POLICY & PROCEDURES	PAGE 1 OF 20
RE:Financial Assistance/Charity Policy	Effective: 07/25/06 Revised 04/01/08,Revised 4/01/09, Revised 06/28/11
Department File: Business Office Misc.	Prepared by: Terry Ellis Business Office Director Dan Vincent Revenue Cycle Director
Approved by: Dave Glyer, CPA VP Finance	Approved by: Gary K. Wilde, President & CEO

POLICY

Community Memorial Health System's (CMHS) mission is to provide the best care to every patient daily through integrated clinical practice and education. CMHS strives to benefit humanity through work in these areas, while supporting the communities in which we live and work. As part of that commitment, CMHS serves, appropriately, patients in difficult financial circumstances. Above all, CMHSs guiding philosophy is that the needs of the patient come first.

Charity Care, hereafter identified as Financial Assistance, is only one component of CMHS's charitable mission. Financial Assistance may consist of full write-off of charges, partial write-off of charges, or offering the patient other payment options. (See Payment Hierarchy Policy)

Patients seeking debt relief from the Financial Assistance Program must be a resident of the CMHS's defined service area. CMHS reaches out to self-pay and under-insured patients in a number of ways, including raising patient awareness of Medi-Cal health insurance. By assisting our patients with application process, CMHS helps patients obtain the benefits for which they qualify.

The Patient Financial Services Department assumes the responsibility to exercise "sound business practices," and to make a hospital-defined "reasonable effort" to collect its accounts. CMHS adheres to the Fair Debt Collection Practices Act and the Association of Credit and Collection Professional's Code of Ethics and Professional Responsibility and patients are treated with respect and in line with our mission and

values.
Attachments to the policy:

A- List of Exclusions

B- Definitions

C- Qualify Income and Debt Reduction

D- Financial Assistance Program Application/Cover Letter/Instructions

I. Financial Assistance Program Identification:

A. Patient Access Process:

1. Financial Assistance Program brochures explaining the policy will be posted at each point of entry.

2. Signs alerting patients to the availability of Financial Assistance will be prominently displayed.

3. Patient Access staff will be trained in the basics of the program and where to refer patients who have additional questions.

4. On the back of each summary statement a message will be printed that explains CMHS Financial Assistance Policy.

    - CMHS recognizes health care is often unplanned and can be expensive. We provide our patients without health insurance and uninsured patients discounts similar to the other payers of health care services. CMHS provides uninsured patients a discount on their bill. We also have a Financial Assistance Program (Charity Care) that you may qualify for.

    - An application must be completed to determine eligibility. Please contact the Customer Service Department for more information.

B. Financial Counseling:

1. Payment source and patient's ability to pay will be evaluated upon admission by the CMHS Financial Advocate.

2. Patient Financial Services staff or a designee of CMHS will assist patients with reimbursement from local, state, and federal programs when there is no other source of payment.

3. In the event that no third party payment source is available, patients/guarantors will be provided with information on the Financial Assistance Program.

4. Patient Financial Services staff will assist patients/guarantors to make payment arrangements if no assistance (e.g., local, state, federal or CMHS's financial assistance program) is available.

C. External Collection Efforts:

Collection agencies performing debt collection on behalf of CMHS will refer back to the hospital all patients/guarantors with Financial Assistance Program applications when the patient/guarantor expresses difficulty in meeting the payment expectations of the collection agency.

II. Eligibility and processing guidelines:

A. Application Process:

1. Application for Financial Assistance may be completed anytime, throughout the revenue cycle process, when a true self-pay is balance due and it is acknowledged (or the patient/applicant has expressed) that there is financial difficulty.

2. An application may be completed prior to receiving services if confirmation is received and the service is true selfpay. Financial Assistance program excludes Cosmetic procedures and will be reviewed for Medical necessity. Maternity patients are excluded from this policy as Medi-Cal will assist with those cases. Other exclusions may apply, see exclusion list.

3. Eligibility is contingent upon patient cooperation with the application process.

4. The application process includes completing the financial assistance application and providing verification of documents.

    a. When an application form cannot be filled out, the Director of Admissions/Patient Financial Services may use discretion in identifying and authorizing the account as Financial Assistance Program.

    b. Upon receipt of the completed application, Director of Admissions/Patient Financial Services or his/her designate, will complete the Financial Assistance Program allowance worksheet

and make a final determination for eligibility.

5. Confirmation of continued eligibility may be updated every three (3) months.

6. For patients that qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CMHS may offer extended payment plans, see Payment Hierarchy Policy, and will not impose wage garnishments or force a foreclosure on primary residences, will not impose actions that force bankruptcy and will not send unpaid bills to outside collection agencies.

