POLICY

1.1 HealthSouth Bakersfield Rehabilitation Hospital shall provide Charity Care for eligible patients who have been approved for the program.

PURPOSE

2.1 To promulgate the policy/procedures for the administration of Charity Care by HealthSouth Bakersfield Rehabilitation Hospital.

DEFINITIONS.

3.1 "Charity Care" means inpatient and outpatient medical treatment and diagnostic services for uninsured patients who cannot afford to pay for the care according to established hospital guidelines. Such treatment is provided by this hospital without expectation of payment. Charity Care does not include bad debt or contractual shortfalls from government programs.

3.2 "Partial Charity Care" means inpatient and outpatient medical treatment and diagnostic service for patients who are underinsured and cannot afford to pay for the rest of the care according to established hospital guidelines. Partial charity care may include the patient's portion of copayments, deductibles, or both.

3.3 "Bad Debt" is defined as expenses resulting from treatment for services provided to a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the contractual arrangements to resolve a bill.

PROCEDURE

4.1 Non-discrimination.
The determination of full or partial Charity Care will be based on the patient's ability to pay and will not be abridged on the basis of age, sex, race, creed, religion, disability, sexual orientation or national origin.

4.2 Charity Care Services.
Available health care services, inpatient and outpatient, shall be available to individuals under this policy. Charity care includes both discounted and free services.

4.3 Determination of Eligibility.
The determination of Charity Care should be made before providing services. If complete information on the patient's insurance or financial situation is unavailable at the time of service, or if the patient's financial condition changes, the designation of Charity Care may be made after rendering services. Efforts will be made to establish whether the patient is eligible for Charity Care before leaving the hospital.

4.4 Confidentiality.
The need for Charity Care may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for those who seek charitable services.

4.5 Staff Information.
Hospital employees in patient accounting, billing, and registration will be fully versed in the hospital's Charity Care policy, have access to the application forms, and be able to direct questions to the appropriate hospital representatives.

4.6 Charity Care Representative.
The hospital designates the Controller as the Charity Care Representative who will review Charity Care applications and together with the CEO, will approve applications. The Charity Care representative will also coordinate outreach efforts and oversee Charity Care practices.

4.7 Staff Training.
Staff in the admissions office and the liaisons in the community will be trained to understand the basic information related to the hospital's Charity Care policy and procedures and provide patients with printed material explaining the Charity Care Program.

5 Application Process.

5.1 Application.
The attached application will be used by patients to apply for Charity Care from the hospital (Appendix A). Patients who do not have insurance may qualify for Charity Care based on their monthly or annual income and their family size. Patients having insurance may also be eligible for Charity Care for the portion of their bill that is not covered by insurance, including deductibles, coinsurance, and non-covered services.

5.2 Application Assistance.
The hospital's Charity Care Representative (as provided under § 3.7) will provide application assistance to patients. Translation services and assistance will be offered to patients.

5.3 Requests for Information.
The hospital shall send anyone who requests information on the hospital's Charity Care Program a letter and application form (Appendix A & B).

5.4 Additional Requestors.
Charity Care requests may be proposed by the patient's legal representative. The patient shall be informed of such a request. This type of request shall be processed like any other.

5.5 Timing.
Attempts should be made by the hospital to have the patient fill out a Charity Care application before the time services are rendered and should be completed within 10 days of delivery outpatient services or discharge.

6 Application Review Process.

6.1 Eligibility Criteria.

6.1.1 Charity Care Review.
Upon review of the patient's financial and employment situation as completed in the Charity Care application, the hospital will determine whether the patient qualifies for Charity Care. To qualify for Partial Charity Care a patient's monthly or annual income must be 350% or less of the federal poverty guidelines (Appendix C). To qualify for full Charity Care, a patient's annual or monthly income must be 100% of FPL or less.
6.1.2 Financial Information.
If verification of financial information is needed, the hospital shall request such information from the patient. Patients must provide at least a paycheck stub and / or income tax return to qualify for Charity Care. If free services are requested to hospital may seek additional information regarding all monetary assets except deferred compensation plans (e.g. 401K, etc.) The hospital may request a waiver authorizing the hospital to obtain account information directly from institutions.

6.1.3 Asset Exemption.
The first $10,000 in monetary assess and 50% of monetary assets over $10,000 and all retirement / deferred compensation accounts are exempted from consideration as assets in considering whether the patient meets the Charity Care financial criteria.

