AdventistHealth

☐ **Facility:**
☒ **System-wide Corporate Policy**
☒ **Standard Policy**
☐ **Model Policy:**

Policy No. **PFS-112**
Page **1 of 18**
Department: **Revenue Management**

POLICY: Patient Billing: Financial Assistance

I. PURPOSE

Adventist Health (AH) facilities exist to serve patients. They are built on a team of dedicated health care professionals – physicians, nurses and other health care professionals, management, trustees, and volunteers. Collectively, these individuals protect the health of their communities. Their ability to serve well requires a relationship with their communities built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. These principles and guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of AH's commitment to caring.

The purpose of this policy is to enact and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable emergency and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

It is the intent of this policy to comply with all federal, state, and local regulations.

II. DEFINITIONS

Allowable Medical Expenses: Total Family Members' medical expenses that would be deductible for federal income tax purposes without regard to whether the expenses exceed the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included.

Amount Generally Billed (AGB): The charge amount generally collected from individuals who have insurance covering such care at AH. The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service together with all private health insurers, including portions paid by insured individuals.

Billed Charges: Charges for services by AH as published in the charge description master (CDM).

Charity Care: Full charity or free care is provided when the patient is not expected to pay or pay only a nominal amount of the Billed Charges.

Discounted Care: Facility determines that the patient does not qualify for Charity Care, but is eligible for a discount and is expected to pay only a portion of Billed Charges.

Emergency Medical Care: Refers to Emergency Services and Care as defined in the AH policy in "compliance with the Emergency Medical Treatment and Labor Act (EMTALA)."

Essential Living Expenses (ELE): Any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses - including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Family Members*:* Family Members of **persons 18 years and older** include spouse, domestic partner as defined by the state where the facility is licensed, and dependent children under 21 years, whether living at home or not. Family Members of **persons under 18 years** include parents, caretaker relatives and other children less than 21 years of age of the parent or caretaker relative, whether living at home or not.

Federal Income Tax Return: The form which is submitted to the IRS for purpose of reporting taxable income. The form must be a copy of the signed and dated form submitted to the IRS.

Federal Poverty Level (FPL): The income level set by the federal government that establishes households living above or below defined poverty or subsistence annual incomes.

Financial Assistance: An AH program that will prospectively or retroactively reduce the amount owed by an Uninsured Patient or Underinsured Patient for AH Billed Charges.

High Medical Costs: Defined as any of the following: a) annual Out-of-Pocket Costs incurred by the individual at the facility that exceed ten percent (10%) of the patient's family income in the prior 12 months; OR b) annual Out-of-Pocket expenses that exceed ten percent (10%) of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Household Income: Income of all Family Members who reside in the same household as the patient, or at the address the patient uses on tax returns or other government documents as the home address.

Limited English Proficiency (LEP) group: A group that constitutes the lesser of 1,000 individuals or five percent (5%) of the community served by the facility, or the populations likely to be affected or encountered by the facility. The facility may use any reasonable method to determine the number or percentage of LEP patients likely affected or encountered by the facility.

Medically Necessary: A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. See California Welfare & Institutions Code §14059.5.

Out-of-Pocket Costs: Costs which the patient pays from personal funds.

Patient Financial Services (PFS): AH department responsible for billing, collection, and payment processing.

Payment Plan: Plan that sets a series of payments over a period of time to satisfy the patient-owed amounts of AH Billed Charges. Monthly payments are not more than ten percent (10%) of a patient's family income for a month, excluding deductions for Essential Living Expenses.

Qualifying Assets: Monetary assets that are counted toward the patient's income in determining if the patient will meet the income eligibility for the program. For purposes of this policy, "Qualifying Assets": 1) include 50% of the patient's monetary assets in excess of $10,000, including cash, stocks, bonds, savings accounts, or other bank accounts; 2) exclude IRS qualified retirement plans, such as IRAs, 401(k) or 403(b) retirement accounts, or deferred-compensation plans; 3) exclude certain real property or tangible assets (primary residences, automobiles, etc.; however, additional residences in excess of a single primary residence and recreational vehicles may be included).

