EISENHOWER MEDICAL CENTER **Rancho Mirage, CA**

DEPARTMENT: PATIENT FINANCIAL SERVICES Created: 11/1/2015

TITLE: PATIENT FINANCIAL ASSISTANCE **Updated: 11/15/2016**

I. PURPOSE

Eisenhower Medical Center (EMC) serves all persons within Rancho Mirage and the surrounding greater desert region. As a regional hospital provider, EMC is dedicated to providing high quality, customer-oriented healthcare services that meet the needs of the patients we serve. Providing patients with opportunities for financial healthcare services assistance coverage is an essential element in fulfilling EMC's mission. This policy outlines the EMC Financial Assistance Program, along with its criteria, systems, and methods.

California acute care hospitals must comply with the Health & Safety Code AB774, and IRS section 501(r), including certain requirements for written policies that provide discounts, charity care and reasonable payment plans to financially-qualified patients. This policy is intended to meet such legal obligations.

The Patient Financial Services department is responsible for patient accounting policies and procedures to ensure the consistent timing, recording and accounting treatment of transactions at EMC. This policy includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of EMC.

II. SCOPE

This policy pertains to financial assistance and discounted payment plans provided by Eisenhower Medical Center. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

III. POLICY

Eisenhower Medical Center is committed to providing access to financial assistance programs for uninsured or underinsured patients who may need help in paying their healthcare service bill. These programs include government-sponsored coverage programs, charity care, and discount partial charity care. This policy:

- Describes the basis for calculating amounts charged to patients who are eligible for financial assistance.
- Describes the method by which patients may apply for financial assistance.
- Describes the limit amounts that EMC can charge for providing emergency or other medically-necessary care to individuals who are eligible for financial assistance. The limit will be based upon the discounted rate that is comparable to EMC's government payers.
- Describes the methods used to widely publicize the policy within the communities served by EMC.

IV. DEFINITIONS

For the purpose of this Policy, terms are defined as follows:

Full Charity Care is defined as a 100% waiver of patient financial obligation for medically necessary and emergent hospital services. A patient's family income must not exceed 100% of the current federal poverty guidelines in order to qualify.

Discount Partial Charity Care is defined as any medically necessary and emergent hospital services provided to a patient who is uninsured or underinsured, and who is below 350% of the current federal poverty guidelines.

Emergency Medical Condition: EMC treats persons from outside of the EMC service area if there is an emergent, urgent, or life threating condition as defined within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Family Income: Family income is determined based on the Federal Poverty Guidelines that is stated under the U.S. Census Bureau definition.

- A patient's family is defined as persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not;
- Family income includes earnings, unemployment compensation, Workers' Compensation, Social Security, Supplemental Security Income, public assistance, Veterans' payments, survivor benefits, disability payments, pension or retirement income, interest, dividends, rents, royalties, income from estates and trusts, educational assistance, alimony, child support, financial assistance from outside the household, and other miscellaneous sources;
- Capital gains or losses determined on a before-tax basis;
- A person's family income includes the income of all adult family members. For patients under 18 years of age, family income includes that of the parents and/or step-parents, unmarried or domestic partners, or caretaker relatives;
- Non-cash benefits (i.e. Medicare, Medicaid, and Golden State Advantage card EBT benefits, heat assistance, school lunches, housing assistance, need-based assistance from nonprofit organizations, foster care payments, or disaster relief assistance) are not counted as income when making an eligibility determination for financial assistance.

Federal Poverty Guidelines: Federal Poverty Guidelines are updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current guidelines can be referenced at http://aspe.hhs.gov/POVERTY/

Financial Assistance: Under this Policy, Financial Assistance is either Charity Care or a Financial Hardship Discount provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medically necessary services provided by EMC, and who meet the eligibility criteria for such assistance. Patients who identify financial hardship to fully pay the expected out-of-pocket expenses for EMC medically necessary services are provided assistance if they meet the eligibility criteria for such assistance.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

***Gross Charges*:** The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Healthcare Services: Medically necessary hospital and physician services.

Medically necessary: Defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Presumptive Charity: Determination of eligibility for Financial Assistance based upon socioeconomic information, specific to the patient that is gathered from market sources.

Proof of Income: For purposes of determining Financial Assistance eligibility, EMC will review annual family income from the prior two (2) pay periods and/or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate.

Reasonable Payment Plan: An extended interest free payment plan that is negotiated between EMC and the patient for any patient out-of-pocket fees. The payment plan shall take into account the patient's income, essential living expenses, assets, the amount owed, and any prior payments. Payment plans will be for a term of no less than 12 monthly payments.