6.2 Approval.

6.2.1 Approval Notification.
The patient shall be notified in writing within ten (10) working days after receipt of the Charity Care application and any supporting materials as to whether the patient qualifies for the Charity Care Program. When the patient is notified that s/he is eligible for Charity Care, the patient shall receive an approval letter. (Appendix D). If approved for partial charity care, the amount of payment expected from the patient will not be more that the hospital would receive from Medicare for similar services. If there is an expected amount from the patient the hospital and the patient may negotiate an extended payment plan which must be interest free. If the patient is at 100% of FPL, he may be approved for 100% charity care and no payment will be expected from the patient.

6.2.2 Expired Patients.
Patients who have died and have no estate are deemed to have no income for the purpose of determining Charity Care eligibility.

6.3 Denial.
If a patient is denied Charity Care, the patient shall be informed within ten (10) working days of the denial. All reason(s) for denial shall be provided at that time
and the patient shall be informed of the appeal process under § 5.4 (Appendix E).

6.4 Appeal.
Each patient denied Charity Care may petition the hospital within thirty (30) days for reconsideration based on extenuating circumstances. The patient will be notified of the appeal process in the correspondence informing the patient of the

Charity Care denial (Appendix F).

7 Publication.

7.1 Publication Inside Hospital.
7.1.1 Posters.
The availability of Charity Care shall be advertised on signage, located in Admissions, Outpatient Registration, and Business Office (Appendix H). Information on the sign will be translated into languages appropriate to the community. Case managers will be trained to identify patients who may qualify for charity care and educate them regarding this option after admission.

7.1.3 Information Sheet.
Information sheets outlining the Charity Care Program, application process shall be available at patient registration desks. (Appendix B). The Charity Care information sheet will be available in Spanish as well as English.

8 Collection Activity.

8.1 Billing
When a bill is sent to a patient who has not provided proof of coverage, information on the charity care policy will be included (Attachments A and B)

8.2 Restriction on Referral.
The hospital will not report adverse information to a credit reporting agency or commence civil action against a patient for nonpayment prior to 150 days after initial billing.

8.3 Equitable Payment Schedule.
The hospital will make efforts to work with the patient to determine an equitable payment schedule considering the patient's financial and medical circumstances.

9. Reporting.

9.1 External Reporting.
The hospital shall file a copy of the hospital's Charity Care Program with appropriate local and state agencies

Table of Appendices

Appendix A: Charity Care Application Form

1. Applicant Information.

Last Name_____ First _____ MI _____
Street Address _____
City _____State_____Zip Code_____
Home phone_____Work_____Cell_____
Mailing Address if different from Street Address_____
Date of Birth _____ Male _____ Female_____ Are you pregnant? Yes ____ No ____
Are you homeless? Yes _____ No _____ Are you uninsured? Yes _____ No _____
Are you unemployed? Yes _____ No _____

2. If you are applying for someone else, complete this section.

Last Name_____ First_____ MI _____
Street Address _____
City _____State_____Zip Code_____
Home phone_____Work_____Cell_____
Relationship to Applicant _____

3. Family Information. List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

Name of family member	Relationship	DOB	Gender	Pregnant

4. List Earned Income before taxes and deductions for each family member who works.

Name, working members	Employer and Address	Amount Earned	How Often

5. Other Income not from an employer.

Name, family member receiving	Type of income (pick from list below)	Amount	How Often

Social Security	Bank Account Income	Pensions	Rental Income
Railroad Retirement	Annuities	Child Support	Trust Income
Veterans' Benefits	Workers Comp	Alimony	County General Relief
Retirement Funds	Dividend income	Unemployment	Refugee Resettlement Program

6. Other Expenses. Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.

Expense Payment Type	Recipient Name	How much	How often

7. Other Insurance. Charity Care can pay for such things as your co-payments and deductibles even if you have other health insurance.

a. Are you covered under any health insurance program, including Medicare? Y ___ N ___
b. If yes list policy holder name, insurance company and policy number:

_____

c. Are you seeking Charity Care because of a work-related accident or injury? Y ___ N ___
c. Are you seeking Charity Care because of a car accident? Y ____ N ____
d. Are you a student? Y ___ N ___ If yes, are you full time? _____ part time? _____
e. Do you have an application pending for any of these programs? *(Check all that apply)*
Medicaid _____ Medicare _____
f. Are you currently approved for Charity Care at another hospital or community health center?
Y ___ N ____ If yes, where?_____

8. Medical Bills. Total medical bills _____
Why can't you pay your medical expenses? Why do you need Charity Care?

_____
_____
_____

9. Ethnicity/Race. Ethnicity/Race will not be used to determine eligibility.

- ❑ Asian or Pacific Islander
- ❑ African-American, not Latino
- ❑ Latino
- ❑ American Indian or Alaskan Native
- ❑ Caucasian, not Latino
- ❑ Other_____
- ❑ I do not wish to answer.

