TITLE: "Allowance for Financially Qualified Patient's"

DEPARTMENT: Business Office

SCOPE: **FINANCIAL PERSONNEL**

POLICY: The Business Office will maintain an understandable, written financial assistance policy for low-income uninsured and underinsured patients, addressing the hospital's Allowance for Financially Qualified Patient's policy.

The written allowance for financially qualified patient's policy will be in compliance with AB 774, AB 1503 and SB 1276.

Financially qualified patients are self-pay as well as insured patients with high medical costs. All patients are eligible to apply under the policy if their family income is at or below 250 percent of the federal poverty level.

The Allowance for Financially qualified patient policy will state the process used to determine whether a patient is eligible for charity care or a discounted payment.

Financially qualified patients are those with no coverage or high-deductible consumer-driven health plans, are eligible to apply under the District's policy. To be eligible, patients must incur out-of-pocket costs that exceed 10 percent of their family income in the prior 12 months.

A patient applying must make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the patient fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that grounds for disqualification.

Emergency Room Physicians will also offer discounts under the law. Please contact Kern Valley Healthcare Financial counselor 760-379-2681 ex 334 regarding any qualifying visits.

PROCEDURE:

If a patient or hospital staff member considers that the patient may be eligible for charity care or discounted payment, they will provide the patient with a Financial Statement form and request that it be returned to the Financial Counselor for eligibility determination.

The Financial Counselor will review all Financial Statements submitted for eligibility determination for either charity care or discount payment as soon as reasonably possible, but in all cases prior to instituting any collection practices other than the initial deposit requirements as specified in the deposit schedule. (attached)

For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. (This includes, but is not limited to Income Tax Returns, W-2's, recent pay stubs and bank statements) This information may not be used for collection activities.

Notice

Business services staff will provide patients with a written notice about the availability of the discount payment and charity care policy. This notice will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, the emergency department, billing office, admitting office, rural health clinic, retail pharmacy and other outpatient locations. This notice will be in English and other languages as required by Insurance Code 12693.30.

Eligibility

For purposes of determining eligibility for discounted payment, documentation of income shall be limited to recent pay stubs or income tax returns.

For purposes of determining eligibility for charity care, documentation of assets may include information on all monetary assets, but shall not include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000.) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.

Billing Requirements

Business services staff will make all reasonable efforts to obtain information from the patient about whether private or public health insurance might fully or partially cover the charges for care, including private health insurance, Medicare, Medi-Cal, Healthy Families, Covered California or other state or federally funded programs.

When a patient is billed who has not provided proof of coverage by a third party at the time the care was rendered or upon discharge, the business services staff will include as part of that billing process a "clear and conspicuous" notice of the following:

- A statement of charges for services rendered;
- A statement that, if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families, Covered California, Medi-Cal or charity care;
- A statement indicating how patients may obtain applications for the Medi-Cal ,Healthy Families Program and Covered California, and that the Hospital will assist in obtaining these applications;
- Information regarding the financially qualified patient and charity care application process, including the following:

A. A statement that indicates that, if the patient lacks or has inadequate insurance and meets certain low and moderate-income requirements, the patient may qualify for a discounted payment or charity care.

B. The name and number of the then current patient financial counselor and the business office for further information about the hospital's discount payment and charity care policy, and how to apply for assistance.

Payment Plan

A reasonable payment plan will be offered to all patients meeting the eligibility requirements. This plan will require that monthly payments do not exceed 10% of a patient's familial income for one month excluding deductions for essential living expenses. Essential living expenses are defined as expenses for any of the following: rent or house payments(including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child and spousal support, transportation and automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. KVHD will not send the bill to a collection agency unless that agency agrees to comply with the requirements of AB774.

KVHD will not use wage garnishments or liens on primary residences as a means of collecting debt from eligible patients. However, an unaffiliated collection agency may obtain a court order authorizing wage garnishment.

Any extended payment plan offered by KVHD to assist patients eligible under the charity care and deposit and discount payment policy, or any other policy adopted by KVHD for assisting low-income patients will be interest free.

