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Origination Date: 12/31/2007	Revised Date: 7/1/2017	Last Reviewed Date: 12/20/2023

SUBJECT: Patient Financial Assistance Program Policy

Purpose:

Pomona Valley Hospital Medical Center (PVHMC) serves all persons in the Pomona Valley and greater Inland Empire community. As a community hospital provider, Pomona Valley Hospital Medical Center strives to provide healthcare services within a high quality and customer service oriented environment. Providing patients with opportunities for financial assistance coverage for healthcare services is an essential element of fulfilling the Pomona Valley Hospital Medical Center mission. This policy defines the PVHMC Financial Assistance Program including its criteria, systems, and methods.

Nonprofit acute care hospitals must comply with the California Hospital Fair Pricing Act (codified in California’s Health & Safety Code Sections 127400 et seq.), and with Section 501(r) of the Internal Revenue Code requiring written policies providing discounts and charity care to financially qualified patients. This policy provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the Pomona Valley Hospital Medical Center Financial Assistance Program.

The Finance Department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at PVHMC. Patient Access and Business Office staff are responsible for assisting the patient with the financial assistance application as needed to include handling of patient accounting transactions in a manner that supports the mission and operational goals of Pomona Valley Hospital Medical Center. PVHMC’s Board of Directors is responsible for approving this policy.

Policy:

It is the policy of Pomona Valley Hospital Medical Center to offer financial assistance to patients who are unable to pay their hospital bills due to a financial inability to pay. Designated management will review individual cases to determine a patient’s eligibility for financial assistance and determine the discount for which the patient qualifies. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy. This policy will be applied to financial assistance applications approved on or after November 1, 2017.

Introduction



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Pomona Valley Hospital Medical Center strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. PVHMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and need help paying their hospital bill. These programs include state- and county-sponsored coverage programs and charity care as defined herein. This policy focuses on charity care for which eligibility for financial assistance and qualification for a discount is determined solely by the patient's and/or patient's family's ability to pay.

The Hospital makes every effort to inform its patients of the Hospital's Financial Assistance Program. Specifically:

- Every registered patient receives a written notice of the Hospital's Financial Assistance Policy written in plain language per IRC 501(r);
- Upon request, paper copies of the Financial Assistance Policy, the Financial Assistance application form and the plain language summary of the Financial Assistance Policy are made available free of charge. These documents are also available on the Hospital's website;
- Whenever possible, during the registration process, uninsured patients are screened for eligibility with government -sponsored programs and/or the Hospital's Financial Assistance Program;
- Public notices are posted throughout the Hospital notifying the public of financial assistance for those who qualify (See "Reporting & Billing: Public Notice" within this policy for more information);
- Guarantor billing statements contain information to assist patients in obtaining government -sponsored coverage and/or financial assistance provided by the Hospital (See "Reporting & Billing: Billing Statements" within this policy for more information);
- The hospital will provide patients with a referral to a local consumer assistance center housed in a legal services office;
- In an effort to widely publicize the Hospital's Financial Assistance Policy, the Hospital has collaborated with several community clinics to provide Financial Assistance literature for clinic patients.

This policy addresses the following:

- Definitions
- Financial Assistance Eligibility Criteria
- Financial Assistance Discount Qualification Criteria
- Application Submission and Review Process
- Reporting & Billing
- General Provisions

DEFINITIONS

Amounts Generally Billed (AGB): The amount generally billed by the hospital for emergency and other medically necessary services to patients who have health insurance. This amount does not represent the Hospital's usual and customary charge. It represents the amounts generally paid by a third-party payer as defined herein.



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Essential living expenses: Expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child and spousal support, transportation and automobile expenses (including insurance, fuel and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

Full Charity: A discount representing 100% of a patient’s liability. A full charity discount is equivalent to 100% of billed charges when the patient is uninsured and equivalent to the patient’s unmet deductible, coinsurance and/or copay when the patient is insured.

High Medical Costs: An insured patient with “High Medical Costs” means:

- A person whose family income does not exceed 350% of the federal poverty level if the individual does not receive a discounted rate from the hospital as a result of third-party coverage, and any of the following:
 - Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient’s family income in the prior 12 months,
 - Annual out-of-pocket expenses that exceed 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
 - A lower level determined by the hospital in accordance with the hospital’s charge care policy

Income: The sum of all the wages, salaries, profits, interests payments, rents and other forms of earnings received by all members of a patient’s family during a one year period of time. This includes gross receipts less cost of goods sold for self-employed family members.

