Fallbrook Hospital

Subject:	Originally Issued	Date of This Revision	Page	No.
CHARITY CARE POLICY	*original policy 02/11/03*	*Closing date or eff 02/03/12*	1 of 13	

POLICY STATEMENT:

In order to serve the health care needs of our community, **Fallbrook Hospital** will provide charity care to patients without financial means to pay *for Inpatient and Emergency Room hospital services.*

Charity care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria.

PURPOSE:

To properly identify those patients who are financially indigent or medically indigent, who do not qualify for state and/or government assistance, and to provide assistance with their Inpatient and Emergency Room medical expenses under the guidelines for Charity Care.

ELIGIBILITY **FOR CHARITY CARE**

1. **FINANCIALLY INDIGENT:**

   A. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or a discounted obligation to pay for services rendered based on the hospital's eligibility criteria as set forth in this Policy.

   B. To be eligible for charity care as a financially indigent patient, the patient's total household income shall be at or below 350% of the current Federal Poverty Income Guidelines. The hospital may consider other financial assets and liabilities for the person when determining eligibility.

   C. The hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The Federal Poverty Income Guidelines are published in the Federal Register in January or

Poverty Income Guidelines are published in the Federal Register in January or February of each year and for the purposes of this Process will become effective the first day of the month following the month of publication.

D. In no event will the hospital establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 350% of the current Federal Poverty Income Guidelines. However, the hospital may adjust the eligibility criteria from time to time based on the financial resources of the hospital and as necessary to meet the charity care needs of the community.

E. Patients covered by out of state Medicaid where the hospital is not an authorized provider and where the out of state Medicaid enrollment or reimbursement makes it prohibitive for the hospital to become a provider, will be eligible for charity upon verification of Medicaid coverage for the service dates. No other documents will be required in order to approve the charity application. The patient will not be required to make a formal charity application. The hospital may submit the application and verification of coverage as proof of qualification.

2. **MEDICALLY INDIGENT:**

A. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as defined herein and who is unable to pay the remaining bill.

B. Patients covered under state Medical Assistance programs that owe copayments or have a 'spend down' amount are excluded from being considered for charity care assistance. Payment of copayments and spend down amounts are a condition of coverage and should not be written off or discounted.

C. To be eligible for charity care as a medically indigent patient, the amount owed by the patient on medical bills for the prior 12 month period, after payment by third party payers, must exceed 50% of the patient's annual gross income and the patient must be unable to pay the remaining bilL The hospital may consider other financial assets and liabilities of the person when determining ability to pay

D. A determination of the patient's ability to pay the remainder of the bill, or portion of the bill, will be based on whether the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.

E. The patient may be eligible for a charity discount for any amount beyond what the patient is expected to pay over a 3-year period.

F. If a determination is made that a patient had the ability to pay the remainder of the bill, such a determination does not prevent a reassessment of the patient's ability to pay at a later date should there be a change in the patient's financial status.

THE PROCESS

1. **Identification of Charity Cases:**

   A. The hospital maintains posted signs, in English, *Exhibit "A"* and Spanish, *Exhibit "8",* one in each admitting offices and one in the emergency lobby that inform customers that charity care is available and what are the charity care criteria. **(SIGNS WILL BE POSTED ONLY IF STATE REQUIRES or if hospital has participated in the Hill Burton Program and will comply with hospital state Jaws which will be attached to this policy)**

   B. All self-pay patients are asked to complete the Financial Assistance form "FA", *Exhibit* "C", during the registration or financial counseling process.

   C. Where required by state law, (copy attached if applicable) hospital will provide written information about the availability of charity care during the registration process.

   D. Where required by state law, (copy attached if applicable) hospital will post information regarding the availability of charity care on the hospital's web site.

   E. Where required by state law, (copy attached if applicable) hospital will provide information on all billing notices about the availability of charity care.

   F. All self-pay accounts will be screened for potential Medicaid eligibility as well as coverage by other sources, including governmental programs. During this screening process an "FA" will be completed if it is determined that the patient does not appear to qualify for coverage under any program.

   G. The "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager.

   H. If the Financial Counselor determines through the application and documented support that the patient qualifies for charity care she/he will give the completed and approved "FA" to the BOM for approval authorization, prior to write off.

