,770.50	4,940.88	5,111.25	5,963.13	6,303.88	6,815.00	8,518.75

Produced by: CMCS/CAHPG/DEEO

### 2016 DUAL ELIGIBLE STANDARDS

	Qualified Medicare Beneficiary (QMB)		Specified Low-Income Medicare Beneficiary (SLMB)		Qualifying Individuals (QI)		Qualified Disabled Working Individuals (QDWI)	
	Single	Couple	Single	Couple	Single	Couple	Single	Couple
<b>Income:</b>								
All (Except AK & HI)	1,001	1,348	1,197	1,613	1,345	1,813	4,009	5,395
Alaska	1,247	1,680	1,492	2,012	1,676	2,261	4,992	6,725
Hawaii	1,150	1,548	1,375	1,853	1,545	2,083	4,602	6,195
<b>Resources:</b>	\$7,280	\$10,930	\$7,280	\$10,930	\$7,280	\$10,930	\$4,000	\$6,000



**Seneca Healthcare District Charity Care Application**

**Instructions:**

1. Prior to completing an application for Charity Care, the patient is referred to Seneca Healthcare District's patient financial specialist (PFS) for application for insurance through Covered California.
2. **The following documents are required to be submitted with your completed SHD Charity Care Application (copies only, originals will not be returned):**
  - Patient must apply to Covered California and/or Medi-Cal Eligibility or denial for insurance coverage must be presented to SHD within 30 days of receipt.
  - Copies of 3 (three) most recent pay stubs from all employers
    - If unemployed, a copy of unemployment benefits award letter or pay stub within the last 30 days
  - Copy of most recent income tax return
  - Copy of most recent bank statement(s)
  - Copy of most recent rent/mortgage receipt
  - Copy of most recent utility bills
3. Return completed application to either:

Seneca Healthcare District P.O. Box 1460 Chester, CA 96020 Attn: Finance Department	Seneca Healthcare District C/O: HRG 12610 E. Mirabeau Pkwy., Suite 900 Spokane Valley, WA 99216 Attn: CBO Department Supervisor
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Or it may be delivered in person at Seneca Healthcare District, 199 Reynolds Road, Chester, CA
4. SHD will complete the remainder of the application, including a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history, and notify the patient of the determination in writing within 90 days of receipt of a completed application.
5. If you have questions or need assistance in completing this application, please contact our Patient Accounts Department at **866-567-8936** or the onsite Patient Financial Specialist at **530-259-3591**.





Seneca Healthcare District Charity Care Application

*In order to be considered for Seneca Healthcare District's Charity Care Plan, the information below must be completed and returned to our office with all required documentation. Incomplete applications will not be considered.*

**PATIENT INFORMATION**

Date of Request: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ (street)  
 \_\_\_\_\_ (city, state, zip code)  
 If Minor, Guardian Name: \_\_\_\_\_ Guardian Social Security \_\_\_\_\_  
 Employer: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_  
 Do you have?     Medi-Cal     Medicare     Other Insurance     Uninsured  
 If uninsured, have you applied for Medi-Cal/Covered California?     Yes     No

**FAMILY INFORMATION**

Spouse's Name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_

List all dependents that you support below:

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ASSET INFORMATION**

Bank Name: \_\_\_\_\_ Account Number: \_\_\_\_\_ Balance: \$ \_\_\_\_\_  
 Bank Name: \_\_\_\_\_ Account Number: \_\_\_\_\_ Balance: \$ \_\_\_\_\_  
 Bank Name: \_\_\_\_\_ Account Number: \_\_\_\_\_ Balance: \$ \_\_\_\_\_  
 Other Assets: \_\_\_\_\_



Seneca Healthcare District Charity Care Application

Application Continued:

INCOME INFORMATION

**Earned Income** (If patient is a minor list parent(s)/guardian(s) income)

Patient's Gross Income: \$ \_\_\_\_\_ (select one)  Monthly  Bi-Weekly  Weekly

Spouse's Gross Income: \$ \_\_\_\_\_ (select one)  Monthly  Bi-Weekly  Weekly

**Other Income**

Unemployment: \$ \_\_\_\_\_ (select one)  Monthly  Annually

Social Security: \$ \_\_\_\_\_ (select one)  Monthly  Annually

Dividends/Annuities: \$ \_\_\_\_\_ (select one)  Monthly  Annually

Rental Property: \$ \_\_\_\_\_ (select one)  Monthly  Annually

Other (explain): \$ \_\_\_\_\_ (select one)  Monthly  Annually

**Total Monthly Income:** \$ \_\_\_\_\_ **Total Annual Income:** \$ \_\_\_\_\_

*(Total of Gross Income, Spouse Gross Income, and Other Income)*

EXPENSES INFORMATION

I am a (select one):  Renter  Homeowner \_\_\_\_\_ years Monthly Payment: \$ \_\_\_\_\_

Do you own property other than your primary residence?  Yes  No Monthly Payment: \$ \_\_\_\_\_

Auto payment: \$ \_\_\_\_\_ /mo Year/Make/Model: \_\_\_\_\_

Auto payment: \$ \_\_\_\_\_ /mo Year/Make/Model: \_\_\_\_\_

Credit Card: Balance \$ \_\_\_\_\_ Limit \$ \_\_\_\_\_ Monthly Payment \$ \_\_\_\_\_

Credit Card: Balance \$ \_\_\_\_\_ Limit \$ \_\_\_\_\_ Monthly Payment \$ \_\_\_\_\_

Monthly Utility Bills: \$ \_\_\_\_\_ Average Monthly Food Bill: \$ \_\_\_\_\_

Are you current on all above payments?  Yes  No

*(Please attach additional sheets if necessary to include additional credit/personal loan/medical obligations)*

**Total Monthly Expenses:** \$ \_\_\_\_\_

If your monthly expenses exceed your monthly income, please describe how you are meeting your expenses

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Seneca Healthcare District Charity Care Application

**Financial Assessment Worksheet:**

**\*\* For Office Use Only \*\***

Patient Name: \_\_\_\_\_

Account: _____	D.O.S: _____	Total Charges: \$ _____	Balance: \$ _____
Account: _____	D.O.S: _____	Total Charges: \$ _____	Balance: \$ _____
Account: _____	D.O.S: _____	Total Charges: \$ _____	Balance: \$ _____
Account: _____	D.O.S: _____	Total Charges: \$ _____	Balance: \$ _____
Account: _____	D.O.S: _____	Total Charges: \$ _____	Balance: \$ _____

**Date and initial upon receipt of the following documentation:**

- \_\_\_\_\_ Covered California/Medi-Cal eligibility or denial
- \_\_\_\_\_ Copies of 3 (three) most recent pay stubs from all employers
- \_\_\_\_\_ If unemployed, copy of unemployment benefits award letter or pay stub within the last 30 days
- \_\_\_\_\_ Copy of most recent income tax return
- \_\_\_\_\_ Copy of most recent bank statement(s)
- \_\_\_\_\_ Copy of most recent rent/mortgage receipt
- \_\_\_\_\_ Copy of most recent utility bills

**If all documentation was not received with the application or additional information was requested, date and initial the 3 attempts to contact the patient:**

- \_\_\_\_\_ 1<sup>st</sup> attempt
- \_\_\_\_\_ 2<sup>nd</sup> attempt
- \_\_\_\_\_ 3<sup>rd</sup> attempt

**Notes:**

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Seneca Healthcare District Charity Care Application

Financial Assessment Worksheet Continued:

**\*\* For Office Use Only \*\***

Summary

Family Size: \_\_\_\_\_  
 Gross Annual Family Income: \$ \_\_\_\_\_ (A)  
 Less Federal Poverty Guideline: \$ \_\_\_\_\_ (B) [@ 150% for Family Size]  
 Adjusted Gross Annual Family Income: \$ \_\_\_\_\_ (C)  
 Cost Share Scale Percentage C÷B: \_\_\_\_\_ %  
 Percentage Discount Applicable: \_\_\_\_\_ %

