Biggs-Gridley Memorial Hospital dba Orchard Hospital

	DEPARTMENT BUSINESS OFFICE	
Policy & Procedure	**EFFECTIVE DATE** 01/2015	**PAGE** 1 OF 9
Community Care Financial Assistance and Discount Payment Program		**APPROVED BY AND TITLE:** Board of Directors
DATES OF REVIEW/REVISION: 12/14		

POLICY

To provide immediate and necessary healthcare to those Patient/Guarantors who may not qualify for state, federal or county aid and who are not eligible for other assistance. Providing healthcare services of this type will be classified as our "Community Care Financial Assistance and Discount Payment Program".

ELIGIBILITY:

Self-Pay Patients/Guarantors:

- Who do not have third party insurance
- With no Medi-Cal or other State Funded program
    - Patients or Guarantors with a Medi-Cal Share of Cost are not eligible
- With no compensable injury for purposes of workers compensation, automobile insurance or other insurance as determined and documented by the Hospital/Clinics and
- Family income at or below 250% of the Federal Poverty Level (See Exhibit A)

Patients with High Medical Costs:

- Patients/Guarantors who are not self-pay
- Family income that is at or below 250% of the Federal Poverty Level (see Exhibit A)
- Out-of-pocket medical expenses in the prior 12 months (whether incurred in or out of the Hospital/Clinics) exceeds 10% of the family income and
- Patient/guarantor does not otherwise receive a discount as a result of third-party coverage

HOSPITAL DISCOUNT PAYMENT PROGRAM BENEFITS:

Self-Pay Patients/Guarantors:

- Hospital cannot collect more than the higher of what Medicare, Medi-Cal or Managed Medi-Cal would pay

- Sliding fee schedule (see Exhibit B), if applicable, will be used for patients/guarantors whose income is greater than 250% of the Federal Poverty level.
- Expected payment will be based on a sliding fee schedule percentage of what Medicare, Medi-Cal or Managed Medi-Cal would pay
- If there is no rate published by Medicare, Medi-Cal or Managed Medi-Cal, a straight 40% discount will be taken by the Hospital/Clinics
- Extended payment plans will be made available without interest
- Limitations on debt collections

High Medical Cost Patients/Guarantors (see example below):

- Hospital cannot collect more than the higher of what Medicare, Medi-Cal or Managed Medi-Cal would pay
- Extended payment plans will be made available without interest
- Limitations on debt collections
- To the extent third-party coverage paid an amount equal to the maximum self-pay rate, patient/guarantor will not have any liability

High Medical Cost Patient Example:

When the third-party payment is $25,000 and the highest reimbursement rate from a government payer is $24,000, no payment will be sought from the patient/guarantor.

If the total government reimbursement rate from a government payer in the example is $30,000, the patient may be billed the $5,000 difference.

GUIDELINES FOR ORCHARD HOSPITAL'S DISCOUNT PAYMENT PROGRAM:

- Patient must apply for Covered California (which includes Medi-Cal or Managed Medi-Cal) and provide an acceptance or denial letter from Medi-Cal or Managed Medi-Cal. In addition, the patient/guarantor must complete and return the "Application/Financial Statement" (see Exhibit C)

- Income not assets will considered for eligibility

- Proof of income will be limited to income tax returns from the previous year

- If this information is not provided, patient/guarantor will not qualify for the Plan

- Sliding scale rates (See Exhibit B), if applicable, will be applied for patients/guarantors whose income is greater than 250% of the Federal Poverty Level

GUIDELINES FOR ORCHARD HOSPITAL'S COMMUNITY CARE PROGRAM:

- Patient must apply for Covered California (which includes Medi-Cal or Managed Medi-Cal) and provide an acceptance or denial letter from Medi-Cal or Managed Medi-Cal. In addition, the patient/guarantor must complete and return the "Application/Financial Statement" (see Exhibit C)

- Income and assets will be considered for eligibility

- Only monetary assets will be considered (monetary assets excludes retirement or deferred compensation). Proof of monetary assets must be provided

- Only 50% of monetary assets over $10,000 will be considered when determining eligibility for the Community Care Plan

- Proof of income will be limited to income tax returns from the previous year and/or pay stubs for previous three (3) months

- Proof of all qualifying medical expenses (expenses to be paid by the patient or guarantor) from the past 12 months must be provided

- If required information is not provided, patient/guarantor will not qualify for the Program

- Sliding scale rates (see Exhibit B) may be applied for patients/guarantors after an asset review and whose income is greater than 250% of the Federal Poverty Level