      The following documents will be required to process the application: copies of current monthly expenses/bills, copies of the previous year's income tax return, current copy of employers check stub, proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills. The hospital has the option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to the credit card. Where patient/guarantor indicates no income, no bank account or does not file taxes, a credit report is required and must be reviewed to determine if there is conflicting information that indicates income. However, if the patient is covered by Medicaid or other similar State or Federal programs (such as Family Planning) a credit report would not be required since income verification has already been validated in order for the patient to be covered under such program. Unless the patient can explain why the credit report reflects conflicting information such as open lines of credit that are current,

mortgage loans that are current, credit cards that are current(any one or combination), or credit scores above 600, the charity care application will be denied. Acceptable explanations such as recent loss of employment must be supported through documentation such as termination letter or a letter from prior employer stating that the patient/guarantor is no longer employed as of (date). Low credit scores (below 500) will be indication of support for statements such as 'do not file taxes or have no bank account'. Where the patient/guarantor indicates they do not file federal tax returns, the hospital will request that the patient/guarantor complete IRS form 4506T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the hospital has completed lines 6 9. Hospital will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, hospital will enter prior year and prior 3 years. (Exhibit F-example and a blank form).

J. The Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.

K. Once approved for Charity, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self pay.

L. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.

M Applications that remain incomplete after 30 days of 'request of information', and determination has been made that patient does not qualify for Medicaid, may be denied or submitted to the CFO for their consideration/approval. (see # 4 on Page 5)

N. The application may be reopened and reconsidered for charity once the **required information is received.**

0. The Business Office Manager (or Assistant BOM) is responsible for reviewing every application to make sure required documents are attached, prior to submitting to CFO or CEO for review and approval. All fields on the application must be completed properly. Drawing lines through fields such as income is not appropriate If the income is zero, zeros must be entered.

P. Medicaid patients who receive covered IP and ER services that meet Medicare medical necessity, but have exhausted state benefit limits (IE limited IP days or limited annual ER visits, for example), will not be required to provide any supporting documents providing verification of Medicaid coverage for the service dates is completed.

Q Once an account has been written off to bad debt, the patient will not be allowed to apply for Charity assistance.

2. **FACTOR TO BE CONSIDERED FOR CHARITY DETERMINATION**

A. The following factors are to be considered in determining the eligibility of the patient for charity care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for charity are attached on *Exhibit "D".* The current Federal Poverty Guidelines are attached as *Exhibit "E"* and they include the definition of the following:

1. Family
2. Income

3. **FAILURE TO PROVIDE APPROPRIATE INFORMATION**

A. Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination.
B. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

4. **EXCEPTION TO DOCUMENTATION REQUIREMENTS**

The CFO may waive the documentation requirements and approve a case for Charity Care, at his/her sole discretion based on their belief the patient does/should qualify for charity. The amount or percentage of charity care discount will be left to the CFO's discretion. Waiver of the documentation requirements should be noted in the comments section on the patient's account, as well as the percent or dollar amount approved for Charity adjustment, printed out and attached to the Financial Assistance (FA) form.

5. **TIME FRAME FOR ELIGIBILITY DETERMINATION**

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

6. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review and approval of

the write-off by signing the bottom of the Charity Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

7. REPORTING OF CHARITY CARE

Information regarding the amount of charity care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

8. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO*	FEB 3, 2012 Date
Hospital CFO*	2/3/12 Date
Corporate VP, Patient Financial Services	3/5/12 Date
Division VP, Finance*	3/5/12

Asterisk above indicates that scanned signatures were not able to be converted into MS Word, please refer to a pdf copy provided by the hospital all of the signatures, if it is required.

Exhibit A
Example of 'Availability of Charity Care" Sign-English Version

CHARITY CARE POLICY

This hospital will provide care to persons who are unable to pay for their care.

In order to be eligible for charity care, you must:

- Have no other source of payment such as insurance, governmental assistance or savings; or
- Have hospital bills beyond your financial resources; and
- Provide proof of income and income resources; and
- Complete an application and provide information required by the hospital.

Forms and information about applying for charity care are available upon request.