Local Consumer Assistance Center: An agency designed to provide consumers with information about health care coverage and services. In California, The Health Consumer Alliance (HCA) was designated as the CCI/CalMediconnect Ombudsprogram effective April 1, 2014. More information regarding HCA can be found at <http://healthconsumer.org>. Consumers may call 888-804-3536 for routing to the correct consumer center.

Monetary Assets: Assets that are readily convertible to cash, such as bank accounts and publicly traded stock but not assets that are illiquid, such as real property and/or the following assets:



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- Retirement funds and accounts;
- Deferred compensation plans qualified under the Internal Revenue Code;
- Nonqualified deferred compensation plans;
- The first \$10,000 of qualified monetary assets;
- 50% of monetary assets after the first \$10,000.

Necessary Services: Inpatient, outpatient or emergency medical care that is deemed medically necessary by a physician. Necessary services would not include purely elective services for patient comfort and/or convenience, including but not limited to a cosmetic lens implanted during cataract surgery.

Patient's Family Size: is dependent on the age of the patient as defined below -

- 1) For patients 18 years of age and older, the patient's family includes the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not;
- 2) For patients under 18 years of age, the patient's family includes the patient's parent(s), caretaker relatives and other children less than 21 years of age

PROCEDURE FOR FINANCIAL ASSISTANCE

FINANCIAL ASSISTANCE ELIGIBILITY

Financial assistance eligibility is based upon the patient's ability to pay as determined by the Patient's Family income relative to the current Federal Poverty Level.

The primary eligibility categories are:

- Patient is uninsured AND Patient's Family Income is at or less than 400% of the Federal Poverty Level designated for the patient's family size
- Patient is insured AND Patient's Family Income is at or less than 400% of the Federal Poverty Level designated for the patient's family size AND patient meets the definition of a "High Cost Medical" patient

The following conditions must also be satisfied:

- If the patient is insured, the patient's liability is NOT a Medicaid share of cost or unmet deductible, coinsurance and/or copay related to subsidized coverage provided through a Covered CA qualified health plan or similar plan;



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- Patient does not qualify for other income-based/means test government-sponsored coverage; o A pending application for another health coverage program shall not preclude eligibility for financial assistance under this policy, however, final approval of financial assistance may be deferred until the pending application is processed and eligibility is determined
- Patient completes and submits a Financial Assistance Application;
- Patient submits all required and requested documents and responds to any questions that arise from the Financial Assistance Application.

A patient who is deemed eligible for financial assistance will not be charged for emergency or other medically necessary care more than amounts generally billed (AGB) to individuals who have insurance covering such care.

Physicians providing emergency services in the hospital are required to provide discounts to uninsured and high medical cost patients whose incomes are at or below 350 percent of the Federal Poverty Level. The discounts by physicians providing emergency services in the hospital are not included in the Hospital’s Financial Assistance Policy. These discounts are administered independently by the physician, physician’s medical group and/or the physician billing agent. Eligible patients are offered a reasonable, extended payment plan. If an agreement is not reached, a reasonable payment formula similar to the hospital’s payment formula defined in the “Payment Plans” section within this policy must be used in determining the monthly payment. See Addendum A for a complete list of emergency providers.

FINANCIAL ASSISTANCE DISCOUNT QUALIFICATION CRITERIA

Once eligibility is established, the discounted amount and/or discounted balance is determined as defined in the following section of this policy depending upon:

- The Patient’s eligibility category;
- The Patient's Family income;
- The Patient's Family Monetary Assets;

Full Charity Discount Criteria

The following chart summarizes the criteria that must be satisfied for a patient to qualify for full charity care:

ELIGIBILITY CATEGORY	INCOME	ASSETS
Uninsured	<400% FPL	<\$10,000
Insured with High Medical Costs	<400% FPL	<\$10,000



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All patients who are eligible for financial assistance within this policy will receive full charity when the patient's family income is at or less than 400% of the Federal Poverty Level and their monetary assets are less than \$10,000. To qualify for this level of discount, the patient will apply for and submit the documentation required for full charity within this policy.