7. After the completed application has been received a letter of acceptance or non-acceptance for the program will be sent to the patient or guarantor within 15 days from the date of receipt.

B. Qualification Criteria and associated Debt Reduction: The Financial Assistance Application is used to determine the patient/guarantors' eligibility for:

    1. Charity Care:

        a. Financial Assistance debt reduction write-offs will be based on a sliding-scale fee schedule (Attachment C) utilizing the current United States Federal Poverty Guidelines.

        b. Information from the applicant's financial application (Attachment D) and supporting documentation will be applied to the list of Exclusions (Attachment A) to determine the amount of the qualified Financial Assistance to be granted. Appropriate documentation includes the following, but may not be limited to:

            ✓ W-2 withholding forms

            ✓ Paycheck stubs

            ✓ Income tax returns

            ✓ Profit and Loss Statement from a self-employed business

            ✓ Forms approving or denying unemployment or workers compensation

            ✓ Written verification from public welfare agencies or any governmental agency which can attest to the Patient's income status for the past twelve (12) months. Verification of income is required every six (6) months for re-evaluation.

- ✓ A Medi-Cal remittance voucher reflecting exhausted Medi-Cal benefits for the applicable Medi-Cal fiscal year.

- ✓ Medi-Cal verification of the Patient Share of Cost.

2. Uninsured, Underinsured or Financially needy:

    a. Financial Assistance debt reduction write-offs will be based on a sliding fee schedule (Attachment C) utilizing the current United States Federal Poverty Guidelines, income, assets, family size, medical needs and catastrophic costs. Financial assistance ranges between Medicare Rates and 100% and is available to all patients regardless of whether or not they have health insurance. Patients who have health insurance may quality for assistance on their remaining balance (coinsurance/deductibles) after insurance pays. See Payment Hierarchy Policy.

    b. Information from the applicant's financial application (Attachment D) and supporting documentation will be applied to the list of Exclusions (Attachment A) to determine the amount of the qualified Financial Assistance to be granted. Appropriate documentation includes the following, but may not be limited to:

        - ✓ W-2 withholding forms

        - ✓ Paycheck stubs

        - ✓ Income tax returns

        - ✓ Profit and Loss Statement from a self-employed business

        - ✓ Forms approving or denying unemployment or workers compensation

        - ✓ Written verification from public welfare agencies or any governmental agency which can attest to the Patient's income status for the past twelve (12) months. Verification of income is required every six (6) months for re-evaluation.

        - ✓ A Medi-Cal remittance voucher reflecting exhausted Medi-Cal benefits for the applicable Medi-Cal fiscal year.

        - ✓ Medi-Cal verification of the Patient Share of Cost.

3. Patients/Guarantors who experience Sudden and Prolonged Loss of Income may qualify for the Financial Assistance Program based upon three (3) months of recent (including current) pay stubs and/or documentation from sources such as Social Services, etc., confirming the claim of Loss of Income.

4. Government Assistance: In determining whether an individual qualifies for Financial Assistance, other county or governmental assistance programs should also be considered.

    a. Community Memorial Health System contracts with third party patient advocate to help individuals determine eligibility for governmental or other assistance, as appropriate.

    b. Persons who are eligible for programs (such as Medi-Cal) but who were not covered at the time that medical services were granted may be approved for Financial Assistance provided that the patient now applies for government assistance. This may be prudent, especially if the patient requires ongoing services.

III. Other Debt Reduction Considerations:

1. Administrative write-offs will not be considered Charity Care.

2. Bad Debts will not be considered Charity Care.

3. Bad Debt accounts returned by third party collection agencies who have determined the patient/guarantor does not have the ability to pay, in accordance to the Financial Assistance Program policy, will be classified as Charity Care.

4. Accounts reduced to a zero balance as the result of the patient/guarantor being deceased with no estate will be considered Charity Care, as evidenced by supporting documentation.

5. Accounts reduced to a zero balance, as the result of bankruptcy, will be considered Charity Care.

6. Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate CMHS provide continuing care

IV. Debt Reduction Authorizations:

Approval Level – All financial assistance applications must be approved according to the following:

From	To	Title
$0	$10,000	Senior Patient Account Representative
$10,001	$100,000	Director of Patient Financial Services or Revenue Cycle Director
$100,001	$Over	VP Finance

V. Presumptive Charity Care:

1. The Presumptive Charity Care model utilizes data variables to assign accounts a relative "ability to pay" score that can pre-qualify balances for charity prior to placement to bad debt. An ability-to-pay score is determined using historical collection activities to identify Patient traits that have historically correlated to low income and asset levels. Such traits can include employment, payment activity, gender, home address, and balance size.