Qualifying Patient: Patient who meets the financial qualifications for the Financial Assistance program as defined in Section III.C.

Self-Pay Liability: Any balance due when the financially responsible party is the patient or the patient's guarantor (not a third-party payer).

Third-party Insurance: An entity (corporation, company health plan or trust, automobile medical pay benefit, workers' compensation, etc.) other than the patient that will pay all or a portion of the patient's medical bills.

Uninsured Patient: A patient who does not have third-party insurance from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the facility.

Underinsured Patient A patient who has some level of Third-party insurance or assistance but still has Out-of-Pocket Costs that exceed the patient's financial abilities

III. POLICY

AH is committed to providing Financial Assistance to patients who have sought Emergency Medical Care or Medically Necessary care but have limited or no means to pay for that care. Financial Assistance refers to what is commonly known as Charity Care and Discounted Care. AH will provide, without discrimination, Emergency Medical Care or Medically Necessary care as defined in this policy, to individuals regardless of their ability to pay, their eligibility under this policy, or eligibility for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for Financial Assistance – Charity (free) and Discounted (partial charity) Care;
- Describes the basis for calculating amounts charged to patients eligible for Financial Assistance under this policy;
- Describes the method by which patients may apply for Financial Assistance;
- Describes how the facility will widely publicize the policy within the community served by the facility; and
- Limits the amounts the facility will charge for Emergency Medical Care or other Medically Necessary care provided to individuals eligible for Financial Assistance to an amount equal to or below the Amount Generally Billed (received by) the facility

Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with the facility's procedures for obtaining charity or other forms of payment or Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance will be encouraged to do so, as a means of assuring access to health care services for their overall personal health and for the protection of their individual assets.

A. Qualifying Care Under This Policy

This policy shall apply to any Emergency Medical Care or other Medically Necessary care provided at AH owned and operated, facilities listed in Appendix A. AH facilities that provide billing services for emergency room physicians are required to treat the physician charges in the same manner as the facility charges relevant to charity and uninsured discount procedures.

Emergency room physicians who provide emergency medical services in a general acute care facility are excluded from this policy unless listed as a "Covered Provider" in the documentation from Appendix C. These physicians should, and in California are required to, have their own Financial Assistance policies to limit expected payment from eligible patients that are uninsured or have High Medical Costs who are at or below 350% of the Federal Poverty Level. Patients who are uninsured or have High Medical Costs and income at or below 350% of the Federal Poverty Level and receive a bill from an emergency room physician should contact that physician's office and inquire about their Financial Assistance policy.

B. Communication of Financial Assistance

Adventist Health provides notice of the availability of Financial Assistance by various means, which may include, but are not limited to, the publication of posted, conspicuous notices in emergency rooms, in the Conditions of Registration form, in admitting and registration areas, in facility Patient Financial Services, and other public places as the facility may elect. One post-discharge billing statement will include standard language informing patients they may request financial screening to determine eligibility for Financial Assistance and how the request may be made. At no cost to the patient, the facility shall publish and widely publicize a plain language summary of this Financial Assistance policy and the policy itself on the

facility website, in brochures, by mail and at other places within the community served by the facility as the facility may elect. Such notices and summary information shall be provided in the primary languages of the patient when the patient is identified as being within a Limited English Proficiency (LEP) group. In addition to the above, AH provides individual notice of Financial Assistance availability to any patient who may be at risk of meeting their financial responsibility. Referral of patients for Financial Assistance may be made by any member of the facility staff or medical staff. A request for charity may be made by the patient or his or her guardian or family member, subject to applicable privacy laws.

Individuals can receive information about the Financial Assistance policy, free of charge, by calling 1-844-827-5047 or writing to:

Adventist Health
ATTN: Financial Assistance
PO Box 619122
Roseville, CA 95661

C. Eligibility for Financial Assistance

Eligibility for Financial Assistance will be considered for those individuals who are uninsured and underinsured with High Medical Costs and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. Any decisions made under this policy, including the decision to grant or deny Financial Assistance, shall be based on an individualized determination of financial need, and shall not take into account race, color, national origin, citizenship, religion, creed, gender, sexual preference, age, or disability.

