POLICY STATEMENT

SUBJECT: CHARITY CARE & DISCOUNT POLICY DEPARTMENT: 8530-06-05

EFFECTIVE DATE: JANUARY 1, 2011_____ SUPERSEDES: NEW

REVIEW DATE(S): _____

REFERENCE: _____

CONCURRENCES:

Department Manager(s) _____ Date: _____

Medical Committee/Advisor: _____ Date: _____

APPROVAL SIGNATURES:

Administration: _____ Date: _____

Medical Executive Cmte: _____ Date: _____

Board of Directors: _____ Date: _____

DISTRIBUTED TO: _____ Date: _____

PURPOSE: The purpose of this policy is to provide guidelines to identify self-pay patients, without any third-party health coverage, who potentially qualify for CRMC's Charity Care or Discount programs and to provide procedures for the processing of individual patient accounts.

DEFINITIONS:

1. "Allowance for financially qualified patient" – with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.
2. "Self-pay patient" – a patient who does not have third-party health insurance coverage, Medicare, or Medicaid, and whose injury is not covered under workers' compensation, automobile insurance, or other coverage as determined by the hospital.
3. "Patient's family" – for persons 18 years or older, includes spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and, for persons under 18 years of age, includes parents, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
4. "Federal poverty guidelines" – the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health & Human Services.
5. "Charity Care" – applies to financially qualified self-pay patients whose hospital bill will be written off in whole or in part using a sliding scale, provided their family income does not exceed 175% of the federal poverty level. Charity Care may also be obtained from our Emergency Physician Group for the medical services they provide.

6. "Discount Payment" – applies to a financially qualified self-pay patient with high medical costs, whose hospital bill will be discounted to the amount of payment the hospital would receive from Medicare for that service, provided their family income is below 200% of the federal poverty level. A Discount Payment may also be obtained from our Emergency Physician Group for the medical services they provide.

PROCEDURE:

1. Written notice will be posted notifying patients of the availability of the hospital's charity care and discount policies, including information about eligibility, as well as how to contact the Business Office to obtain further information about these policies. This notice will be posted in: Admitting; Business Office; Emergency Room; and other areas of the hospital where outpatients are registered. The notice will be posted in both English and Spanish.
2. A patient with no, or limited, resources to pay for services rendered must demonstrate through financial screening and means testing their inability to pay vs. a patient who demonstrates the ability to pay but is not willing to.
3. Business Office employees will perform financial screening and means testing for patients who potentially qualify. A patient may be granted either full or partial Charity Care depending upon their financial situation.
4. All patients who cannot afford treatment will be assessed at the time of admission/registration to determine if they have unexplored insurance benefits or are eligible for public funded programs.
5. All potentially eligible patients should first apply for assistance through State, County and other programs before Charity Care is applied for.
6. Collection activity by the hospital will cease when the patient is declared eligible for Charity Care. Potentially eligible patients may be referred to a collection agency, on occasion, for additional documentation or information.
7. For purposes of determining eligibility under the charity care policy, we consider income and monetary assets of the patient. Monetary assets shall not include retirement or deferred-compensation plans. Furthermore, the first $10,000 of a patient's monetary asset shall **not** be counted in determining eligibility, nor shall 50 percent of the patient's monetary assets over the first $10,000 be counted in determining eligibility.
8. The purpose of the patient financial information documents is to determine a patient's eligibility for the Charity Care or Discount programs. Account documentation requirements include:
   - Exhibit A - CHARITY CARE REQUEST FORM
   - Exhibit B - POVERTY INCOME GUIDELINES
   - SUPPORTING DOCUMENTATION SUCH AS PRIOR YEAR TAX RETURNS, W-2 FORM, CURRENT PAY STUBS, BANK STATEMENTS, ETC.
9. Information collected on the patient financial information documents will be verified by hospital personnel via tax returns, pay stubs, bank statements and other documents when available. Patient's family members, guardians, or conservators may assist the patient and the hospital in securing the necessary information.
10. Patient financial information used to determine eligibility under these programs will not be used for collection activities by a collection agency.
11. The patient's signature will certify that information contained in the documents is accurate and complete. The Hospital may halt the application process at any time that the patient and/or family becomes uncooperative or refuses to supply essential documents.
12. If a patient can be adequately documented as 'homeless' or as 'transient', then further financial screening and income verification is not necessary.