Exhibit B
Example of 'Availability of Charity Care" Sign-Spanish Version

REGLAS PARA SERVICIOS DE CARIDAD

El hospital ofrece servicios gratuitos a personas que no pueden pagar por su atencion medica.

Para obtener derecho a servicios caritativos, se necesita tener los siguientes requisitos:

No tener otro medio de pagar, por ejemplo, seguro medico, asistencia del gobierno federal, o sus propios ahorros o bienes

Tener cuentas de hospital que esten mas alia de sus recursos cconomicos.

Tambien hay que:

Presentar pruebas de sus ingresos y recursos economicos

Completar Ia solicitud de servicio y dar Ia informacion que le pide al hospital.

Formularios con informacion y datos tocante a Ia solicitacion de servicios caritativos se proveeran. A aquellos individuos interesados.

Exhibit C
Financial Assistance Form
(Hospital Name)
Charity Care/Financial Assistance Program Application

Patient Account Number:_____ Date of Application_____

PATIENT INFORMATION

Name_ _ _ _ _ _ _ _ _ _ _ _ _ _

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work _____

Length of Employment_____

Supervisor_____

PARENT/GUARANTOR/SPOUSE

Name_____

Address_____

City_____

State/Zip_____

SS#_____

Employer_____

Address_____

City_____

State/Zip_____

Work _____

Length of Employment_____

Supervisor_____

RESOURCES

Checking: yes_ no_
Savings: yes_ no_

Cashon hand: ------

Vehicle 1: Yr_____ Make_____Model_____
Vehicle 2: Yr Make Model_____
Vehicle 3: Yr_____ Make_____Model_____

Exhibit C (continued)
Charity Care/Financial Assistance Program Application

INCOME

PatienUGuarantor:	Spouse/Second Parent:
Wages(monthly): ————————	Wages(monthly) ————————
Other Income: Child Support: $_____	Other Income: Child Support: $_____
VA Benefits $_____	VA Benefits: $_____
Workers' Camp: _____	Workers' Comp: $_____
SSI: $_____	SSI _____
Other $_____	Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment$_____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 3 months bank statements, last 4 pay check stubs, if applicable, or a letter from employer, or letter from Social Security, etc. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant._____

Hospital Representative Completing Application: ————————————————

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The below signatures is indication of your review of the application and supporting documentation and that you find the information to meet policy requirements.

Approval/Authorization of Charity Write-Off **Amount Approved** ——————

BOM_____ **CEO_____**

CFO_____

Exhibit D

Income Guidelines For Determining% of Charity Care Discount
(For Financially Indigent Patients)

Based Current Year's Federal Poverty Income Guidelines

% of Poverty Income	Discount from Gross Charges
100-150%	100%
150-200%	90%
200-250%	80%
250-300%	75%
300-350%	50%

MEMORANDUM

TO: Business Office Managers

FROM: Lola Davis

DATE: January 27, 2012

CC: CFOs, Division VPs, Larry Cash, Marty Schweinhart

RE: **Poverty Income Guidelines 2012**

The Department of Health and Human Services has issued updated Poverty Income Guidelines for 2012 (reference: Federal Register: January 26, 2012, Volume 77, Number 17 pp. 4034-4035).

2012 Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family/household	Poverty Income Guideline
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/households with more than 8 persons, add $3,960 for each additional person.

2012 Poverty Income Guidelines for Alaska

Persons in family /household	Poverty Income Guideline
1	$13,970
2	18,920
3	23,870
4	28,820
5	33,770
6	38,720
7	43,670
8	48,620

For families/households with more than 8 persons, add $4,950 for each additional

person.

2012 Poverty Income Guidelines for Hawaii

Persons in family /household	Poverty Income Guideline
1	$12,860
2	17,410
3	21,960
4	26,510
5	31,060
6	35,610
7	40,160
8	44,710

For families/households with more than 8 persons, add $4,550 for each additional person.

Please update your Charity Care Policies to use the new income guidelines effective February 1st. as well as any other polices that use the Poverty Income Guidelines. As noted in the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the poverty income guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program. To find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.