Dates of Service included in Application

When the hospital determines that a patient qualifies for Financial Assistance, that determination will apply to the specific services and service dates for which the patient or the patient's family representative submitted the application. In cases of continuing care relating to a patient diagnosis that requires ongoing, related services, the hospital will treat continuing care as a single case for which qualification applies to all related ongoing services provided by the hospital. Management may, based on its review, determine that other pre-existing patient account balances outstanding at the time of qualification may be eligible for write-off. Generally, a patient will re-apply for financial assistance eligibility at least every 180 days, but management has the discretion to not require further application(s) for subsequent services following an initial application approval.

Other Eligible Circumstances qualifying for Charity: Medi-Cal Payment Denials

PVHMC deems those patients that are eligible for government-sponsored low-income assistance programs (e.g. Medi-Cal/Medicaid, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP and CCS)), where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage limited to the amount the payer denied instead of paid. Consistent with Medicare cost reporting guidance for the calculation of the Hospital's low income percentage for Medi-Cal DSH, non-covered services and all other denied services provided to eligible Medicaid beneficiaries will be reported as "Uncompensated Care" for cost reporting purposes without requiring a FAP application from each patient. Specifically included as Uncompensated Care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as Charity Care.

The patient is NOT eligible for financial assistance on Medi-Cal share of cost or a patient's subsidized or discounted out-of-pocket expenses determined by Covered California or any other state or federal government insurance exchange. A patient's unsubsidized out of pocket expense may qualify for a discount as defined within this policy.

Other Eligible Circumstances qualifying for Charity: Medicare Deductibles and Coinsurance Denials Patients whose primary coverage is Medicare and secondary coverage is Medi-Cal are eligible for financial assistance and may qualify for full charity. The amount qualifying for full charity is limited to the Medicare coinsurance and



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deductible amounts unreimbursed by any other payer including Medi-Cal/Medicaid, and which is not reimbursed by Medicare as a bad debt, if:

- 1) The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of lowincome patients; or
- 2) The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the writeoff provided for under this policy.

Other Eligible Circumstances qualifying for Charity: Reassignment from Bad Debt to Charity

Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care.

Documentation of the patient or family representative’s inability to pay for services will be maintained in the Charity Care documentation file.

Criteria for Re-Assignment from Bad Debt to Charity Care:

All outside collection agencies contracted with PVHMC to perform account follow-up and/or bad debt collection will utilize the following criteria to identify a status change from bad debt to charity care:

- 1) Patient accounts must have no applicable insurance (including governmental coverage programs or other third party payers);
- 2) The patient or family representative has not made a payment within 150 days of assignment to the collection agency;
- 3) The patient’s credit & behavior score is within the lowest 25th percentile as of November 2007, PVHMC’s secondary agency has determined the credit and behavior score representing the lowest 25th percentile is 547 or lower as reported by Transunion;);
- 4) The collection agency has determined that the patient/family representative is unable to pay; and/or 5) The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score

All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.

Prompt Pay Discount

A patient is not eligible for financial assistance when the patient’s family income is greater than 400% of the established Federal Poverty Level. Instead, uninsured patients qualify for a prompt pay discount, which shall apply to all necessary inpatient, outpatient and emergency services provided by PVHMC. The discounted balance is dependent on the type of service provided:



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- 1) For outpatient services, the discounted balance represents the average commercial HMO/PPO collection rate on outpatient services, not to exceed established cash prices
- 2) For inpatient services, the discounted balance represents the MediCal APR DRG amount for obstetrics and pediatric services and the Medicare DRG amount for all other acute inpatient services, not to exceed established cash prices.

The standard term for a prompt payment discount is 30 days. However, the term may be negotiated per the Payment Plans guidelines below.

Payment Plans

When a discount has been made by the hospital, the patient shall have the option to pay any or all outstanding amounts due in one lump sum payment, or through a scheduled term payment plan.

The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be negotiated between the hospital and patient based upon the patient’s ability to effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If the patient and the hospital are unable to agree on negotiated payment terms, the hospital shall offer the patient the default payment plan. Under the default payment plan, the patient’s monthly payment shall not exceed 10% of a patient’s family income for one month, excluding deductions for “essential living expenses” as defined herein above.