This is for data collection and analysis purposes only.

10. Assignment of Rights. Read this section carefully and sign.
I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Charity Care. All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

_____ _ _____
Signature of applicant Date

_____ __ _____
Signature of authorized representative Date

If you have questions about this application, contact the Charity Care Representative at 661-864-4002
Mail the completed application to:

HealthSouth Bakersfield Rehabilitation Hospital
Controller
5001 Commerce Drive
Bakersfield, CA 93309

Appendix B: Letter to Patient Regarding Charity Care Availability

Dear Patient:

You may be eligible for medical care even if you cannot pay for it.

If you do not have health insurance coverage, you may be eligible for Medicare, Healthy Families, Medi-Cal or other coverage. The hospital can provide these applications to you by contacting the Charity Care Representative at 1-661-864-4002

HealthSouth Bakersfield Rehabilitation Hospital also has a Charity Care Program for patients who cannot afford to pay for medical care and are not eligible for coverage. Eligibility for the program is based on your family's income and the number of people in your family. It may also be based on whether your medical expenses would constitute a medical hardship.

In order to be considered for care you need but cannot pay for, please complete the attached application form. If you have any questions or need assistance in completing this application, please contact the Charity Care Representative at 1-661-864-4002. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please send your application to:

HealthSouth Bakersfield Rehabilitation Hospital
Controller
5001 Commerce Drive
Bakersfield, CA 93309

We will notify you within ten (10) business days as to whether your Charity Care application has been approved.

If you are denied Charity Care, you may: 1) appeal the denial; 2) re-apply for Charity Care at any time if your financial situation changes; or 3) work out a payment plan with our patients account office, considering your existing financial obligations.

Thank you.

HealthSouth Bakersfield Rehabilitation Hospital

Appendix C: Charity Care Eligibility Based on 2007 Federal Poverty Guidelines

2007 Poverty Guidelines for the 48 Contiguous States and District of Columbia				
Persons in family unit	Annual Income	200%	300%	350%
1	$10,210	$20,420	$30,630	$35,735
2	$13,690	$27,380	$41,070	$47,915
3	$17,170	$34,340	$51,510	$60,095
4	$20,650	$41,300	$61,950	$72,275
5	$24,130	$48,260	$72,390	$84,455
6	$27,610	$55,220	$82,830	$96,635
7	$31,090	$62,180	$93,270	$108,815
8	$34,570	$69,140	$103,710	$120,995
For Family units with more than 8 persons, add $3480 for each additional person				

SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

Appendix D: Notification Letter for Patients Eligible for Charity Care

Dear Patient,

You are eligible to receive Charity Care from this hospital for your recent services. The amount that you owe is _____.

Notify the hospital immediately if your situation changes and you can afford to pay for your medical care.

If you have further questions, call the Charity Care Representative at 1-661-864-4002.

Thank you.

Appendix E: Denial Letter / Appeal Form (Translated)

Dear Patient:
This hospital cannot provide you coverage with Charity Care at this time because:

_____
_____
_____
_____
_____
_____

You can:

Appeal this denial of Charity Care by completing the Appeal Application. Mail it to:

HealthSouth Bakersfield Rehabilitation Hospital
Controller
5001 Commerce Drive
Bakersfield, CA 93309

The hospital will notify you within ten (10) business days if your Appeal is approved.
If your financial circumstances change, you may be eligible for Charity Care. Please reapply if your income or expenses change.
You may be eligible for a reduced payment plan. Contact the Business Office 661-864-4018 to discuss this.

If you have further questions, call 1-661-864-4002 to speak with the Charity Care Representative.

Sincerely,
HealthSouth Bakersfield Rehabilitation Hospital

Appendix F: Charity Care Appeal Form

Complete this form if you have been denied Charity Care and want your case reconsidered.

If you have questions about this form contact 1-661-864-4002

Please mail the completed form to:

HealthSouth Bakersfield Rehabilitation Hospital
Controller
5001 Commerce Drive
Bakersfield, CA 93309

Your Name _____
Address _____
_____
_____
_____
Patient Number _____
Services Provided / Dates of Service_____
_____
_____

I am appealing the denial of Charity Care. I request that my Charity Care application be reconsidered for the following reasons. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Date this Appeal is submitted: _____
Signature_____

Appendix G: Notification Located Throughout Hospital Area

CHARITY CARE

We believe all people should get medical care whether or not they can pay.

If you cannot pay your medical expenses, you may qualify for the hospital's Charity Care Program.

For more information, contact us at:

661-864-4002