Subject: California DISCOUNT/UNINSURED/SELF-PAY POLICY	Originally Issued	Date of This Revision	Page No.
	01/01/2007	06/15/12	1 of7

POLICY STATEMENT:

As a condition of participation in the Medicaid disproportionate share program (if applicable) and to serve the health care needs of our community, **Fallbrook Hospital** ("Hospital") will provide discounted care ("Discounted Care") to patients without financial means to pay for hospital services, who do not otherwise receive a discount through their insurance as a result of a negotiated contract or through coverage of a governmental payer or to uninsured patients, who do not otherwise qualify for third party coverage, local, state and/or government assistance with their health care needs.

Discounted Care will be provided to all patients without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility criteria.

PURPOSE:

To properly identify uninsured patients and those patients with insurance through a non discounted payer; patients who are financially indigent or medically indigent; patients who do not qualify for state and/or government assistance, and to provide assistance with their medical expenses under the guidelines of this Discount Policy.

ELIGIBILITY FOR DISCOUNT CARE

1. **FINANCIALLY INDIGENT:**

A. A financially indigent ("FI") patient is a person (i) who is insured, (ii) whose insurance does not provide a discount off gross charges, based on the Hospital contractual agreement with that payer, and (iii) who meets the Hospital's eligibility criteria as set forth in this Discount Policy.

B. The Hospital's eligibility criteria for FI is that either (i) the patient's total household income shall

be at or below 350% of the current Federal Poverty Income Guidelines, or (ii) the patient's annual out-of-pocket medical costs incurred exceed 10% of the patient's family income in the prior 12 months (this can be incurred at any facility). In determining FI eligibility, the Hospital may also consider the patient household's monetary assets including cash, stock, bonds and similar investment vehicles ("Monetary Assets"). The Hospital's calculation of Monetary Assets will not include (i) retirement or deferred compensation plans, (ii) the first $10,000 of relevant assets, or 50% of relevant assets in excess of $10,000.

The Hospital will use the most current Federal Poverty Income Guideline issued by the U.S. Department of Health and Human Services to determine

C. The Federal Poverty Income Guidelines are published in the Federal Register in January or February of each year and for the purposes of this Discount Policy will become effective the first day of the month following the month of publication.

D. In no event will the Hospital establish FI eligibility criteria that set the income level lower than that required for counties under the State Indigent Health Care and Treatment Act, or higher than 350% of the current Federal Poverty Income Guidelines. However, the Hospital may adjust its eligibility criteria from time to time based on the financial resources of the Hospital and as necessary to meet the needs of the community, providing the changes are in compliance with State Law AB 774.

E. To be eligible under the Hospital's Charity Care Policy or Discount/Uninsured Policy, a patient must be uninsured and the hospital services must not be covered in whole or part, by any other third party source.

F. The services must be provided on or after 06/15/12

G. Uninsured patients who do not apply for Charity Care and/or do not provide the documents required to make a determination of eligibility for Charity Care will still be eligible for a discount under the California Discount/Uninsured/Self-Pay Policy.

H. To be eligible for Discounted Care, Charity Care or Uninsured/Self-Pay Discount, the services the patient receives must be medically necessary based on Medicare Medical Necessity criteria.

2. **MEDICALLY INDIGENT:**

A. A medically indigent ("MI") patient is a person (i) whose income is at or below 350% of the Federal Poverty Income Guideline and (ii) who does not already receive a reduction in their portion of the bill based on the payer agreement with the Hospital.

B. Patients who qualify as MI will not be charged an out-of pocket amount in excess of 10% of their prior 12 months income. To make this determination, the Hospital shall consider the medical expenses an MI patient incurs in the prior 12 months whether or not the services were provided at the Hospital. Patients must provide proof of medical expenses.

C. The Hospital will make a determination of a patient's ability to pay the remainder of the bill, or portion of the bill, based on whether the patient reasonably can be expected to pay the account, or portion thereof, over a 3-year period.

D. A determination that a patient has the ability to pay the remainder of their bill does not prevent a reassessment of the patient's ability to pay at a later date if there is a change in the patient's financial status.

3. **SELF-PAY PATIENTS:**

A. Except for the exclusions described below, all uninsured inpatients who do not qualify as FI or MI ("Self-Pay Patients") are eligible for a discount of 30% off billed charges for inpatient services.