Uninsured Patient: An individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including, without limitation, Medicare, Medicaid, SCHIP and CHAMPUS), Workers' Compensation, or other third-party assistance to assist with meeting his/her payment obligations. It also includes patients that have third-party coverage, but have either exceeded their benefit cap, been denied coverage or coverage is not provided for the particular medically necessary healthcare services for which the patient is seeking treatment from EMC.

Underinsured Patient: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by EMC.

V. GENERAL GUIDELINES

A. Eligible Services:

- Financial Assistance, under this policy, shall apply to medically necessary and emergent hospital services.
- In the event that there is uncertainty as to whether a particular service is medically necessary, a determination shall be made by EMC administrative staff.

B. Services NOT Eligible:

- Services that are generally not considered to be medically necessary
- Any elective services

C. General Provisions:

- The EMC Financial Assistance Program utilizes a single, unified patient application for both

Full Charity Care and Discount Partial Charity Care. The process 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 the hospital with information that is necessary for assessing patient qualification. Such information will be used to determine the patient's or family representative's eligibility for maximum coverage under the EMC Financial Assistance Program.

- Eligible patients may qualify for the EMC Financial Assistance Program by following the application instructions and making every reasonable effort to provide the hospital with supporting 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 EMC Financial Assistance Program. EMC must complete a process of applicant evaluation and determine coverage before full charity care or discount partial charity care may be granted.

- The EMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, EMC will use a financial assistance application and all submitted documentation to make the determination on financial assistance. All patients unable to demonstrate financial coverage by third-party insurers will be offered an opportunity to complete the financial assistance application, even if those charges included discounted rates as a result of the third-party insurance coverage. Uninsured patients will also be offered information, assistance and referral to government-sponsored programs for which they may be eligible. Patients may obtain applications for coverage offered through the California Health Benefit Exchanges, using the web site address www.coveredca.com or through the Riverside Department of Public Social Services at 1 (800) 274-2050 or dpss.co.riverside.ca.us.

- 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 provided and the patient has been discharged.

- Applicants for financial assistance are responsible for applying to public programs for available coverage. They are also expected to pursue public or private health insurance payment options for healthcare services provided by EMC. The patient's, or a patient's Guarantor's, cooperation in applying for applicable programs and identifiable funding sources, including COBRA coverage (a federal law allowing for a time-limited extension of health care benefits), is required.

- A completed financial assistance application is not required if EMC determines it has sufficient patient financial information from which to make a financial assistance qualification decision. This includes, but is not limited to, cases of indigent or deceased patients.

VI. PROCEDURES

A. Qualification: Full Charity Care and Discount Partial Charity Care

- Qualification for full or partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, Veteran status, disability or religion.

- The patient and/or patient family representative who requests assistance in meeting his/her financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. A Patient Financial Services representative can be contacted at (760) 340-3911 extension 3813.

- 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 eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

- Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Patient Financial Services department at EMC. This office shall be clearly identified on the application instructions.

- EMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

- A financial assistance determination will be made only by approved Hospital personnel according to the following levels of authority:

    - Manager, Patient Financial Services: Accounts less than $25,000
    - Director, Patient Financial Services: Accounts less than or equal to $50,000
    - Vice President, Revenue Cycle: Accounts less than or equal to $100,000
    - Chief Financial Officer: Accounts greater than $100,000

- Qualification criteria are used in making each individual case determination for coverage under the EMC Financial Assistance Program.

- Financial Assistance Program qualification may be granted for full financial assistance or

partial financial assistance, depending upon the patient's or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.

- Once determined, Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient's diagnosis which requires on-going related services, the hospital, at its sole discretion, may 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 qualification determination by the hospital will be included as eligible for write-off at the sole discretion of Hospital management.

- If there were any payments made prior to the determination of the financial assistance, these payments will be refunded promptly on all accounts with dates of service encompassed within the Financial Application Approval time period. The hospital is required to reimburse patient payments made prior to the approval of the financial assistance application. However, the hospital is not required to reimburse the patient if the amount due is less than five dollars ($5.00). The hospital must give the patient a credit for the amount due within 60 days from the date the financial assistance has been granted.

- Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to Medi-Cal/Medicaid may be considered for financial assistance. Patients at or below 350% of the FPL will not pay more than Medicare would typically pay for a similar episode of service. This shall apply to all medically necessary hospital and emergency services provided by EMC.

B. Full and Discount Partial Charity Care Income Qualification Levels

- If the patient's family income is 350% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualifications, the patient may qualify for up to 100% adjustment of liability.