13. As a guideline for determining the amount of Charity Care adjustment to be applied to a patient account, the following income standard will be used, according to the Federal Poverty Guidelines in Exhibit D:
    - If family income is below 125% of federal poverty level, then 100% Charity Care adjustment may be approved.
    - If family income is between 125-150% of federal poverty level, then 50% Charity Care adjustment may be approved. Patient balance due will not exceed the Medicare payment for the same service.
    - If family income is between 150-175% of federal poverty level, then 25% Charity Care adjustment may be approved. Patient balance due will not exceed the Medicare payment for the same service.
    - If family income is between 175-200% of federal poverty level, then Charity Care adjustment will not be granted, however patient balance due will not exceed the Medicare payment for the same service.
14. Accounts being written off either in whole or in part as Charity Care require complete documentation of the circumstances, including all necessary forms and copies of required documents. In addition, the appropriate Hospital employee, determined by approval level, must approve all Charity Care. Charity Care adjustment approval limits are defined as follows:
    - Under $1,000 can be approved by the Business Office Manager
    - $1,000 to $10,000 requires approval of the Chief Financial Officer
    - $10,000 and above requires approval of the Chief Executive Officer
15. At the time a decision is made for the approval or denial of an account for Charity Care, a letter will be sent to the patient as a notification of the decision made. The letter should be signed by either the Business Office Manager or the Chief Financial Officer.
16. All approved Charity Care will be logged to provide historical and financial data. The logs will include:
    - Demographic Data
        - Patient ID
        - Date of birth
        - Sex
        - Family Size
        - Family gross monthly income
        - Family principal income source
    - Service Data
        - Date of service for outpatient or Dates of service for inpatient
        - Type of service
        - Total billed charges on account
        - Expected Medicare payment for services
        - Discount allowed per policy

EXHIBIT A

CHARITY CARE REQUEST FORM

1. WHAT IS YOUR CURRENT ADDRESS? _____
   _____
2. TELEPHONE NUMBER? _____
3. ARE YOU BUYING OR RENTING YOUR HOME? _____
4. WHAT IS YOUR SPOUSES NAME? _____
5. HOW MANY CHILDREN, LIVING AT HOME UNDER THE AGE OF 18? _____
6. DO YOU RECEIVE CHILD SUPPORT? _____
7. DO YOU PAY CHILD SUPPORT? _____ HOW MUCH? _____
   IS IT PAID VOLUNTARILY OR ATTACHED TO YOU WAGES? _____
8. WHO IS YOUR CURRENT EMPLOYER? _____
   HOW LONG? _____ POSITION HELD? _____
   FULL OR PART-TIME? _____ WHEN ARE YOU PAYDAYS? _____
   DO YOU RECEIVE COMMISSIONS OR BONUSES? _____
9. WHAT IS YOUR MONTHLY INCOME BEFORE TAXES? _____
10. IF SPOUSE IS EMPLOYED – EMPLOYER'S NAME: _____
11. WHAT IS YOUR COMBINED MONTHLY INCOME BEFORE TAXES? _____
12. MONTHLY PAYMENTS?
    HOME: _____
    FIRST VEHICLE: _____
    SECOND VEHICLE: _____
    BOAT/CAMPER/RV:_____
    PG&E: _____
    CREDIT CARDS: _____
    OTHER (PLEASE LIST):
    _____
    _____
    _____
    _____
    _____
    _____

_____ _____
SIGNATURE DATE

Exhibit B

2011 Federal Poverty Guidelines

Gross Annual Household Income

Persons in Family or Household	100% of Poverty Level	125% of Poverty Level	150% of Poverty Level	175% of Poverty Level	200% of Poverty Level
1	10,890	13,613	16,335	19,058	21,780
2	14,710	18,388	22,065	25,743	29,420
3	18,530	23,163	27,795	32,428	37,060
4	22,350	27,938	33,525	39,113	44,700
5	26,170	32,713	39,255	45,798	52,340
6	29,990	37,488	44,985	52,483	59,980
7	33,810	42,263	50,715	59,168	67,620
8	37,630	47,038	56,445	65,853	75,260
For each add'l person, add	3,820	4,775	5,730	6,685	7,640