Limitation on Charges: Amounts Generally Billed (“ABG”)

Patients below 400% of the current Federal Poverty Level, who meet all eligibility and qualification criteria, will not pay more than Medicare (or the applicable MediCal APR DRG as defined below) would typically pay for a similar episode of service as defined by the “Prospective” method per Section 501(r) of the Internal Revenue Code (“IRC”). The applicable MediCal APR DRG reimbursement applies to obstetrics, newborns, neonatal intensive care and pediatrics. The Medicare DRG and respective outpatient rates applies to all other services. A deposit collected from a patient for scheduled services will be limited to Amounts Generally Billed as defined herein. At the time a patient is determined to qualify and be eligible for financial assistance, the amount billed to the patient will be limited to the Amount Generally Billed. Prior to submitting an application for financial assistance, the amounts billed will represent full billed charges consistent with the Hospital’s usual and customary charges.

Collection Efforts

The Hospital’s Business Office is responsible for billing a patient’s guarantor unpaid copays, coinsurance, deductibles, balances covered under a payment arrangement and charges not covered by insurance.

Guarantor statements are mailed to the guarantor’s address on file.

Guarantor balances are due and payable within 30 days from the date of the first patient billing.



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The business office will send the guarantor a minimum of three cycle statements. A collection letter will be sent to the guarantor if the balance remains unpaid after three cycle statements.

Guarantor balances are considered past due after 30 days from the date of the first billing and may be advanced to a collection agency after 120 days from the date of first billing and after a minimum of three cycle statements have been sent to the guarantor. A guarantor balance may be advanced to a collection agency prior to these standard timelines if it is determined the patient or guarantor provided fraudulent or inaccurate demographic or billing information.

Guarantor balances will not be forwarded to a collection agency when the guarantor makes reasonable efforts to communication with the business office and makes good faith efforts to resolve the outstanding balance including but not limited to applying for government insurance coverage, applying for a discount under the Hospital's Financial Assistance Policy, submitting regular partial payments of a reasonable amount or negotiating a payment plan with the business office.

If the Hospital uses a collection agency, it will obtain a written agreement that the agency will abide by the hospital's standards and scope of practice.

Prior to commencing collection activities, the hospital will provide the patient with a clear and conspicuous written notice containing information regarding the patient's rights under applicable laws, certain patient rights and related information.

The Hospital will not engage in extraordinary collection activities ("ECAs"), either directly or indirectly through any purchaser of debt, collection agency or other party to which the hospital facility has referred the individual debt relating to seeking payment for care covered by the Hospital's Financial Assistance Policy including but not limited to:

- 1) Placing a lien on an individual's property
- 2) Foreclosing on real property
- 3) Attaching or seizing an individual's bank account or other personal property
- 4) Commencing a civil action against an individual
- 5) Causing an individual's arrest or writ of body attachment for civil contempt
- 6) Garnishing an individual's wages

For a patient that lacks coverage or has high medical costs, the hospital or its agent shall not report adverse information to a credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after initial billing. Prior to authorizing any extraordinary collections activities, the Hospital will ensure a Financial Assistance Application is mailed to the guarantor's current address on file allowing the guarantor no less than 30 days to respond or inform the business office of the interest to pursue financial assistance. The Director of Patient Financial Services will ensure all reasonable efforts are taken to determine if a patient is eligible



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for financial assistance under this policy before engaging in Extraordinary Collection Activities. All collection efforts will be suspended while a guarantor is actively participating in the Financial Assistance Application process.

APPLICATION SUBMISSION & REVIEW PROCESS

Single, Unified Application

The financial assistance application provides patient information necessary for determining patient qualification and such information will be used to qualify the patient or family representative for maximum coverage under the PVHMC Financial Assistance Program. The financial assistance application should be completed as soon as there is an indication that the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Financial counselors, eligibility services liaisons and/or patient account representatives are available to provide guidance over the phone or meet in person.



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The application will cover all outstanding guarantor balances at the time the application is completed. Patients may be required to re-apply for financial assistance at least every 180 days.