B. Excluded from the Self-Pay Patients Policy are: Patients who qualify and receive a Charity Care Discount; Cosmetic procedures or services not considered medically necessary based on Medicare Medical Necessity criteria or any other patient/account already receiving a discount, such as (but not limited to) Industrial Accounts or Client accounts.

THE PROCESS

1. **Identification of Patients Eligible for Discount Policy:**

A. The Hospital maintains posted signs, in English, *Exhibit "A* " and Spanish, *Exhibit "B* ", one in each In-take or Registration area that inform customers that Discount care is available and what the discount care criteria is.

B. Upon admission to the Hospital, all uninsured patients and patients with a non-discounted insurance will be provided information in writing regarding the availability Discounted Care, as well as the availability of a financial counselor who can screen the patient for coverage eligibility under Medicare, Medi-Cal

and other third party payors. The patient will be asked to sign an acknowledgement of receipt of such written information. The original signed acknowledgement will be maintained in the patient medical record and the patient will be provided with a copy.

C. All uninsured patients and patients with a non discounted insurance will also be provided a brochure that explains the Hospital Discount Policy and Charity Care Program. Patients who are interested will be provided with a Financial Assistance form ("FA", at Exhibit "C") to fill out during the registration or financial counseling process.

D. During the screening process described in this Discount Policy, the financial counselor or self pay screening vendor will screen the patient for potential Medi-Cal eligibility as well as coverage by other sources, including governmental programs. If the patient does not qualify for coverage under any third party payor program, the financial counselor will assist the patient in completing an "FA".

E. When the patient appears to qualify for Discount Care, the "FA" will be sent to the Business Office for final determination by the Financial Counselor or Business Office Manager ("BOM").

F. If the Financial Counselor determines that the patient qualifies for Discount Care she/he will give the completed and approved "FA" to the BOM for approval authorization, prior to write off.

G. The following documents are required to process an "FA": copies of current monthly expenses/bills, copies of the previous year's income tax return, current copy of employers check stub, proof of any other income, copies of all bank statements for prior 3 months, and copies of all other medical bills. The Hospital has the option to pull a credit report to verify information and determine if there are credit cards with available credit that the balance, or portion thereof, could be charged to the credit card.

H. Once an account is approved for Discount Care, the Financial Counselor will contact any vendor who may be working the account, to stop all collection efforts on the account.

I. Once approved for Discount Care, the account will be moved to the appropriate financial class until the adjustment is processed and posted/credited to the account. After the adjustment is posted, if there is a remaining balance due from the patient, the financial class will be changed to self pay and a letter sent to the patient for the remaining balance. The letter will indicate that the Discount has been credited to the patient account.

J. If the "FA" is incomplete it will be the responsibility of the Financial Counselor to contact the patient via mail or phone to obtain the required information.

K. A "FA" that is incomplete after 30 days of request for information will be denied.

L. An "FA" may be reopened and reconsidered for Discount care once the required information is received.

M. Once an account has been written off to bad debt, the patient will not be allowed to apply for Discounted Care assistance.

N. Patients must be provided with interest free monthly payment arrangements that are agreed upon by both parties.

O. Patients who make reasonable payments and making an effort to pay their debts will be considered valid under the Hospital's time payment program unless the patient does not pay or re-negotiate a new time payment for 90 days. After the 90 days, collection efforts will resume.

P. Patient's who wish to appeal the denial of assistance under the Discount Policy should direct their appeal to the BOM and must include an explanation of the reason the application should be reconsidered. BOM will review any additional information. If the information would still result in a denial, BOM will submit the application to the CFO who will make a final determination. The CFO's decision is final.

Q. A collection agency or other assignee dealing with a patient under the Hospital's discount payment policies, shall not use the following as a means of collecting unpaid hospital bills: (1) A wage garnishment, except by order of the court upon noticed motion (2) Conduct a sale of the patient's primary residence during the life of the patient or his or her spouse, or during the period a child of the patient is a minor, or a child of the patient who as attained the age of majority is unable to take care of himself or herself and resides in the dwel1ing as his or her primary residence.