POLICY STATEMENT

SUBJECT: DISCOUNT PAYMENT POLICY DEPARTMENT: 8530-01-07

EFFECTIVE DATE: JANUARY 1, 2011_____ SUPERSEDES: NEW

REVIEW DATE(S): _____

REFERENCE: _____

CONCURRENCES:

Department Manager(s) _____ Date: _____

Medical Committee/Advisor: _____ Date: _____

APPROVAL SIGNATURES:

Administration: _____ Date: _____

Medical Executive Cmte: _____ Date: _____

Board of Directors: _____ Date: _____

DISTRIBUTED TO: _____ Date: _____

PURPOSE: The purpose of this policy is to provide guidelines to identify "high medical cost" patients, with third-party health insurance, who potentially qualify for CRMC's Discount Payment Plan and to provide procedures for the processing of individual patient accounts.

DEFINITIONS:

1. "Allowance for financially qualified patient" – with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.
2. "Financially qualified patient with high medical costs" – a person who is **not** a self-pay patient whose family income does not exceed 200% of the federal poverty level; **and** that person does not receive a discounted rate from the hospital as a result of his or her third-party coverage; **and** the patient provides documentation that his/her family out-of-pocket medical expenses exceed 10% of the patient's family income during the prior 12 months.
3. "Patient's family" – for persons 18 years or older, includes spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and, for

persons under 18 years of age, includes parents, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

4. "Federal poverty guidelines" – the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health & Human Services.

5. "Discount Payment" – applies to a financially qualified patient with high medical costs, whose hospital bill will be discounted to the amount of payment the hospital would receive from Medicare for that service, provided their family income is below 200% of the federal poverty level. A Discount Payment may also be obtained from our Emergency Physician Group for the medical services they provide.

PROCEDURE:

1. Written notice will be posted notifying patients of the availability of the hospital's discount payment and charity care policies, including information about eligibility, as well as how to contact the Business Office to obtain further information about these policies. This notice will be posted in: Admitting; Business Office; Emergency Room; and other areas of the hospital where outpatients are registered. The notice will be posted in both English and Spanish.
2. Patients must submit a Request for Discount Eligibility to the Business Office to be considered for a discount under this policy.
3. Business Office employees will perform a Financial Screening Assessment for patients who potentially qualify for, and request a discount under this policy.
4. For purposes of documenting income under this Discount Payment Policy, CRMC may only require recent pay stubs or income tax returns. **Asset testing is not allowed under this policy.**
5. EXHIBIT C details the Federal Poverty Guidelines to use in determining whether the documented income is below 200% of the federal poverty level. This Exhibit will be updated periodically as new figures are reported in the Federal Register by the U.S. Department of Health & Human Services.
6. Patients must demonstrate eligibility to qualify as a high medical cost patient by providing documentation that out-of-pocket medical expenses incurred by the patient and/or family members exceed 10% of the family's gross income, during the preceding twelve (12) month period.
7. If the patient received a discount on their bill as a consequence of third party coverage, they are not eligible for any further discount under this policy.
8. If the patient is financially qualified for a discount based on the above criteria, their bill will be reduced to the expected payment that would be received from Medicare for the same service.
9. If payment for services received from a third-party payer exceeds the payment that would be received from Medicare for the same service, an allowance will be made and the patient will not be liable to the hospital for any remaining balance..
10. CRMC will allow an extended payment plan to allow payment of the discounted price over time, with no interest. The hospital and the patient may negotiate the terms of the payment plan, with the following **minimum payment** guidelines:
    - Patient balance due of $1,200 or less will be paid off in no more than 12 equal monthly payments,
    - Patient balances exceeding $1,200 shall be paid with minimum monthly payments of $100, until the discounted balance is paid in full.