Before commencing collection activities, KVHD will provide the patient with a clear and conspicuous written notice regarding the patient's rights under state and federal fair debt collection rules. The notice must include a statement that the Federal Trade Commission enforces these requirements.

Attachments: Charity Criteria
Sliding Scale
Deposit Schedule

Reference: AB 774 –AB 1503 - SB 1276

APPROVAL	DATE	APPROVAL	DATE
Department/Division Manager	12/14	Interdisciplinary Team	N/A
Unit Medical Director (if applicable)	N/A	Governing Board	
Medical Staff Committee (if applicable)	N/A	Administration	
Reviewed By:		Reviewed By:	

KERN VALLEY HEALTHCARE DISTRICT

HOSPITAL AND CLINIC CHARITY CRITERIA

FAMILY UNIT	MONTHLY INCOME A
1	2,431
2	3,277
3	4,123
4	4,969
5	5,815
6	6,660
7	7,506
8	8,352
9	9,198
10	10,044

Patient Owes:

RHC	$20.00	
Lab	$10.00	
Xray	$15.00	
U.S	$15.00	
CT	$30.00	
OP Serv	$25.00	
Rehab(PT,OT)	$20.00	per visit
Surg/Proc	$50.00	
CRNA	$50.00	
Phy-Surg	$400.00	
E/R	$50.00	
Phy-ER	$50.00	
Acute Care	$50.00	daily
Swing	$50.00	daily

EFFECTIVE: 03/01/14

KERN VALLEY HEALTHCARE DISTRICT
SLIDING FEE SCALE
HOSPITAL AND CLINIC
DISCOUNTS

THE DISCOUNTS SHOWN BELOW MAY NOT BE COMBINED WITH ANY OTHER CASH OR POLICY DISCOUNT.

Family Members	25%		50%		75%		100%		
	A		B		C		D		E
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
1	0	2,431	2,432	2,836	2,837	3,241	3,242	3,646	3,647
2	0	3,277	3,278	3,823	3,824	4,369	4,370	4,915	4,916
3	0	4,123	4,124	4,810	4,811	5,496	5,497	6,183	6,184
4	0	4,969	4,970	5,797	5,798	6,624	6,625	7,452	7,453
5	0	5,815	5,816	6,783	6,784	7,752	7,753	8,721	8,722
6	0	6,660	6,661	7,770	7,771	8,880	8,881	9,990	9,991
7	0	7,506	7,507	8,757	8,758	10,007	10,008	11,258	11,259
8	0	8,352	8,353	9,744	9,745	11,135	11,136	12,527	12,528
9	0	9,198	9,199	10,731	10,732	12,263	12,264	13,796	13,797
10	0	10,044	10,045	11,718	11,719	13,391	13,392	15,065	15,066

Hospital Charges:
(Including ER, IP, Phy, Lab, Radiology and/or ancillary services)

A= CHARITY CARE
Laboratory -$10.00
Radiology - $15.00
Ultra Sound - $15.00
Cat Scan - 30.00
OP Services - $25.00
Surgical Services - $50.00
CRNA - Anesthesia - $50.00
Surgical Physician- $400.00
Emergency Services - $50.00
Emergency Physician - $50.00
Acute Care Services (Inpatient Services) - $50.00 Each Day
Swing (Inpatient Services) - $50.00 Each Day

B= 25% of total charges ($50.00 minimum non Surgical $500.00 minimum Surgical)
C= 50% of total charges ($60.00 minimum non Surgical $500.00 minimum Surgical)
D= 70% of total charges ($70.00 minimum non Surgical $500.00 minimum Surgical)
E= 100 % of total charges

RHC Discounts:

Discount Category	**Patient Pays**
A=	$20.00 CHARITY CARE
B=	$40.00 + 50% OF SUPPLIES
C=	$50.00 + 50 % OF SUPPLIES
D=	$60.00 + 50% OF SUPPLIES
E=	$60.00 + 50% OF SUPPLIES (CASH PAY)

NOTE: SLIDING SCALE IS BASED ON JANUARY 24, 2014 FEDERAL POVERTY GUIDELINES.
THIS SLIDING SCALE IS BASED ON 250% OF FEDERAL POVERTY GUIDELINES
THE ABOVE FIGURES ARE BASED ON MONTHLY GROSS INCOME.