- If the patient's family income is between 101% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the actual percentage paid by any individual patient shall be based on the sliding scale shown in Table 1 below.

TABLE 1: Sliding Scale Payment Schedule

Percent of Poverty Level	Patient Responsibility Waived
100%	100%
101 - 199%	70%
200 - 299%	50%
300 - 350%	10%

- 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 be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, the patient will have no further payment obligation.

C. Presumptive Eligibility for Charity Care

EMC recognizes that not all patients, or patients' Guarantors, are able to complete the Financial Assistance application or provide requisite documentation.

For patients, or patients' Guarantors, who are unable to provide required documentation but meet certain financial need criteria, EMC may nevertheless grant financial assistance. In particular, presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Homeless or one who received care from a homeless clinic
- Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down)
- Patient is deceased with no known estate

For patients, or their Guarantors, who are non-responsive to the EMC application process, other sources of information, as described below, may be used to make an individual assessment of financial need. This information will enable EMC to make an informed decision on the financial need of non-responsive patients.

For the purpose of assisting a patient that communicates a financial hardship, EMC may utilize a third-party to review a patient's, or the patient's Guarantor's, information to assess financial need.

Information from the predictive model may be used by EMC to grant presumptive eligibility to, or to satisfy the documentation requirements for, patients or their guarantors. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive eligibility to patients in financial need.

In the event a patient does not qualify under the presumptive rule set, the patient may still provide requisite information and be considered under the traditional Financial Assistance application process set forth above in Section V.

Patient accounts granted presumptive eligibility status will be adjusted accordingly. These accounts will be reclassified under the Financial Assistance Policy. The discount provided will not be sent to collection and will not be included in EMC bad debt expense.

Presumptive screening provides a community benefit by enabling EMC to systematically identify patients in financial need, reduce administrative burdens and provide financial assistance to patients and the guarantors, some of whom have not been responsive to the financial assistance application process.

D. Payment Plans

An extended payment plan will be offered on any outstanding balance or when a determination of partial financial assistance has been made by the Hospital. The patient shall have the option to pay any or all outstanding amount(s) due in one lump sum payment, or through a scheduled term payment plan.

EMC will offer the patient a reasonable extended payment plan that does not exceed 10% of the patient's family income for one month, excluding deductions for essential living expenses. A payment calculator will be utilized by internal and outside vendors as a way to validate the exclusions mentioned above.

"Essential living expenses" are defined as expenses for any of the following: rent or mortgage payments (including maintenance expenses), food and household supplies, utilities, clothing, medical or dental payments, insurance, school, child care, spousal support, transportation, or automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. EMC will work with the outside vendor to make sure that these expenses are taken into consideration prior to a payment plan being offered.

The Hospital will discuss extended payment plan options with each patient based on the AB1276 Fair Billing Act. Individual extended payment plans will be arranged based upon the patient's ability to effectively meet the payment terms. As a general rule, payment plans will be structured to last no longer than 12 months unless the patient qualifies under the AB776 extended payment plan guidelines. The Hospital shall negotiate in good faith with the patient; however, there is no obligation to accept the payment terms offered by the patient. No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy. Once a payment plan has been approved by EMC, any failure to pay all consecutive payments due during a 150-day period will constitute a payment plan default.

It is the patient's or guarantor's responsibility to contact the EMC Patient Financial Services department if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, EMC will make a reasonable attempt to contact the patient or their representative by telephone and also give notice of the default in writing. The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Financial Services representative within Fourteen (14) Days from the date of the written notice of extended payment plan default. If the patient fails to request renegotiation of the extended

payment plan within fourteen (14) days, the payment plan will be deemed inoperative and the account will become subject to collection. Any balance that does not adhere to the payment plan agreement, and ages greater than 150 days, will be deemed eligible for Bad Debt and would be assigned to Eisenhower's out-sourced collections vendor.

E. Other Special Circumstances

If the patient is determined to be homeless, he/she will be deemed eligible for financial assistance. No application is required. An adjustment will be made on the account to show a zero balance.

Deceased patients who do not have any third party coverage, an identifiable estate or for whom no probate hearing is to occur, shall be deemed eligible for financial assistance. No application is required. An adjustment will be made on the account to show a zero balance.

EMC deems those patients that are eligible for government-sponsored low-income assistance programs (e.g. Medi-Cal/Medicaid, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental programs. 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 EMC Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full adjustment as Charity Care. All Treatment Authorization Request (TAR) denials, lack of payment for non-covered services provided to MediCal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care.