11. CRMC may deny a patient eligibility for discounted payments because a patient either is not financially eligible or did not provide the documentation allowed under this policy.
12. Patients, or their immediate family members, may appeal the denial of eligibility either to the Business Office Manager or the Chief Financial Officer of CRMC.
13. For any patient who is financially qualified under this policy, the hospital or our collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing.
14. If a patient is attempting to qualify for eligibility under this policy, and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee.
15. The hospital, or its collection agency, in dealing with patients eligible under this policy, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills.
16. The purpose of the patient financial information documents is to determine a patient's eligibility for the Discount Payment program. Account documentation requirements include:
    - EXHIBIT A – Patient Request for Discount Eligibility
    - EXHIBIT B – Financial Screening Assessment
    - EXHIBIT C – Federal Poverty Guidelines
    - Any supporting documentation received from patient or patient's family, such as: current pay stubs, tax returns, proof of out-of-pocket medical expenses, proof of family size, etc.
17. Any allowance for financially qualified patients under this policy requires complete documentation of the circumstances, including all necessary forms and copies of required documents. In addition, the appropriate Hospital employee, determined by approval level, must approve all discounts. Discount approval limits are defined as follows:
    - Under $1,000 can be approved by the Business Office Manager
    - $1,000 to $10,000 requires approval of the Chief Financial Officer
    - $10,000 and above requires approval of the Chief Executive Officer
18. At the time a decision is made for the approval or denial of an account for Discount Payment, a letter will be sent to the patient as a notification of the decision made. The letter should be signed by either the Business Office Manager or the Chief Financial Officer.
19. All approved discounts under this policy will be logged to provide historical and financial data. The logs will include:
    - Demographic Data
        i. Patient ID
        ii. Date of birth
        iii. Sex
        iv. Family Size
        v. Family gross annual income
        vi. Family out-of-pocket medical expenses last 12 months
    - Service Data
        i. Date of service for outpatient or Dates of service for inpatient
        ii. Type of service

iii. Primary insurance / payer
iv. Total billed charges on account
v. Payment received from primary payer
vi. Patient balance due after primary payment
vii. Expected Medicare payment for service
viii. Discount allowed per policy

EXHIBIT A

Patient Request for Discount Eligibility

1. Patient's name: _____
2. Current address: _____
3. Phone number: _____
4. Date(s) of service at the hospital: _____
5. Inpatient or Outpatient: _____
6. Primary health insurance: _____
7. Number of people in your family: _____
8. Current employer: _____
9. Estimated family gross annual income: _____
10. Estimated family annual out-of-pocket medical costs: _____

_____ _____
SIGNATURE DATE

EXHIBIT B

Financial Screening Assessment

1. Patient's name: _____
2. Current address: _____
3. Phone number: _____
4. Date(s) of service at the hospital: _____
5. Inpatient or Outpatient: _____
6. Primary health insurance: _____
7. Total billed charges on account: _____
8. Payment received from primary payor: _____ (A)
9. Allowance due to contractual agreement with primary payor: _____

Continue only of there is no contractual allowance, otherwise not eligible

10. Verified number of people in your family:_____

    i) How documented or confirmed? _____

    ii) 200% of Poverty Level for family size: _____ (B)

11. Current employer: _____
12. Verified family gross annual income: _____ (C)

    i) Confirmed by pay-stubs or tax return? _____

Continue only if "C" is less than "B", otherwise not eligible for discount

13. Verified family annual out-of-pocket medical costs: _____ (D)

    i) How documented or confirmed? _____

    ii) Medical Costs (D) / Income (C) % _____

Continue if "D" divided by "C" is greater than 10%, otherwise not eligible

14. Patient balance after primary insurance: _____ (E)

15. Expected Medicare payment for service: _____ (F)

16. Which is greater? – The payment received (A) or Medicare payment for this service (F):_____

If "A" is greater than "F", patient is eligible for discount allowance of entire balance due after primary payor has paid.

If "F" is greater than "A", patient is responsbible for paying the difference between the payment received from primary payor, and the expected payment from Medicare for the same service. A discount will be allowed to reduce the Patient Balance Due (E) to the difference between "A" and "F".

17. DISCOUNT allowed by this policy: _____ (G)

18. Adjusted balance due ("E" minus "G"): _____

If adjusted balance due from patient is less than $1,200, patient may elect to pay this over a maximum of 12 monthly payments, interest free.
If balance due is greater than $1,200, patient may elect to make payments of <u>at least</u> $100 per month until balance is paid in full, interest free.

19. Monthly payment agreed to: _____

19. How many months to pay off balance? _____

_____ _____
Collection Representative Date

_____ _____
Patient Date

_____ _____

Business Office Manager or CFO Date

Exhibit C

2011 Federal Poverty Guidelines

Gross Annual Household Income

Persons in Family or Household	100% of Poverty Level	125% of Poverty Level	150% of Poverty Level	175% of Poverty Level	200% of Poverty Level
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8	37,630	47,038	56,445	65,853	75,260
For each add'l person, add	3,820	4,775	5,730	6,685	7,640