2. The Presumptive Charity model will serve as an additional and final "screening" for those Patients with limited capacity to pay their medical expenses.

3. This program will be administrated by Medical Financial Solutions (MFS) and monitored by a member of Community Memorial Health System management as a component of the "Pre-Collection" campaign. Presumptive Charity Care will be evaluated for the Patient subsequent to collection efforts by MFS, but prior to bad debt placement (i.e., approved Presumptive Charity Care Patient accounts will not be placed to collection agencies).

4. Presumptive Charity Care approvals will follow the Standard Charity Care approval guidelines.

VI. Other Financial Assistance Program considerations:

Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate Community Memorial Health System to provide continuing care.

Factors Not Considered:

The following factors will not be considered when making a recommendation for Financial Assistance and/or in granting of assistance:

- Bad Debt
- Contractual Allowances
- Perceived underpayments for operations
- Cases paid through a charitable contribution
- Community service or outreach programs or employment status.

In other words, these monetary sources have no bearing on the patient's eligibility.

Equal Opportunity:

When making decisions on Financial Assistance, Community Memorial Health System is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service or any other classifications protected by federal, state or local laws.

Reasons for Denial:

1. Sufficient Income
2. Asset Level
3. Uncooperative despite reasonable efforts to work with the patient
4. Incomplete Financial Assistance Application despite reasonable efforts to work with the patient
5. Withholding insurance payment and/or insurance settlement funds
6. Failure to complete applications for Medi-Cal
7. Failure to participate and cooperate with Medi-Cal Eligibility Vendor

Coverage period:

Services provided by hospitals and clinics of Community Memorial Health System are covered by the Financial Assistance Program.

Services incurred by the patient/guarantor and future services, not extending beyond 30 days, may be included in the reduction. Patients/guarantors receiving health care services three (3) months beyond the initial Financial Assistance Program approval will re-verify their financial income information.

Entities not covered under the Financial Assistance Program policy:

Long Term Care, Assisted Living Center, HME/DME and any other service not typically provide by the traditional hospital or clinics are not eligible for inclusion in the Financial Assistance Program.

Only services provided to patients as urgent or emergent qualify for charity care. Elective services are not eligible for Financial Assistance Program reduction, unless they have been pre-qualified via the Financial Assistance Program guidelines.

ATTACHMENT A

Financial Assistant Program Exclusions:

1. **Abortion:** Services, supplies, care or treatment in connection with an elective abortion.

2. **Acupuncture:** Shiatsu, electrical stimulation to the periosteum, chelation therapy, immunoaugmentive therapy (IAT), thermograph, joint reconstruction therapy, joint sclerotherapy, prototherapy, or ligamentous injections with sclerosing agents, Osteopathic manipulative treatment, spinal manipulative treatment, and kebiozen.

3. **Complications:** Complications of Non-covered Procedures.

4. **Cosmetic surgery:** Cosmetic surgery or any complications arising from Cosmetic surgery including; laser treatment or ablation of benign skin lesions [except for condyloma acuminatum], dermabrasion, superficial chemical peels, and medium or deep chemical peels not directed at the treatment of pre-cancerous skin lesions. **This exclusion does not apply to:** Cosmetic surgery required for correction of a condition arising from an Accidental Injury, or when rendered to correct a congenital anomaly where the correction restores a functional bodily process.

5. **Custodial care:** Care whose primary purpose is to meet personal rather than medical needs and which can be provided by persons with no special medical skills or training is considered as Custodial Care. Such care includes, but is not limited to: helping a patient walk, get in or out of bed, and take normal self-administered medicine. Domiciliary care and inpatient hospitalization are not covered for the purposes of Custodial Care.

6. **Dental treatment:** Routine dental treatment, unless medically necessary due to a serious medical condition or an accidental injury.

7. **Exercise programs:** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy.

8. **Experimental or not Medically Necessary:** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

9. **Gastric surgery:** Any services, supplies, or programs involving gastric surgeries for weight loss.

ATTACHMENT A (continued)

10. **Impotence:** Care, treatment, services, supplies or medication in connection with diagnosis and treatment for impotence.

11. **Infertility:** Care, supplies, services, diagnosis and treatment for infertility, sterility, artificial insemination, embryo transplants and storage, or in-vitro fertilization.

12. **Massage:** Services from a masseur, physical culturist, physical education instructor, or health club attendant.

13. **No Physician recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the patient is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

14. **Obesity:** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.