Required Documentation

Eligible patients may qualify for the PVHMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with documentation and health benefits coverage information such that the hospital may make a determination of the patient’s qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the PVHMC Financial Assistance Program. To determine eligibility and to maximize the qualifying assistance/discount amount, the following documentation is required when applicable:

- 1) Completed & signed financial assistance application;
- 2) Current pay stubs from the last two pay periods or if self-employed, current year-to-date profit & loss statement to determine current income;
- 3) Award letters for social security, SSI, Disability, Unemployment, General Relief, Alimony, etc.;
- 4) Last calendar year’s filed tax return with all required schedules to determine income generating assets including monetary assets;
- 5) Last two months’ bank, brokerage & investment statements;
- 6) Copies of prior year’s 1099 for interest income, dividends, capital gains, etc.

Completion of a financial assistance application provides:

- Information necessary for the hospital to determine if the patient has income sufficient to pay for services;
- Documentation useful in determining qualification for financial assistance; and
- An audit trail documenting the hospital’s commitment to providing financial assistance

The Hospital may require waivers or releases from the patient or the patient’s family authorizing the hospital to obtain account information from financial or commercial institutions or other entities including but not limited to credit reporting entities that hold or maintain the monetary assets, in an attempt to verify information the patient has provided on the charity care application. Information obtained pursuant to this paragraph regarding assets of the patient or the patient’s family shall not be used for collection activities.

Reasons for Denial of Assistance

The PVHMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full assistance. Financial assistance may be denied for failure to submit applicable required documentation.

The hospital may deny financial assistance for reasons including, but not limited to, the following:

- 1) Patient is not eligible for full charity care based on amount of income plus monetary assets;



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- 2) Patient is uncooperative or unresponsive, preventing the Hospital from determining financial assistance eligibility and qualification;
- 3) Service provided to a full charity care patient is not considered medically necessary;
- 4) 4) Application is incomplete;
- 5) Patient's balance results from withholding from the Hospital an insurance payment;
- 6) Patient's balance after insurance pays does not meet the definition of high medical cost;
- 7) Assistance was requested on a service provided more than 180 days after the most recent request for assistance was approved.; and
- 8) Patient's liability is a Medicaid share of cost or out-of-pocket expense related to means tested and/or incomebased coverage such as a subsidized Covered CA qualified health plan.

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to service, during a patient stay, or after services are completed and the patient has been discharged.

Approval Process

The patient or patient's representative shall submit the financial assistance application and required supplemental documents to the Patient Financial Services department at PVHMC. The Patient Financial Services department's contact information shall be clearly identified in the application instructions.

PVHMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response. Upon receipt of a completed financial assistance application, assigned staff in the business office will prepare a "Request for Consideration of Uncompensated Care (Charity)" attaching all supporting documentation as defined within this policy and submit to an applicable manager based upon the amount of the discount requested as defined below. For the circumstances defined below which do NOT require submission of a financial assistance application, the staff will prepare a "Request for Consideration of Uncompensated Care (Charity)" clearly noting the reason an application was NOT prepared and attaching a credit report if a valid social security number is available.

A financial assistance determination will be made only by approved hospital management personnel according to the eligibility criteria specific to the patient and the amount of financial assistance requested. Financial assistance shall not be provided on a discriminatory or arbitrary basis. The hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.



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The Hospital’s designee authorized to approve financial assistance applications is based on the amount of the financial assistance requested; larger discounts require a higher level of approval as indicated below:

- Discounts less than \$25,000: Director of Patient Financial Services or the Director of Patient Access
- Discounts greater than \$25,000: Chief Financial Officer

Application Exceptions

A completed financial assistance application may not be required in certain circumstances. These circumstances are limited to situations when PVHMC determines it has sufficient patient financial information from which to make a financial assistance eligibility and qualification decision. Examples of circumstances not requiring a financial assistance application include, but are not necessarily limited to:

- 1) Patient is homeless;
- 2) Patient is a resident at a shelter including but not limited to Prototypes and The American Recovery Center;
- 3) Patient’s address is the address for the Department of Public Social Services (DPSS) 2040 Holt Ave Pomona;
- 4) Patient is unknown;
- 5) Patient is receiving General Relief, Cal WORKS or Cal Fresh (documentation required);
- 6) Patient qualified for Medi-Cal without a share of cost (SOC) during a portion of the confinement or subsequent to their discharge/visit (proof of eligibility required); or
- 7) Non-covered and/or denied services provided to Medi-Cal eligible patients; 8) A patient’s balance after VOVC pays;
- 8) Patient’s qualifying for Susan G. Komen funding; the grant from Susan G. Komen will be recorded as Non-operating revenue (904050)

Appeal Process

In the event that a patient disagrees with the hospital's determination regarding qualification, the patient may file a written appeal for reconsideration with the hospital as follows:

The written appeal should contain a complete explanation of the patient’s dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient’s claim should be attached to the written appeal.