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a financial assistance application which will show a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Notwithstanding the preceding, 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 classified as charity care 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 whose income is at or below 350% of the established poverty income level and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes, do not qualify for routine financial assistance. 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 all assets as reported at the time of occurrence on the financial assistance application. Hospital Administration shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.

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, may be deemed eligible for financial assistance/Charity Care. Documentation of the patient's or family representative's inability to pay for services will be maintained in the financial assistance documentation file.

F. Criteria for Re-Assignment from Bad Debt to Charity Care

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

A. The collection agency has determined that the patient/family representative is unable to pay.
B. Patient meets criteria under section VI. Presumptive Eligibility.

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.

The Hospital will make all reasonable efforts, as described in AB774, to determine whether an individual is eligible under the Hospital's financial assistance policy before engaging in extraordinary collection actions, either directly or indirectly through any purchaser of debt, collections agency or other party to which the hospital facility has referred the individual debt.

Eisenhower Medical Center will not do any of the following seeking payment for care covered by the hospital:

- Sell an individual debt to another party
- Report adverse information about the individual to consumer credit reporting agencies.
- Place a lien on an individual property. However, a lien that a hospital is entitled to assert under state laws on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which the hospital provided care is not an ECA (Extraordinary Collections Action)
- Foreclose on real property
- Attach or seize an individual's bank account or other personal property
- Commence a civil action against an individual
- Cause an individual arrest or writ of body attachment
- Garnish an individual's wages
- Defer or deny medically necessary care because of non-payment of a bill for previously

provided care covered under the hospital's financial assistance policy.

- Require a payment before providing medically necessary care because of outstanding bills for previously provided care.

VII. Notification

A. To make information readily available about its Financial Assistance Policy and program, EMC will do the following:

1. Post this Policy, a summary, and the EMC Financial Assistance Application on the EMC website.
2. Post conspicuous notices on the availability of Financial Assistance in emergency departments, urgent care centers, admitting and registration departments, Patient Financial Services, and at other locations that EMC deems appropriate.
3. Make paper copies of the FAP, FAP application form and the plain language summary of the FAP available upon request and without charge both by mail and in public locations.
4. Make available notices and other information on Financial Assistance to all patients
5. Print the policy in the primary languages of 5 percent or more of the hospital's patients.
6. Make available its Financial Assistance Policy or a program summary to appropriate community health and human services agencies and other organizations that assist people in financial need.
7. Make available information on Financial Assistance, including a contact number, on patient bills and through oral communication with uninsured and potentially underinsured patients.
8. Provide financial counseling to patients about their EMC bills and make the availability of such counseling known. (Note: it is the responsibility of the patient or the patient's Guarantor to schedule assistance with a financial counselor.)
9. Provide information and education on its Financial Assistance and collection policies and practices available to appropriate administrative and clinical staff.
10. Encourage referral of patients for Financial Assistance by EMC representative or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains and religious sponsors.
11. Encourage and support requests for Financial Assistance by a patient, a patient's Guarantor, a family member, close friend or associate of the patient, subject to applicable privacy laws.

B. Once a determination of eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

1. **Approval:** The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient.

2. **Denial:** The reasons for denial of the financial assistance application will be explained to the patient. Any outstanding amount owed by the patient will also be identified.

3. **Pending:** The applicant will be informed as to why the financial assistance application is incomplete. All outstanding information will be identified and requested to be supplied to the hospital by the patient or family representative.

VIII. Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the Hospital. The written appeal should contain a thorough explanation of the patient's dispute and rationale for reconsideration. All additional relevant documentation to support the patient's claim should be attached to the written appeal.

Appeals will be 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 Director of Patient Financial Services, the patient may request in writing, a review by the hospital's Vice President of Revenue Cycle or Chief Financial Officer. The Chief Financial Officer (CFO) shall review the patient's written appeal and documentation, as well as the findings of the director of patient financial services. The CFO shall make a determination and provide a written explanation of findings to the patient. All determinations by the CFO shall be final. There are no further appeals.

IX. Public Notice

EMC will provide the Office of Statewide Health Planning and Development (OSHPD) with a copy of this Financial Assistance Policy which includes the full charity care and discount partial charity care policies within a single document. The Financial Assistance Policy also contains:

1. All eligibility and patient qualification procedures.
2. The unified application for full charity care and discount partial charity care.
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.

EMC 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 about financial assistance programs 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 on a reasonable basis.

X. 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 these values.

XI. Good Faith Requirements

EMC 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, EMC 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.

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