2. ADDITIONAL FACTORS TO BE CONSIDERED FOR DISCOUNT DETERMINATION

A. The following factors are to be considered in determining the eligibility of the patient for Discounted Care:

1. Gross Income
2. Family Size
3. Employment status and future earning capacity
4. Other financial resources
5. Other financial obligations
6. The amount and frequency of hospital and other medical bills

B. The income guidelines necessary to determine the eligibility for Discount Care are attached on *Exhibit "D"*. The current Federal Poverty Guidelines are attached as *Exhibit "E"* and they include the definition of the following:

1. Family
2. Income

3. FAILURE TO PROVIDE APPROPRIATE INFORMATION

Failure to provide information necessary to complete a financial assessment within 30 days of the request may result in a negative determination. The account may be reconsidered upon receipt of the required information, providing the account has not been written off to bad debt.

If a patient receives a discount under the Self-Pay Policy, and it is later determined that the patient qualified for coverage by Medicare, Medicaid or any other third party coverage or met the criteria for the Hospital Charity Care Discount program, any discount provided for under the Self-Pay Patient Policy shall be reversed.

4. TIME FRAME FOR ELIGIBILITY DETERMINATION

A determination of eligibility will be made by the Business Office within 30 working days after the receipt of all information necessary to make a determination.

5. DOCUMENTATION OF ELIGIBILITY DETERMINATION AND APPROVAL OF WRITE-OFF

Once the eligibility determination has been made, the results will be documented in the comments section on the patient's account and the completed and approved "FA" will be filed attached to the adjustment sheet and maintained for audit purposes. The CEO, CFO, BOM will signify their review and approval of the write-off by signing the bottom of the Discount Care/Financial Assistance Program Application form. The signature requirements will be based on the CHS financial policy for approving adjustments.

Once the eligibility determination has been made under the Self Pay Patient Policy, the results will be documented in the comments section on the patient's account. Any discount will be set in the system and will not require Hospital authorization. The transaction code used will reflect 'Self Pay Patient Discount' and will not be considered Charity. The Hospital will use transaction code 556 for inpatient uninsured discounts, and 557 for outpatient uninsured discounts.

6. REPORTING OF DISCOUNT CARE

Information regarding the amount of discount care provided by the hospital, based on the hospital's fiscal year, shall be aggregated and included in the annual report filed with the Bureau of State Health Data and Process Analysis at the State Department of Health. These reports also will include information concerning the provision of government sponsored indigent health care and other county benefits. (Only for those states that require).

Hospital must submit to the Office of Statewide Health Planning and Development a copy of their Discount Policy at least every other year on January 1, or when a significant change is made. If the facility made no significant change since the information was previously provided, the Hospital may notify OSHPD of the lack of change to satisfy this requirement.

7. POLICY REVIEW AND APPROVAL

The below individuals have read and approved this policy:

Hospital CEO	Date 6/25/12
Hospital CFO	Date 6/15/12
Corporate VP, Patient Financial Services	Date 6/20/12
Division VP ~~Operations~~ Finance	Dat 6/21/12

Exhibit A
Example of Availability of Charity Care" Sign-English Version

FINANCIAL ASSISTANCE AVAILABLE

If you do not have adequate insurance coverage, you may be eligible for a reduction of your balance under the hospital's Discount Program.

If you do not have any insurance you may be eligible for coverage under various government sponsored health insurance programs or for a reduction in your balance under the hospital Charity Care Program or for a self-pay patient discount.

Income requirements may apply.

To obtain information about these programs or to obtain an application for a discount or assistance, contact the hospital business office or financial counselor.

California Health & Safety Code Section 127410

Exhibit B
Example of 'Availability of Charity Care" Sign-Spanish Version

ASISTANCIA FINANCERA DISPONIBLE

Si usted no tiene fondos de seguro medico adecuados, usted puede ser elegible para una reduccion de su balance bajo el Programa de Descuento de hospitales.

Si usted no tiene seguro medico, usted puede ser elegible para fondos bajo varios programas de seguro de salud patrocinados por el gobierno o para una reduccion de su balance bajo el Programa de Caridad del hospital.

Aplican requisitos de ingreso.