Medicaid Share of Cost (SOC) amounts are not eligible for Financial Assistance, as the SOC is determined by the state to be an amount the patient must pay before the patient is eligible for Medicaid

A patient may qualify for Financial Assistance under this policy if they meet one of the following guidelines based on income or expenses.

1. Income. A patient is eligible to receive Charity or Discounted Care based on income under this policy if Household Income (as defined in policy) is at or below 400% of the FPL.

2. Expenses. Patients not eligible based on income may be eligible for Financial Assistance through an exception-based review if their Allowable Medical Expenses have depleted the family's income and resources so that they are unable to pay for eligible services. The following two qualifications must both apply:

    a. Expenses: The patient's Allowable Medical Expenses must be greater than 50% of the Household Income.
    b. Resources: The patient's excess medical expenses (the amount by which Allowable Medical Expenses exceed 50% of the Household Income) must be greater than available Qualifying Assets

Charity Care: In determining eligibility for Charity Care, also known as free care, Household Income and Qualifying Assets do not exceed an amount equal to 200% of the Federal Poverty Level.

Emergency and Medically Necessary Care

Uninsured Patients	
Family Income	Amounts Charged
200% or less of the Federal Poverty Level	Zero

Discounted Care: In determining eligibility for **Discounted Care**, documentation of income shall include recent pay stubs or income tax returns.

Emergency and Medically Necessary Care

Uninsured Patients	
Family income	Amounts Charged
> 200% to 300% of the Federal Poverty Level	50% of the Amount Generally Billed
>300% to 400% of the Federal Poverty Level	75% of the Amount Generally Billed
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs	
Family Income	Amounts Charged
400% or less of the Federal Poverty Level	The amount that would be allowed by the Amount Generally Billed for the same service LESS the amount paid by the patient's insurer. If the insurer paid an amount equal to or greater than the Amount Generally Billed, patient liability is zero.
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, the patient is responsible for their Self-Pay Liability amount

Non-Emergency and non-Medically Necessary Care

Uninsured Patients	
Family income	Amounts Charged
200% or less of the Federal Poverty Level	50% of the Amount Generally Billed
>200% to 400% of the Federal Poverty Level	100% of the Amount Generally Billed
>400% of the Federal Poverty Level	Not covered under the Financial Assistance Policy, refer to the Uninsured Discount Policy

Patients with Commercial Insurance or non-Contracted Managed Care plans & High Medical Costs	
Family Income	Patient Liability
350% or less of the Federal Poverty Level	The amount that would be allowed by the Amount Generally Billed for the same service LESS the

	amount paid by the patient's insurer. If the insurer paid an amount equal to or greater than the Amount Generally Billed, patient liability is zero.
>350% of the Federal Poverty Level	Not covered under the Financial Assistance Policy; the patient is responsible for their Self-Pay Liability amount

D. Method by Which Patients May Apply for Financial Assistance

1. In order to qualify for Financial Assistance under this Policy, a patient or guarantor must:

   a. Cooperate with AH in identifying and determining alternative sources of payment or coverage from public and private payment programs;
   b. Submit a true, accurate and complete confidential Financial Assistance application within 240 days of the first post-discharge billing statement;
   b. AH staff members including financial counselors and Patient Financial Services staff can assist individuals who request or require assistance to complete an application;
   c. Provide a copy of patient's or guarantor's most recent pay stub (or certify that he or she is currently unemployed);
   d. Provide a copy of patient's or guarantor's most recent Federal Income Tax Return (including all schedules); and
   e. Provide such documents and information regarding patient's or guarantors' monetary assets as may be reasonably requested by AH.