Cost Share Scale

<u>Percentage of Adjusted Gross Annual Income to Federal Poverty Guidelines</u>	<u>Percentage Discount for Charity Care</u>
Less than or equal to zero ( $\leq 0\%$ )	One hundred percent (100%)
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%)
Greater than one hundred ( $> 100\%$ )	Zero percent (0%)

Worksheet Prepared By: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**APPROVAL/DENIAL**

Approved:  Denied:  Reason \_\_\_\_\_

Charity Care Amount Approved: \$ \_\_\_\_\_

Accounts to apply charity care write off to:

Account: _____	Amount: \$ _____	Date of write off: _____	Initials _____
Account: _____	Amount: \$ _____	Date of write off: _____	Initials _____
Account: _____	Amount: \$ _____	Date of write off: _____	Initials _____
Account: _____	Amount: \$ _____	Date of write off: _____	Initials _____
Account: _____	Amount: \$ _____	Date of write off: _____	Initials _____

If total amount of charity care approved  $\leq$  \$5,000, approval required by Director of Finance

If total amount of charity care approved  $>$  \$5,000, approval required by CEO

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**Attachment C: Write Off Matrix**

	Estimated or Actual Amount
Director of Finance	Up to and including \$5,000
Chief Executive Officer	Above \$5,000

*\*Amounts shown are maximum per account or combined account balance.*

## Attachment D: Financial Policy Handout



### Financial Policy

Seneca Healthcare District (SHD) is committed to providing the highest quality of patient care within a framework of sound fiscal management. To attain this objective, patients requesting services at SHD are expected to pay for their portion of estimated charges for care provided at the time services are rendered.

All out-of-pocket payment amounts for non-emergent or elective services are expected at the time of service unless previous payment arrangements have been made. This includes deductibles, co-insurance amounts, and co-payments.

### Payment Options

SHD works with each patient individually on their account balances. Here are some payment options available to you:

- We are happy to accept Visa, MasterCard, and Discover (both debit and credit). Money orders, cashier's checks, traveler's checks, and personal checks are also accepted.
- You can pay online using a credit or debit card.
- You can pay over the phone using a credit or debit card by calling our customer service department at (866) 567-8936.
- If paying in full at the time of service, you will receive a 20% discount and your insurance will not be billed.

### Payment Plans

Upon request, a patient may be eligible to establish a payment plan based on the guidelines below. If you are unable to pay your bill in full, please contact our patient financial specialist at (530) 259-3591 for additional information and to discuss your options.

- \$0 to \$50 balance - Pay in Full
- \$51-\$100 balance - \$50/month (2 month max pay off)
- \$101-\$200 balance - \$75/month (3 month max pay off)
- \$201-\$1,000 balance - \$100/month
- \$1,001-\$2,000 balance - \$150/month
- Balance over \$2,001 - Balance divided by 12 months
- Any balances that cannot be paid in full within 12 months as detailed above will require approval from SHD's Director of Finance.

**Attachment E: Eligibility Determination Form**



**ELIGIBILITY DETERMINATION FOR CHARITY CARE PROGRAM**

Seneca Healthcare District has conducted an eligibility determination for SHD's Charity Care Program for: \_\_\_\_\_ (Patient's Name) for the following accounts and dates of service:

Account: \_\_\_\_\_ DOS: \_\_\_\_\_  
Account: \_\_\_\_\_ DOS: \_\_\_\_\_  
Account: \_\_\_\_\_ DOS: \_\_\_\_\_  
Account: \_\_\_\_\_ DOS: \_\_\_\_\_  
Account: \_\_\_\_\_ DOS: \_\_\_\_\_

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 partial charity care was approved and a remainder balance remains due, our office will need to be informed as to how your account balance will be satisfied. Please contact our patient financial specialist at (530) 259-3591 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 Carlene Slusher, Director of Finance at (530) 258-3099.

Thank you,

Seneca Healthcare District  
Finance Department