Effective: 3/1/14

KERN VALLEY HEALTHCARE DISTRICT

DEPOSIT SCHEDULE:

Hospital Admission		$ 3,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Skilled Nursing		$ 8,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Outpatients / Clinics		$ 100.00	Or the verifiable Co-pay requirement from the primary insurer.
Emergency Room		$ 200.00	Or the verifiable Co-pay requirement from the primary insurer.

AVAILABLE DISCOUNTS: **MULTIPLE DISCOUNT TYPES WILL NOT BE COMBINED**

Cash / Uninsured		30%	Based on all charges. Pay arrangements may be made based on amount due.
Sliding Scale			Sliding scale discount based on 250% of the currently posted "Poverty Guidelines" (see sliding scale schedule)
Employee & Board		30%	Applicable to the patient's personal liability portion of the hospital's charges; not to include patient deductible and or co-pay's.
Administrative Allowance			From time -to-time the CEO may grant a special discount when warranted by special circumstances. Such discounts or allowances will only be granted upon written authorization from the CEO/CFO to the Business Office Manager or Controller.

Acceptable payment arrangements may be made by seeing the Financial Counselor.

Revised: 3/16/12

KVHD
"We Care For You"
Kern Valley Healthcare District
6412 Laurel Ave - Mt. Mesa - P.O. Box 1628, Lake Isabella, CA 93240 - (760) 379-2681 Fax (760) 379-6609

SLIDING FEE SCALE PROGRAM

Kern Valley Healthcare District (KVHD) offers our uninsured patients a Sliding Fee Scale Program upon qualification. The application process is simple. One must apply for Medi-Cal before applying for our Sliding Scale Program. Once this is done, a Financial Statement must be filled out showing the monthly income of all members of the patient's household, along with other relevant financial information. Documentation that supports the Financial Statement must also be provided - see the attached requirements.

Eligibility will be based on 250% of the Federal Poverty Guideline. Once eligibility is established, it remains in effect for a maximum of one year or earlier, at the discretion of KVHD. Any changes in a patient's financial information must be reported to KVHD immediately so eligibility can be re-evaluated.

You have been given this information because we believe you may qualify for consideration under this program. Please complete our Financial Statement (attached) and return it to the reception staff immediately. Provide us with your supporting documentation as soon as possible by bringing it to our facility or by mailing it to: P.O. Box 1628, Lake Isabella, CA 93240 ATTN: Business Office

You will be notified in writing of our decision as soon as possible after we review your Financial Statement and supporting documentation. Prompt payment for the services you receive is required, whether or not they qualify for a reduction under our Sliding Scale Program.

Contact our Business Office by calling (760) 379-2681, Extension 334, if you have any questions or need assistance concerning this program.

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HOW TO COMPLETE THE FINANCIAL STATEMENT AND PROVIDE SUPPORTING DOCUMENTATION

It is important to complete the Financial Statement in its entirety. Please read and answer every question asked. If the question does not apply to you, write "N/A" for not applicable. If your answer is none, please write "none" so we know you have considered the question. The information requested on this form is to be provided for all members of your household.

If you are working, provide copies of your most recent pay stubs.

If you receive unemployment income, disability income, social security income, retirement and/or pension income, provide copies of the statements showing the amounts you receive. If you receive child support or alimony, provide copies of documentation showing the amounts you receive.

If you are employed or self-employed, provide copies of your most recent income tax return including relevant schedules.

If you receive monies in the form of gifts, assistance, loans or any other unreported compensation, provide a written statement of explanation.