APPROVAL PROCESS/DISPUTE RESOLUTION FOR THE COMMUNITY CARE AND DISCOUNT PAYMENT APPLICATION:

- The PFS Supervisor will review all Community Care Financial Assistance and Discount Payment applications:

  o Approval or rejection will based on the financial information received

  o A request for an appeal of the final determination must be made in writing to the Patient Financial Services (Revenue Cycle Director) within 30 days of the final determination. Patients must provide written appeals outlining the reasons they believe the Community Care determination was incorrect. The Revenue Cycle Director will perform an independent review of the guarantor/patient financial information. The patient/guarantor will be notified of the outcome of the review within 10 business days.

  - All written requests may be submitted to:
    Orchard Hospital – Patient Financial Services
    Financial Assistance Reconsideration Dept.
    240 Spruce Street – Gridley, CA 95946

AVAILABILITY OF THE COMMUNITY CARE AND DISCOUNT PAYMENT PROGRAM:

- Notice of the availability will be posted throughout the Hospital and Clinics including the Emergency Department, Billing Office, and Registration Office.

- Patients will be given written notice that contains:

    - Information about eligibility, as well as contact information for a Hospital employee from which a patient/guarantor may obtain further information about these policies

    - Notice will be provided to patients/guarantors who are admitted as well as patients who present to the Emergency Department or Outpatient Departments

- When the Hospital bills patients who did not provide proof of third-party coverage by discharge, our statement will include the following information:

    - Total charges

    - Statement advising the patient/guarantor they must notify the Hospital if they have health coverage or other coverage

    - Statement advising the patient that they may be eligible for Medicare, Medi-Cal or Managed Medi-Cal, or Community Care and the Hospital (if requested) will provide applications to Covered California which includes Medi-Cal and Managed Medi-Cal.

- Applications for Covered California (which includes Medi-Cal or Managed Medi-Cal) will be provided to Self-Pay patients prior to discharge (if the patient has been admitted) or to patients receiving emergency or outpatient care

- Information regarding the financially qualified patient/guarantor and Community Care application will include the following:

    - Statement that indicates if the patient lacks insurance or is underinsured and meets certain low-moderate income requirements, the patient may qualify for a discounted payment or charity care

- Name and telephone number of the Hospital employee from whom the patient may obtain information about the Hospital's Community Care Financial Assistance and Discount Payment Program and how to apply for that assistance

Attachment A

2014 Federal Poverty Guidelines

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

ATTACHMENT B

SLIDING FEE SCHEDULE FOR FINANCIAL ASSISTANCE

2010 Poverty Guidelines (taken from the Federal Register) using 250% multiplier

% of Discount	100%		75%		50%		25%		Full Fee if more than
Family Size*	From	To	From	To	From	To	From	To	
1	$0	$27,075	$27,076	$36,426	$36,427	$45,777	$45,778	$55,128	$55,129
2	$0	$36,425	$36,426	$45,776	$45,777	$55,127	$55,128	$64,478	$64,479
3	$0	$45,775	$45,776	$55,126	$55,127	$64,477	$64,478	$73,828	$73,829
4	$0	$55,125	$55,126	$64,776	$64,777	$73,827	$73,828	$83,178	$83,179
5	$0	$64,475	$64,476	$73,826	$73,827	$83,177	$83,178	$92,528	$92,529
6	$0	$73,825	$73,826	$83,176	$83,177	$92,527	$92,828	$101,878	$101,879
7	$0	$83,175	$83,176	$92,526	$92,527	$101,877	$101,878	$111,228	$111,229
8	$0	$92,525	$92,526	$101,876	$101,877	$111,227	$111,228	$120,578	$120,579

Note: this matrix needs to be updated from 2010 to 2014

ATTACHMENT C
APPLICATION/FINANCIAL STATEMENT

ORCHARD HOSPITAL
240 SPRUCE STREET

APPLICATION/FINANCIAL STATEMENT

APPLICANT'S NAME:_____ **SPOUSE NAME:** _____

ADDRESS:_____ **PHONE:**_____

ACCOUNT #:_____ **SSN:** _____ _____
(APPLICANT) **(SPOUSE)**

FAMILY STATUS (List all dependents that you support)

NAME	RELATIONSHIP	AGE	SEX
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female
			☐ Male ☐ Female