2. If the patient has Third-party insurance that would have covered the qualifying services, the patient or guarantor is responsible for complying with the conditions of coverage for their health insurance. Failure to do so, when the patient could have reasonably complied, may result in a denial of eligibility under the Financial Assistance program.

3. An uncooperative patient is any patient or guarantor who is unwilling to disclose the necessary financial information as requested for Medicaid and/or Financial Assistance determination during the application process. Uncooperative patients or guarantors will be notified in writing that unless they comply and provide information, no further consideration will be given for Financial Assistance processing and standard A/R follow-up will commence.

4. AH values of human dignity and stewardship shall be reflected in the application process, financial need determination, and granting of Financial Assistance.

5. AH shall not use any information submitted by a patient regarding the patient's monetary assets in connection with his or her application for any collection activities of AH. Information provided by the patient regarding the patient's monetary assets will only be used for the determination of whether or not such patient qualifies for Financial Assistance under this policy.

E. Eligibility for Other Government Programs

The facility shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered to a patient, including but not limited to, any of the following:

1. Private health insurance, including coverage offered through the Health Benefit Exchange;

2. Medicare; or

3. The Medicaid program, the Healthy Families Program, the Children's Services program, or other state-funded programs designed to provide health coverage.

If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a facility Financial Assistance program, neither application shall preclude eligibility for the other program.

F. Presumptive Financial Assistance Eligibility

On an individual patient basis, the staff or management member of Patient Financial Services will complete an internal Financial Assistance application to include a full explanation of:

1. The reason the patient or patient's guarantor cannot apply on his/her own behalf, and the patient's documented extenuating medical or socio-economic circumstances that preclude the patient or patient's guarantor from completing the application.

2. AH may also assign accounts to presumptive Charity Care eligibility, without a Financial Assistance application submitted by the patient, based on predetermined criteria collected from approved sources. These criteria include:

    a. The patient having documented in his/her medical record as being homeless or verification received through AH or a family member that the patient is expired with no known estate or currently incarcerated; **OR**

    b. The patient qualifies for a public benefit program including Social Security, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, or other similar indigence-related programs with eligibility requirements that reasonably meet the qualifications for the AH Financial Assistance program; **OR**

    c. After normal collection efforts have not produced any payment and the patient has been unable to complete a Financial Assistance application, or comply with requests for documentation, or is otherwise nonresponsive to the application process the account will be screened for presumptive eligibility using demographic software. As a result, these accounts may be screened for the patient's qualification for Financial Assistance without completing the formal assistance application. Under these circumstances, an AH facility will utilize other sources of information to make an individual assessment of financial need. This information will enable AH to make an informed decision on the financial need of nonresponsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

        AH facilities will utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards as the traditional application process.

        The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows AH facilities to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need to qualify at 200% FPL or less for retrospective dates only.

        Patient accounts granted presumptive eligibility will be reclassified under the Financial Assistance policy. They will not be sent to collection, will not be subject to further collection

actions, will not be notified of their qualification and will not be included in the facility's bad debt expense.

G. Eligibility Period

If a patient qualifies for Charity Care or Discounted Care for a specific eligible service or facility stay, a retroactive Financial Assistance discount will be applied to all patient balances for eligible services prior to the application approval date. Also, any eligible services for an additional 180 days after the approval date of an application will qualify for a Financial Assistance discount. For any services that occur 180 days after the application approval date, the patient must submit a new application to be considered for Financial Assistance for that episode of care.

H. Refund of Amounts Previously Paid

In the event a patient pays all or part of his or her bill for services rendered, and is subsequently determined to qualify for Charity Care or Discounted Care under this policy, AH shall promptly refund to the patient the amount of any such overpayment made to AH.

I. Appeal Regarding Application of this Policy

In the event any patient believes his or her application for Financial Assistance was not properly considered in accordance with this policy, or he or she otherwise disagrees with the application of this policy in his or her case, a patient may submit a written request for reconsideration to the Chief Financial Officer (CFO) of the AH facility where the eligible services were rendered who shall be the final level of appeal.