Any or all appeals will be reviewed by the hospital Director of Patient Financial Services.. The director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient’s claims, the director shall provide the patient with a written explanation of findings and determination.



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In the event that the patient believes a dispute remains after consideration of the appeal by the Director of Patient Accounting, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient’s written appeal and documentation, as well as the findings of the Director of Patient Financial Services. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

REPORTING AND BILLING:

Billing Statements

Consistent with Health and Safety Code Section 127420, the Hospital will include the following clear and conspicuous information on a patient’s bill:

- (1) A statement of charges for services rendered by the hospital.
- (2) A request that the patient inform the hospital if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage.
- (3) A statement that if the consumer does not have health insurance coverage, the consumer may be eligible for coverage offered through the California Health Benefit Exchange (Covered CA), Medicare, Medi-Cal, California Children’s Services Program, or charity care.
- (4) A statement indicating how patients may obtain an application for the Medi-Cal program, coverage offered through the California Health Benefit Exchange, or other state- or county-funded health coverage programs and that the hospital will provide these applications. If the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care, then the hospital shall provide an application for the Medi-Cal program, or other state- or county-funded programs to the patient. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care. The hospital shall also provide patients with a referral to a local consumer assistance center housed at legal services offices.
- (5) Information regarding the financially qualified patient and charity care application, including the following:
 - (A) A statement that indicates that if the patient lacks, or has inadequate, insurance, and meets certain low- and moderate-income requirements, the patient may qualify for discounted payment or charity care.
 - (B) The name and telephone number of a hospital employee or office from whom or which the patient may obtain information about the hospital's discount payment and charity care policies, and how to apply for that assistance.
 - (C) 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 hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.



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Public Notice

PVHMC shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in high volume inpatient, areas and in outpatient service areas of the hospital, including but not limited to the emergency department, inpatient admission and outpatient registration areas, or other common patient waiting areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

These notices shall be posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital’s service area. The notice states the following:

Pomona Valley Hospital Medical Center provides financial assistance to our patients who qualify. Contact our Eligibility Services Department at (909) 630-7720 to speak with a representative to obtain more information.

Access to the Financial Assistance Policy

A copy of this Financial Assistance Policy and a plain language summary is available on the Hospital’s website. A hard copy of the policy will be made available to the public upon request at the Hospital’s main campus or by mail.

OSHPD Reporting

PVHMC will report actual Charity Care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with the applicable requirement, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

In compliance with OSHPD adopted regulations approved by the Office of Administrative Law on August 8, 2007 (Title 22, Sections 96040-96050), the Director of Patient Financial Services will submit an electronic copy of its discount payment and charity care policies, eligibility procedures and review process (as defined and documented in one, comprehensive Financial Assistance Program Policy) and its Financial Assistance application form to OSHPD at least every other year by January 1 beginning January 1, 2008, or whenever a significant change to the policy is made.



Policy Name: Patient Financial Assistance Program Policy		Policy #:
Division:	Manual: Hospital Wide Policy	Page 16 of 16
Origination Date: 12/31/2007	Revised Date: 7/1/2017	Reviewed Date: 12/20/2023

GENERAL PROVISIONS:

Equal Opportunity

The Hospital 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 classification protected by federal, state or local laws.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values. The Charity Care documentation will not be reviewed or accessed by staff involved in collection activities.

Good Faith

PVHMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.

Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, PVHMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify for the PVHMC Financial Assistance Program.