15. **Occupational:** Charges for or in connection with an Injury or Illness, which is occupational—that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Participant waives or fails to assert his right under the law, or expenses resulting from wage or profit. One example of this is if the individual is self-employed and experiences an Injury or Illness, which arises out of or in the course of that employment, the charges will not be covered by the FAP if the self-employed individual elected not to participate in a Worker's Compensation program, as consistent with any applicable State or Federal Law.

16. **Private duty nursing:** Charges in connection with care, treatment or services of a private duty nurse.

17. **Surgical sterilization:** Elective surgical sterilization procedures.

18. **Surgical sterilization reversal:** Care and treatment for reversal of surgical sterilization.

19. **Surrogacy:** Any service associated with any type of surrogacy agreement or arrangement, including traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement or gestational or invitroferilization surrogacy.

ATTACHMENT B

FINANCIAL ASSISTANCE PROGRAM DEFINITIONS

Bad Debt: Gross charges incurred in providing services to patients who were determined to have the ability to pay for such services, but eventually do not. This determination can be made upon admission, or any time subsequent thereto.

Charity Care: Gross charges incurred in providing services to patients who *were* determined *not to* have the ability to pay for such services and for which Community Memorial Health System ultimately does not expect payment. This determination can be made upon admission or any time subsequent thereto. In addition, **Financial Assistance Program should *also* include:**

Service Area: The service area of the hospital for the purpose of this policy is considered to be a geographical area extending to Western Ventura County.

Sudden and Prolonged Loss of Income: Patients who experience a sudden and prolonged loss of income of at least 90 days due to illness, will complete a Financial Assistance Program application.

Miscellaneous Write-offs: Gross charges incurred in providing services to patients who it was determined had the ability to pay but, based upon litigation's, disputes, etc.; an administrative decision was made not to require payment.

Amounts Returned by Collection agencies: After a certain time period has elapsed, the collection agency will return any accounts deemed to be uncollectible. Their returned accounts should be written off as Charity Care provided the professional agency has determined that the patient is unable to pay the bill.

Deceased with No Estate: Outstanding accounts for person, who expires with no estate, should be written off as Charity Care. If partial payment from the estate is received, the remainder of the bill should be considered Charity Care.

Bankruptcy: Outstanding accounts for a person, who declares bankruptcy, should be written off as Charity Care.

Income: Cash equivalent received/earned by household.

Assets: Resources/Possessions other than income. To include but not limited to real property assets, savings, checking, and investment assets.

ATTACHMENT B (continued)

Net Assets: Assets less debt.

Means Testing: Net assets in excess of 200% of household income will be considered income for the purpose of the Financial Assistance Program.

Episode of Care: Course of treatment prescribed by a physician delivered over a finite period of time.

ATTACHMENT C

Federal Poverty Guidelines (FPG):

Persons in Family or Household	2011 FPG Gross Income 6 Months	200% of FPG Adjustment	201%-300% of FPG Adjustment	301% and over Refer to Financial Assistance Charity Policy
1	$10,890	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
2	$14,710	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
3	$18,530	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
4	$22,350	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
5	$25,170	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
6	$29,990	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
7	$33,810	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
8	$37,630	100%	Medicare Rates	Refer to Financial Assistance Charity Policy
Each additional Person	$3,820			

Federal Poverty Guidelines at 3, 6, & 12 Months of Income:

Persons in Family or Household	2011 FPG Gross Income 3 Months	2011 FPG Gross Income 6 Months	2011 FPG Gross Income 12 Months
1	$5,445	$10,890	$21,780
2	$7,355	$14,710	$29,420
3	$9,265	$18,530	$37,060
4	$11,175	$22,350	$44,700
5	$12,585	$25,170	$50,340
6	$14,995	$29,990	$59,980
7	$16,905	$33,810	$67,620
8	$18,815	$37,630	$75,260
Each additional Person	$1,910	$3,820	$7,640

ATTACHMENT C (continued)

At 200% of the FPG equals 25% of Charges or the Medicare Inpatient DRG whichever is less:

Persons in Family or Household	2011 200% FPG Gross Income 3 Months	2011 200% FPG Gross Income 6 Months	2011 200% FPG Gross Income 12 Months
1	$5,445	$10,890	$21,780
2	$7,355	$14,710	$29,420
3	$9,265	$18,530	$37,060
4	$11,175	$22,350	$44,700
5	$12,585	$25,170	$50,340
6	$14,995	$29,990	$59,980
7	$16,905	$33,810	$67,620
8	$18,815	$37,630	$75,260
Each additional Person	$1,910	$3,820	$7,640

At 300% of the FPG equals 40% of Charges or the Medicare Inpatient DRG whichever is less:

Persons in Family or Household	2011 300% FPG Gross Income 3 Months	2011 300% FPG Gross Income 6 Months	2011 300% FPG Gross Income 12 Months
1	$8,168	$16,335	$32,670
2	$11,033	$22,065	$44,130
3	$13,898	$27,795	$55,590
4	$16,763	$33,525	$67,050
5	$18,878	$37,755	$75,510
6	$22,493	$44,985	$89,970
7	$25,358	$50,715	$101,430
8	$28,223	$56,445	$112,890
Each additional Person	$2,865	$5,730	$11,460

ATTACHMENT D

Community Memorial Health System

Where Excellence Begins with Caring

Community Memorial Health System
5855 Olivas Park Dr.
Ventura, CA 93003

To apply in person:
5855 Olivas Park Dr
Ventura, Ca 93003

REGUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE APPLICATION

Patient Name_____

Patient Account Number(s)_____

Guarantor Name_____

Date of Birth:_____**SS#**_____-_____-_____

Phone ( )_____

Address_____

City, State, Zip_____

Spouse Name_____**SS#**_____-_____-_____

Are you a U.S. Citizen? ____**Yes** ___**No**

If not, a resident alien ? ____**Yes** ___**No**

If not, non-resident alien? ____**Yes** ___**No**

FAMILY STATUS: List all dependents who you support

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

EMPLOYMENT AND OCCUPATION:

Employer_____Position:_____
_____

If self employed, name of business_____

Employer
Address_____

Phone Number_____How long employed_____

Spouse
Employer:_____Position:_____

If self employed, name of
business_____

Statement of Current Income and Expenditures

Current Monthly Income:	**Patient**	**Spouse**
Gross Pay	**$_____**	**$_____**
Income from business (if self employed)	**$_____**	**$_____**
Interest and dividends	**$_____**	**$_____**
Income from real estate or personal property	**$_____**	**$_____**
Social Security/Retirement Income	**$_____**	**$_____**
Alimony, support payments	**$_____**	**$_____**
Unemployment compensation	**$_____**	**$_____**
Other Income	**$_____**	**$_____**

Total Monthly Income	**$_____**	**$_____**

Current Monthly Expenses:

Rent or House Payment	**$_____**	**$_____**
Real Estate Taxes	**$_____**	**$_____**
Utilities	**$_____**	**$_____**
Alimony, support payments	**$_____**	
$_____		
Education	**$_____**	**$_____**
Food	**$_____**	**$_____**
Payroll Deductions	**$_____**	**$_____**
Medical, dental and medicines	**$_____**	**$_____**
Other_____	**$_____**	**$_____**
Total Monthly Expenses	**$_____**	**$_____**
Net Monthly Income after Expenses	**$_____**	**$_____**

By signing this Application, I agree to allow Community Memorial Health System to contact my employer, bank and other sources, as well as request a credit history for the purpose of determining my Charity Care eligibility. I understand that I do not qualify for services under the Charity Care guidelines that I will be personally liable for the charges of the services rendered. I attest that the information provided on this application is true and accurate. If it is determined that any information provided here is false or misleading, I understand that eligibility for Charity Care will be denied.

I also understand that this application is for Community Memorial Health Systems charges only. All physicians, radiology professional, Ojai emergency room professional, ambulance, anesthesiology services or pathology services are billed separately from Community Memorial Health Systems are not covered by this application.

_____	_____
(Signature of Patient or Guarantor)	**(Date)**
_____	_____

(Signature of Co-Applicant) **(Date)**

Community Memorial Health System

Where Excellence Begins with Caring

To apply in person please visit:

5855 Olivas Park Dr.
Ventura, CA 93003
Business Hours
Mon. – Fri. 8:00 am – 4:00 pm

REQUEST FOR FINANCIAL ASSISTANCE
UNCOMPENSATED CHARITY CARE APPLICATION INSTRUCTIONS

Date: _____

Patient Name: _____

Account Number(s): _____

Total Balance for Consideration: $_____

In response to your request for financial assistance regarding the above identified account number(s), please submit the following documentation, no later than ten (10) days of the date of this letter.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill.

(1) Fully completed charity application (enclosed with this letter)

(2) Copies of your current period payroll check stubs for the last three months. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with

someone, please have him or her write a statement explaining the situation.

(3) Rent or mortgage verification.

(4) Copy of your prior month's bank statement (savings, checking, IRAs, money market accounts, etc…)

(5) Copy of your prior year's tax return (the completed and signed 1040)

Please send copies of these documents because they will not be returned to you.

If you have any questions, please telephone me directly at (805)_____

for assistance.

_____

Patient Account Representative
Community Memorial Health System