FAMILY SIZE

Total Family Members (add applicant, spouse and dependents from above):_____

EMPLOYMENT AND OCCUPATION

APPLICANT'S EMPLOYER:_____ POSITION:_____

CONTACT PERSON & TELEPHONE: _____

IF SELF EMPLOYED, NAME OF BUSINESS:_____

SPOUSE'S EMPLOYER:_____ POSITION:_____

CONTACT PERSON & TELEPHONE: _____

IF SELF EMPLOYED, NAME OF BUSINESS:_____

CURRENT INCOME (Select One): Weekly_____ Bi-Weekly_____ Monthly ____ Yearly_____ Other____

CATEGORY	APPLICANT	SPOUSE	OTHER FAMILY MEMBER
Gross Pay (before deductions):	$_____	$_____	$_____
Farm or self-employment:	$_____	$_____	$_____
Public Assistance:	$_____	$_____	$_____
Social Security:	$_____	$_____	$_____
Unemployment Compensation:	$_____	$_____	$_____
Workman's Compensation:	$_____	$_____	$_____
Strike Benefits:	$_____	$_____	$_____
Alimony:	$_____	$_____	$_____
Child Support:	$_____	$_____	$_____
Military Family Allotments:	$_____	$_____	$_____
Pensions:	$_____	$_____	$_____
Income from Dividends and Interest:	$_____	$_____	$_____
Income from Rent, Real Estate or Property:	$_____	$_____	$_____
TOTAL:	**$_____**	**$_____**	**$_____**

COMPLETE SECTION _____ (Orchard Hospital representative to place X in appropriate box)

☐ **A. COMMUNITY CARE FINANCIAL ASSISTANCE MONETARY ASSETS (must include assets for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS

Cash on Hand: $_____
Checking Account Balance: $_____
Savings Account Balance $_____
Credit Union Account Balance: $_____
Trust Accounts: $_____
Additional Income: $_____

TOTAL MONETARY ASSETS: **$_____**

In order for us to consider your request, you must include one of the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. Orchard Hospital reserves the right to determine the most fair and appropriate application of this policy.)

2. Last years' tax returns

☐ **B. HIGH MEDICAL COMMUNITY CARE (LIABILITY AFTER INSURANCE {EXCLUDES HMO AND PPO}) – MONETARY ASSETS AND LIABILITIES (must include monetary assets and liabilities for applicant, spouse and other family member listed on page 1 of 3)**

ASSETS		MONTHLY LIABILITIES	
Cash on Hand:	$_____	Real-Estate Payments:	$_____
Checking Account Balance:	$_____	Rental Payment (Home or Apartment):	$_____
Savings Account Balance	$_____	Ins. Premiums (Auto, Home, Medical):	$_____
Credit Union Account Balance:	$_____	Avg. Annual Taxes:	$_____
Property Owned Value:	$_____	Avg. Monthly Utilities:	$_____
Home Value (if owned):	$_____	Other Liabilities (provide descriptions):	
Trust Accounts:	$_____	_____	$_____
Additional Income:	$_____	_____	$_____
Automobile(s) Estimated Value:	$_____	_____	$_____
Make & Model: _____		_____	$_____
Make & Model: _____		_____	$_____
Make & Model: _____		_____	$_____
TOTAL MONETARY ASSETS:	**$_____**	**TOTAL LIABILITIES:**	**$_____**

MEDICAL EXPENSES INCURRED AND PAID

Total patient's out-of-pocket costs incurred at this hospital in prior 12 months (net of any discounts or write- offs): $_____

Total patient and patient's family out-of-pocket medical expenses (including but not limited to, hospital services, physician services, drugs, and all other medical services) paid by the patient or patient's family in prior 12 months: $_____

In order for us to consider your request, you must include the following items:

1. Verification of income. (Note: Normally income consideration will be based on, but not limited to, the average of the previous three (3) months. Sometimes, however, in certain cases, e.g. self-employment, it may be appropriate to use an averaging of the previous 12 months' income. O r c h a r d H o s p i t a l reserves the right to determine the most fair and appropriate application of this policy.)
2. Last years' tax returns
3. Checking and/or savings accounts statements for the past two months
4. Copies of rental or mortgage payment (1 month)
5. Copies of utilities bills (1 month)
6. Copy of auto loan payments (1 month)
7. Copies of other outstanding liabilities

By signing this completed Financial Statement Condition form, I hereby declare the foregoing to be true under penalty of perjury under the laws of the state of California. I also agree to allow Orchard Hospital to check employment and credit history for the purpose of determining my eligibility for a financial discount.

_____ _____

(Applicant's signature) (Date)

_____ _____

(Spouse's signature) (Date)