Pomona Valley Hospital Medical Center
Financial Assistance Policy - Addendum A List
of Emergency Room Providers
Updated: December 27, 2017

Physician/Physician Group	Made Payable to (Billing Agent)	Specialty
California Emergency Physicians (CEP)	California Emergency Physicians (Med America Billing Services)	Emergency Medicine
Pomona Valley Imaging Medical Group (PVIMG)	PVIMG	Radiology
Inland Valley Anesthesia	Inland Valley Anesthesia	Anesthesiology
PV Clinical Lab Medical Group	PV Clinical Lab Medical Group (APS Billing)	Pathology
Michael Consolo, DO	Michael Consolo, MD	Urology
Adam Hickerson, MD	Adam Hickerson, MD	Urology
Aaron Nguyen, MD	Aaron Nguyen, MD	Urology
Elmer Pineda, MD	Elmer Pineda, MD	Urology
Christopher Tsai, MD	Christopher Tsai, MD	Urology
Vinod Garg, MD	Vinod Garg, MD	Vascular Surgery
Christopher Marrocco, MD	Vascular & Thoracic Associates of Los Angeles	Vascular Surgery
Shahin Pourrabbani, MD	Vascular & Thoracic Associates of Los Angeles	Vascular Surgery
Morteza Sajadian, MD	Pars Medical Inc.	Vascular Surgery
Mark Barak, MD	Mark Barak, MD	Ophthalmology
Jeffrey Huang, DO	Jeffrey Huang, MD	Ophthalmology
Ayaz Khan, DO	Ayaz Khan, MD	Ophthalmology
Anshul Varshney, MD	Anshul Varshney	Ophthalmology
Lance Siegel, MD	Lance Siegel, MD	Pediatric Ophthalmology

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Sam Arasoghli, MD	Sam Arasoghli, MD	Otolaryngology
Stuart McCarthy, MD	Stuart McCarthy, MD	Otolaryngology
Natee Poopat, MD	Natee Poopat, MD	Otolaryngology

Tyson Shih, MD	Tyson Shih, MD	Otolaryngology
Walter Stevens, MD	Walter Stevens, MD	Otolaryngology
Lew Disney, MD	Inland Neurosurgery Institute	Neurosurgery
Scott Lederhaus, MD	Inland Neurosurgery Institute	Neurosurgery
Siraj Gibani, MD	Inland Neurosurgery Institute	Neurosurgery
Jose Rodriguez, MD	Inland Neurosurgery Institute	Neurosurgery
Aaron Cutler, MD	Inland Neurosurgery Institute	Neurosurgery
Ramin Amirnovin, MD	Inland Neurosurgery Institute	Neurosurgery
On-Call Physician	Made Payable to	Specialty
Sharyn Brekhus, MD	Sharyn Brekhus, MD	Neurosurgery
Yvette Marquez, MD	Chaparral Medical Group	Neurosurgery
Srinath Samudrala, MD	Srinath Samudrala, MD	Neurosurgery
Kenneth Lee, MD	Kenneth Lee MD & Assoc., Inc	Gastroenterology
Krishan Malhotra, MD	Krishan Malhotra, MD	Gastroenterology
Nischita Merla, MD	Merla Nischita	Gastroenterology
Dwaraknath Reddy, MD	Dwaraknath Reddy, MD	Gastroenterology
Jason Shin, MD	Jason Shin, MD	Gastroenterology
Bhupat Desai, MD	Bhupat Desai, MD	Neurology Stroke
Sadiq Altamimi, MD	The Neurology Medical Group, Inc.	Neurology Stroke

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Mukhtair Kundi, MD	Mukhtair Kundi, MD	Neurology Stroke
Adeel Popalzai, DO	Adeel Popalzai, MD	Neurology Stroke
Faisal Qazi, DO	Faisal Qazi, MD	Neurology Stroke
Kelvin Ma, MD	The Neurology Group, Inc.	Neurology Stroke
Sundeeep Adusumalli, MD	Chaparral Medical Group	Cardiology
Muthusamy Muthiah, MD	Muthusamy Muthiah, MD	Cardiology
Gaurav Parikh, MD	Chaparral Medical Group	Cardiology
Jayapal Reddy, MD	Jayapal Reddy, MD	Cardiology
Rama Thumati, MD	Rama Thumati, MD	Cardiology
Nitanth Vangala, MD	Chaparral Medical Group	Cardiology
Sarika Jain, MD	Chaparral Medical Group	Cardiac Surgery
Guangqiang Gao, MD	Chaparral Medical Group	Cardiac Surgery