Para obtener informacion acerca de estos programas o para obtener una aplicacion, pongase en contacto con Ia oficina de negocios del hospital o con un consejero financiero.

Codigo de Salud y Seguridad de California Secci6n 127410

Exhibit C
Example of Financial Assistance Form

----------Regional Medical Center
Discount Care/Financial Assistance Program Application

Patient Account Number: Date of Application_____

PATIENT INFORMATION	PARENT/GUARANTORISPOUSE
_____	_____
Address_____	_____
_____	_____
State/Zip_____	State/Zip_____
_____	_____
Employer_____	Employer_____
Address_____	Address _____
_____ _____	_____
State/Zip_____	State/Zip _____
Work _____	Work Phone _____
Length of Employment_____	Length of Employment_____
Supervisor_____	Supervisor_____

RESOURCES

Checking: yes___ no
Savings: yes_ no

Cash on hand: _____

Vehicle 1: Yr_____ Make_____ Model_____
Vehicle 2: Yr_____ Make_____ Model_____
Vehicle 3: Yr_____ Make_____ Model_____

Exhibit C (continued)
Discount Care/Financial Assistance Program Application

INCOME

Patient/Guarantor:
Wages(monthly): _____

Other Income: Child Support: $_____
VA Benefits: $_____
Workers' Comp: $_____
SSI: $_____
Other: $_____

Spouse/Second Parent:
Wages(monthly): _____

Other Income: Child Support: $_____
VA Benefits: $_____
Workers' Comp: $_____
SSI: $_____
Other: $_____

LIVING ARRANGEMENTS

Rent_____ Own_____ Other (explain)_____

Landlord/Mortgage Holder: _____

Phone Number_____ Monthly payment _____

REQUIRED DOCUMENTS

The following documents must be attached to process your application for Charity Care/Financial Assistance:

Proof of Income: Prior year income tax return, last 4 pay check stubs, letter from employer, Social Security, etc. Last 3 months bank statements. Other documents as requested.

Proof of Expenses: Copy of mortgage payment or rental agreement, copies of all monthly bills (including credit cards, bank loans, car loans, insurance payments, utilities, cable and cell phones). Other documents as requested.

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in denial of any financial assistance by the hospital.

The Hospital reserves the right to pull a copy of your credit report.

Signature of Applicant_____

Hospital Representative Completing Application:_____

Approval Authorization of Discount Write-Off

Amount Approved _____

BOM_____

CEO_____

CFO_____

Exhibit D

Income Guidelines For Determining% of Discount Care
(For Financially Indigent Patients)

Based Current Year's Federal Poverty Income Guidelines

% of Poverty Income		Amount Due From Patient
Equal to or Below Poverty:		
	InPatient Services	$
	Emergency Room Services	$
	Out-Patient Services	$
	Out-Patient Observation Svcs	$
	Major OP Diagnostics	$
	Other Out-Patient Services	$
From 101% - 200%		
	InPatient Services	$
	Emergency Room Services	$
	Out-Patient Services	$
	Out-Patient Observation Svcs	$
	Major OP Diagnostics	$
	Other Out-Patient Services	$
From 201% - 350%		
	InPatient Services	$
	Emergency Room Services	$
	Out-Patient Services	$
	Out-Patient Observation Svcs	$
	Major OP Diagnostics	$
	Other Out-Patient Services	$

Exhibit E

The Department of Health and Human Services has issued updated Poverty Income Guidelines for 2012 (reference: Federal Register: January 26, 2012, Volume 77, Number 17 pp. 4034-4035).

2012 Poverty Income Guidelines for the 48 o11_tiguous sta.tes and the District of Columbia

Persons in family/household	Poverty Income Guideline
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/households with more than 8 persons, add $3,960 for each additional person.

Please update your Charity Care Policies to use the new income guidelines effective February 1st, as well as any other polices that use the Poverty Income Guidelines. As noted in the Federal Register notice, there is no universal administrative definition of income that is valid for all programs that use the poverty income guidelines. The office or organization that administers a particular program or activity is responsible for making decisions about the definition of income used by that program. To find out the specific definition of income used by a particular program, you must consult the office or organization that administers that program.