J. Billing and Collection

AH facilities will follow standard procedures for assignment to collection agencies including levels of authorization. Collection agency contracts will define the agencies' scope of practices that includes collection practices within this policy as well as a requirement to report to an AH facility when a patient indicates that they are financially unable to pay their bill.

Before commencing any collection activity against a patient, the facility must provide a plain language summary of the patient's rights. The summary language will be sufficient if it appears in substantially the following form:

> "State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."

The facility must also include a statement that nonprofit credit counseling services may be available in the area. The above wording will be incorporated into a data mailer attachment and be included in the initial data mailer for all patient liabilities.

AH facilities will halt collection efforts from a patient or guarantor while they are in the process of applying for government assistance programs, such as Medicaid, which includes any time necessary to appeal an eligibility determination. When the facility determines the individual is not eligible for coverage for which they have applied or failed to cooperate, then collection efforts can continue. Any failure to meet eligibility requirements or failure to cooperate must be thoroughly documented.

Upon submission of a Financial Assistance application for a patient or guarantor, all collection activity will cease until a determination has been made and the patient is notified of that determination. The

determination must be communicated to the patient by sending the letter found in Exhibit B (English or in a Limited English Proficiency language that meets definition).

In cases where the patient or the patient's guarantor is approved for Charity Care under the Financial Assistance program, then all collection efforts will cease and reasonable efforts must be made to reverse any extraordinary collection actions taken against the patient or the patient's guarantor.

In cases where the patient or the patient's guarantor is approved for Discounted Care with a liability under the Financial Assistance program, the facility may negotiate a reasonable monthly Payment Plan when requested to do so by the patient or guarantor with the patient or guarantor and will not send unpaid bills to outside collection agencies, and will cease any extraordinary collection actions. Any extended Payment Plan agreed to by the facility to assist patients eligible under the facilities' Financial Assistance policy shall be interest free. Extended Payment Plans may be declared inoperative when the patient or guarantor fails to make all consecutive payments due during a 90-day period. Before declaring the agreement inoperative, the facility or collection agency will make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended Payment Plan may become inoperative, and of the opportunity to renegotiate the extended Payment Plan. Before the facility can declare the extended Payment Plan inoperative, they must attempt to renegotiate the terms of the defaulted extended Payment Plan, if requested by the patient or their guarantor. Neither the facility nor the collection agency may report adverse information to a credit-reporting bureau before the extended Payment Plan has been declared inoperative.

AH facilities and collection agencies will not engage in any **extraordinary collection actions** such as wage garnishments, selling the debt, reporting debt to credit bureau(s), requiring payment prior to delivery of care, liens on primary residences, or other legal actions for any patient, within 241 days of the first post-discharge patient billing statement .

The facility and collection agencies will make reasonable efforts to notify the patient prior to engaging in any extraordinary collection actions. Reasonable actions include providing written notice of the Financial Assistance policy, providing a written Plain Language Summary, identifying and notifying of the specific extraordinary collection action in writing that will be performed, and making reasonable efforts to verbally notify the patient or guarantor. All of these actions are required to take place at least 30 days prior to performing any extraordinary collection actions to allow reasonable time to respond to the notice.

In those cases where the collection agency has an indication the patient or guarantor has the ability to pay for the medical services received but is refusing to do so, the agency may be permitted to take legal action to collect the unpaid balance as long as it is not within 240 days of the first post-discharge billing statement. When the agency has determined that legal action is appropriate and criteria for extraordinary collection actions have been met, the agency must forward an individual written request to the facility's CFO for approval prior to taking any legal action. The request must include all the particulars of the encounter including a copy of the agency's documentation that led them to believe that the patient or guarantor has the ability to pay for the services. The facility CFO must approve each individual legal action in writing. This authority may not be delegated by the CFO. Facilities must maintain a permanent copy of the signed authorization for legal action and there must be a notation in the electronic PFS patient account notes. In no case will the agency be allowed to file a legal action as a last resort to motivate the patient to pay when they have no information as to the patient or guarantors financial means.

K. Patient/Family Education

Provided through publication of this policy on the AH website, direct education from financial counselors, and posted information as outlined in this policy (Section III.B.).

L. Documentation

Confidential Financial Assistance application (See Exhibit A to this policy.)

M. List of Covered Providers

The list of Covered and Noncovered providers, in Appendix C of this policy, who deliver Emergency Medical Care and other Medically Necessary care within the facility will be maintained at least quarterly, and made available using methods described in the section III.B. of this policy.

N. Financial Assistance Standard Procedures

The facility will adhere to standard internal procedures to administer the Financial Assistance policy that are maintained in a separate Financial Assistance procedures document published by AH.

O. Authorized Body

Adventist Health Legal Board of Directors is the authorized body to approve this policy and any subsequent changes to this policy.

AUTHOR: Patient Financial Services
APPROVED: Revenue Cycle Governance 9/18/2015; Exec Cabinet 12/1/2014; Board Approved 12/15/2015
EFFECTIVE DATE: 12/29/2015
REVIEWED: 11/12/14; REVISION: 12/21/09, 1/25/11, 6/3/2011, 1/27/11, 5/13/13, 2/3/14, Nov 2014 (SB1276), 1/22/15 (revised FPL); 12/17/2015 (501(r)); 4/19/17 (revised PFS);
DISTRIBUTION: PFS Directors, CFOs

EXHIBIT A

Patient Name_____	**Facility:_____DOS:_____**
Patient Number_____	**Confidential Financial Statement (Application)**

RESPONSIBLE PARTY

Name		Marital Status	Social Security Number
Street Address, City, State, Zip		How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)			Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net	Length of current employment

SPOUSE

Name			Social Security Number
Employer Name and Address			Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of dependents in household____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	**$**	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$	Balance: $	Medical / Dental		$
Own Home? (Yes/No)			Doctor – Name		$
Food	$		Doctor – Name		$
Utilities:	$		Doctor – Name		$
Electric	$		Credit Cards:		$
Gas	$		Visa	Limit	$
Water / Sewer	$		Mastercard	Limit	$
Trash	$		Discover	Limit	$
Phone	$		Other	Limit	$
Cable	$		Installment Loans		$
Auto Payments	$		Child Support		$
Auto Expenses	$		Miscellaneous Expenses		$
Insurance:					
Auto Premium	$				
Life Insurance	$				
Health Insurance	$				

OFFICE USE ONLY
Gross income_____
Net income_____
Total Expenses_____
Total Net income(loss)_____

To my knowledge the information provided above is true.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

EXHIBIT B

Facility Name
Facility Address
Facility Phone

Date

Guarantor Name
Guarantor Address

RE: Account Number:
Patient Name:
Dates of Service:
Account Balance:

- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do meet eligibility guidelines for full charity assistance on this account.
- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do not meet eligibility guidelines for full charity assistance on this account.
- ❑ Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you meet eligibility guidelines for partial charity assistance on this account. (account balance) is the remaining portion, which is your responsibility to pay.

If you believe this decision is in error, you have the right to submit an appeal. Your appeal must be made in writing, addressed to the Patient Financial Services Director and mailed to the address on this letter.

If you have any questions, please feel free to contact us at (facility phone) during normal business hours.

Patient Financial Services Department
Facility Name
Facility Phone Number

EXHIBIT C

2017 FEDERAL POVERTY LEVELs (FPL)

Persons in family	48 Contiguous States and the District of Columbia	Alaska	Hawaii
1	$12,060	$15,060	$13,860
2	16,240	20,290	18,670
3	20,420	25,520	23,480
4	24,600	30,750	28,290
5	28,780	35,980	33,100
6	32,960	41,210	37,910
7	37,140	46,440	42,720
8	41,320	51,670	47,530
For each additional person, add	4,180	5,230	4,810

http://www.aspe.hhs.gov/poverty/

APPENDIX A

COVERED FACILITY LIST

List of Adventist Health facilities covered under this policy:

Doing Business As (DBA)
Adventist Medical Center - Hanford
Adventist Medical Center - Portland
Adventist Medical Center - Reedley
Adventist Medical Center – Tehachapi Valley
Adventist Medical Center - Selma
Castle Medical Center
Feather River Hospital
Glendale Adventist Medical Center
Frank R. Howard Memorial Hospital
Lodi Memorial Hospital
St. Helena Hospital Clear Lake
St. Helena Hospital Napa Valley
St. Helena Hospital Center for Behavioral Health
San Joaquin Community Hospital
Simi Valley Hospital
Sonora Regional Medical Center
Tillamook Regional Medical Center
Ukiah Valley Medical Center
Walla Walla General Hospital
White Memorial Medical Center
Adventist Health Physicians Network
Western Health Resources

APPENDIX B

Amount Generally Billed (AGB) for facilities in California:

AGB Table #1

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change

Facility	Service	Effective	AGB Rate
Adventist Medical Center - Hanford	All Services	1/1/2017	18%
Adventist Medical Center - Selma	All Services	1/1/2017	18%
Adventist Medical Center - Reedley	All Services	1/1/2017	18%
Adventist Medical Center – Tehachapi Valley	All Services	1/1/2017	2%
Feather River Hospital	All Services	1/1/2017	13%
Glendale Adventist Medical Center	All Services	1/1/2017	13%
Frank R. Howard Memorial Hospital	All Services	1/1/2017	36%
Lodi Memorial Hospital	All Services	1/1/2017	10%
St. Helena Hospital Clear Lake	All Services	1/1/2017	38%
St. Helena Hospital Napa Valley	All Services	1/1/2017	16%

St. Helena Hospital Center for Behavioral Health	All Services	1/1/2017	16%
San Joaquin Community Hospital	All Services	1/1/2017	19%
Simi Valley Hospital	All Services	1/1/2017	15%
Sonora Regional Medical Center	All Services	1/1/2017	19%
Ukiah Valley Medical Center	All Services	1/1/2017	21%
White Memorial Medical Center	All Services	1/1/2017	16%

Amount Generally Billed (AGB) for facilities in Oregon, Washington and Hawaii:

AGB Table #2

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service together with all private health insurers, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility	Service	Effective	AGB Rate
Adventist Medical Center - Portland	All Services	1/1/2017	30%
Castle Medical Center	All Services	1/1/2017	42%
Tillamook Regional Medical Center	All Services	1/1/2017	53%
Walla Walla General Hospital	All Services	1/1/2017	18%

AGB Table #3

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually on January 1st of each year and implemented within 120 days of any AGB rate change.

Facility	Service	Effective	AGB Rate
Adventist Health Physician Network	All Services	1/1/2017	30%
Western Health Resources	All Services	1/1/2017	73%

APPENDIX C
Covered and Noncovered Physicians List

The list of Covered and Noncovered Physicians within the facility who are covered under this policy who provide Emergency Medical Care or other Medically Necessary care in the facility is maintained in a supplemental document called "PFS-112 Financial Assistance Covered and Noncovered Physicians List". This list is updated quarterly and is published on the website and provided in writing with the policy.

Below is a list of facilities included within this supplemental document:

Doing Business As (DBA)
Adventist Medical Center - Hanford
Adventist Medical Center - Selma
Adventist Medical Center - Portland
Adventist Medical Center - Reedley
Adventist Medical Center – Tehachapi Valley
Castle Medical Center
Feather River Hospital
Glendale Adventist Medical Center
Frank R. Howard Memorial Hospital
Lodi Memorial Hospital
St. Helena Hospital Clear Lake
St. Helena Hospital Napa Valley
St. Helena Hospital Center for Behavioral Health
San Joaquin Community Hospital
Simi Valley Hospital
Sonora Regional Medical Center
Tillamook Regional Medical Center
Ukiah Valley Medical Center
Walla Walla General Hospital
White Memorial Medical Center
Adventist Health Physicians Network
Western Health Resources