If you have bank accounts, investment or retirement accounts, treasury bills, certificates of deposit, money market funds, stocks, bonds, or other certificates, please provide copies of your most recent monthly or quarterly statements. If you receive income from notes of indebtedness or under a rental contract, provide a copy of the document or contract that details the arrangement.

KVHD "We Care For You" Kern Valley Healthcare District
6412 Laurel Ave - Mt. Mesa - P.O. Box 1628, Lake Isabella, CA 93240 - (760) 379-2681 Fax (760) 379-6609

Dear Patient,

We need financial information in order to complete your application for our Sliding Scale Program. We need this information within **30 days** from the date that you applied for our program. You will continue to be billed and responsible for **all** Clinic/Hospital charges until this information is received. ***The information must be provided for all members of the household.***

Listed below are some of the most common items that we can use in determining eligibility (Please provide as many as possible).

Financial Statement ***(required)***
Paycheck Stubs (2 months)
Income Tax Returns
Unemployment Income
Any Other Income (CD's, Market Funds, Stocks, etc.)
State Disability Income
Social Security Income (SSI)/Social Security Disability (SSD)
Child Support
General Assistance
Bank Statements (2 months)
Letter of Support (From the person who is helping you)
Golden State Advantage Card (Food Stamp Card)
Medi-Cal Denial Letter ***(**Must have this in order to qualify**)***

If I can be or any assistance or you have any questions, please do not hesitate to contact me.

Thank you for your assistance,

Michele L. Hurst
Financial Counselor
(760) 379-2681 ext. 334

KVHD "We Care For You" Kern Valley Healthcare District
6412 Laurel Ave - Mt. Mesa - P.O. Box 1628, Lake Isabella, CA 93240 - (760) 379-2681 Fax (760) 379-4795

Financial Statement

Patient Name			Med Rec Number	Account Number
Address	City	State	Zip	How Long?
Telephone Number	If less than one year, Previous Address			

Circle Reason Patient Is Applying

Clinic Appointment | Pre-Admission Arrangements | Hospital Services

Payment Arrangements | Delinquent Account | Collection Letter

Members of Household (including patient): List additional members of household on separate sheet.

	Last Name	First Name	MI	Birthdate	M / S	Social Security Number	Gross Monthly Income
1							
2							
3							
4							
5							
6							

Personal Property. Do you or members of your household have any of the following?:

X	Item	$ Value	X	Item	$ Value
	Checks/Cash (on hand, home, elsewhere)			Certificates of Deposit	
	Treasury Bills			Money Market Funds	
	Notes: Mortgages, Deeds of Trust, etc.			Stocks, Bonds, Certificates	
	Checking Account(s): Bank, Address				
	Savings Account(s): Bank, Address				
	Resources which can be converted to cash (specify):				
	Other:				

Motor Vehicles (include autos, trucks, motorcycles, jet skis, motor homes, boats, trailers):

X	Year	Make	Model	Used for Work?	Owner	$ Value

Other Income:

X	Source	Monthly Amt.	X	Source	Monthly Amt.
	Social Security/ Disability/Unemployment			Dividends/ Interest/ Royalties	
	Pension/Retirement			Child Support / Alimony	
	Rental Income			Self-employment or Business Income	
	Other (specify)				

Living Arrangements: Circle the one that applies

Renting Own/Buying Room with another person Other (explain)

Real Property:

x	Description	$ Value

Accident:

Was patient's problem caused by an accident? Yes No If yes, date of accident: / /
Where did accident occur? How?
Is patient seeking compensation through an insurance settlement or lawsuit Yes No Comment:

Circle any of the following that apply to the patient:

Have or Will apply for Medi-cal	65 or Over	Blind	Pregnant

Other Information:

Provide Address & Phone of any Employer

I declare or affirm that the statements above are true and correct to the best of my knowledge and belief. I understand that withholding information or giving false information will make the patient and/or responsible party liable for payment of all charges for services render

Signature of Patient or Provider of Information:	Date:
Signature of Witness:	Date:

Do Not Write Below this Area for Office Use Only:

Financial Counselors Notes: