



GATEWAYS HOSPITAL
AND MENTAL HEALTH CENTER

GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER

AB 774

**CHARITY CARE AND DISCOUNT PAYMENT
AND POLICIES**

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GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER

SECTION I

Background

Gateways Hospital and Mental Health Center is a private non-profit public beneficiary corporation. The Acute Psychiatric Hospital and Mental Health Center receives 100% of its funding from the Los Angeles County, Department of Mental Health (“DMH”) through a short Doyle/Short Doyle Medi-Cal contract. These funds ensure the delivery of mental health services to indigent Medi-Cal eligible persons residing in Service Area four.

Gateways Hospital and Mental Health Center operates a fifty-five bed acute psychiatric hospital, with two distinctly separate units, with twenty-seven beds for adolescents from thirteen (13) to seventeen (17) years of age, and twenty-eight beds for adults (eighteen to sixty-four years). In addition to in-patient care, Gateways also provides partial hospital and out-patient services to children, adolescents, and adults.

CHAIRTY CARE AND DISCOUNT PAYMENT POLICY

I. POLICY.

As a Short Doyle/Short Doyle Medi-Cal provider, Gateways Hospital and Mental Health Center (“Gateways”) has adopted and implemented the screening protocol outlined by the DMH and the California State Department of Mental Health for indigent and Medi-Cal eligible recipients respectively. The purpose is to ensure that payment assistance is provided to persons who have health care needs, but are uninsured, underinsured, ineligible for Social Security Insurance, and/or other governmental benefits, and otherwise unable to pay for medically necessary treatment based on each individual’s financial disposition. Consistent with our mission to deliver effective and efficient levels of care to all persons referred, Gateways strives to ensure that the financial capacity of people who need mental health services does not disqualify them from pursuing or receiving treatment within the delivery system. Payment assistance is not considered to be a substitute for personal

responsibility, and patients are expected to cooperate with Gateways' procedures for obtaining payment assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capability to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health and protection of their individual assets.

To manage the available resources in a responsible manner, the Board of Directors of Gateways has approved the following protocol to enable the provision of services to the greatest number of persons in need.

II. **PROCEDURES.**

A. **Eligible Services.** For the purposes of the Charity Care and discount payment policy, "payment assistance" refers to mental health care provided to clients without charge or at a discount rate to qualifying patients. Thus, the following mental health services are eligible for payment assistance:

- Crisis and psychiatric emergency services for patients who are assessed to be in acute crisis involving threatened suicide or injury to others, or actual self-injury who are experiencing major disruption in their life circumstances such as traumatic bereavement, violence, and other mentally dysfunctional behavior .
- Services for a condition such as "grave disability" where assessment determines that the patient cannot care for self as a result of a psychiatric disorder.

- Any other medically necessary services, evaluated on a case by case basis.

B. Eligibility for Patient Payment Assistance. Eligibility for payment assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

C. Assessment of Financial Need.

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need in which; (a) the patient or the patient's guarantor are required to cooperate and supply personal, financial, and other information, and documentation relevant to making a determination of financial need; (b) include reasonable efforts by Gateways to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist patients to apply for such programs; (c) take into account the patient's available assets, and all other financial resources available to the patient; and (d) include a review of the patient's outstanding accounts receivables for prior services rendered, and the patient's payment history. This determination is made based on payor financial information obtained from patients at initial interview (see Payor Financial Information Form Attachment One).
2. It's preferred, but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance shall be re-evaluated at each subsequent

rendering of services, if the last financial evaluation was completed more than a year prior, and at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

3. Requests for payment assistance will be assessed by Gateways' billing and collections department expeditiously, and the patient will be notified of the outcome within two weeks.

D. Patient Payment Assistance Guidelines: Services eligible under this policy are available to patients on a sliding scale utilizing a Uniform Patient Fee Schedule for community mental health services (see Attachment Two). This method is utilized by Short Doyle/Short Doyle Medi-Cal providers as part of the contractual requirements with the Los Angeles County Department of Mental Health. The determination to pay based on this fees scale is as follows:

1. Patient with an annual income of less than \$8,549 receives services free of charge through Short Doyle funds allocated for indigent care. This corresponds to persons with an annual income below 67% of the Federal Poverty Level ("FPL").
2. Patients whose income is above the 68%, but less than 350% of the FPL are required to pay an annual fee based on the number of dependents and the average rate of payment Gateways would receive for providing services to Short Doyle Medi-Cal, Medi-Care, Healthy Families or any health program of health benefits in which Gateways participates.
3. Patients with income greater than 350% of the FPL, but not more than 500% of FPL, are eligible to receive services at 135% of the average rates of payment Gateways would receive from Los Angeles County (Short Doyle,

Medi-Cal, Medi-Care, Healthy Families or any other governmental sponsored health program in which Gateways participates.

4. Patients with an annual income in excess of 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, but such services will be delivered at the discretion of Gateways.

E. Notification of Payment Assistance Programs to Patients and to the Public.

Information about patient payment assistance available through Gateways is disseminated by various means, including, without limitation, by posting notices in waiting rooms, admitting and registration department, located at Gateways' hospital location and at other public places as Gateways may elect. Information shall also be included on facility websites. Such information shall be provided in the primary languages spoken by the populations served by Gateways. Referral of patients for payment assistance may be made by any member of Gateways' staff or medical staff, including physicians, nurses, social workers, and case managers. A request for payment assistance may be made by the patients, or a family member, a close friend or associate of the patient, subject to applicable privacy laws.

F. Budgeting and Reporting.

Specific dollar amounts obtained from contributions and fundraising events will be included in Gateways' Fundraising Budget. When necessary, these funds will be used to augment indigent care dollars provided to Gateways by the Los Angeles County, Department of Mental Health. Gateways may voluntarily report patient assistance costs as deemed appropriate. Patient payment assistance statistics shall be disclosed in annual financial statements, but shall not include amounts that are considered to be bad debts or contractual discounts.

G. Collection Policies.

Gateways' Business Office management staff has developed policies and procedures for internal and external collection practices. Such policies take into consideration the extent to which patients qualify for payment assistance, patients good faith efforts to applying for County or State assistance, and the patients good faith efforts to honor the payment agreement with Gateways. For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Gateways will offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences, and will not send unpaid bill to outside collection agencies.

H. Regulatory Requirements.

In implementing this policy, Gateways management shall comply with all other Federal, State and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER

**ELIGIBILITY & APPLICATION POLICY AND
PROCEDURE FOR PAYMENT ASSISTANCE FOR
PSYCHIATRIC IN-PATIENT & OUT-PATIENT SERVICES**

SECTION II

I. POLICY:

To enable Gateways Hospital and Mental Health Center (“Gateways”) to provide the maximum level of assistance to the greatest number of persons in need, and to meet the requirements set forth in California Assembly Bill 774, the hospital administration of Gateways has established the following eligibility and application guidelines for the provision of patient financial assistance as outlined in Gateways’ Payment Assistance Policy.

II. PURPOSE:

The purpose of this policy is to establish financial criteria and the process to be used by Gateways to determine patient eligibility for financial assistance through Gateways’ Patient Payment Assistance Program.

III. DEFINITIONS:

Eligible Psychiatric Services. Psychiatric services eligible for Payment Assistance Discount include the following:

1. Crisis Intervention services provided in the psychiatric out-patient departments at Gateways;
2. Psychiatric emergency services (i.e., patients considered to be dangerous to self and/or others and/or gravely disabled) requiring in-patient treatment;
3. Any other medically necessary services not addressed in one (1) and two (2) above.

Federal Poverty Level (“FPL”): The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Financially Qualified Patient: A patient who is self-pay, or has high medical costs as defined in California State Assembly Bill 774 (see Article 3, 127400(g)).

Income The Payment Assistance application requires the requestor to submit information pertaining to gross income (i.e., annualized before tax amounts).

1. Sources of gross income include, but are not limited to: wages, salaries, payments from Social Security, public assistance, unemployment and worker's compensation, veterans benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets, and one-time insurance or compensation payments.
2. The ability to borrow against assets (e.g., a life insurance policy), should also be considered as another source of income. The ability to borrow against a primary home shall not be considered.
3. Food or rent in lieu of wages will also be considered as a source of gross income if appropriate documentation is provided.
4. A portion of the Qualified Monetary Assets (as defined below) are to be included in determining gross income with the exception of those patients applying for Payment Assistance who meet criteria of a Person with High Medical Costs as defined below. The amount to be included is based on the following:
 - a. The first ten thousand dollars (\$10,000.00) of a patient's monetary assets shall not be counted in determining eligibility; and
 - b. Only 50% of a patient's monetary assets over the first ten thousand dollars (\$10,000.00) will be counted in determining income and eligibility.

Payment Assistance Rank Ordering ("PARO") Score: PARO is a patient account scoring mechanism which uses patient demographic data to estimate the financial status of patients by accessing numerous publicly available databases. PARO provides an estimate of the patient's household include and size thus allowing Gateways to estimate the patient's FPL. As this amount is only an estimate, it is not used as the sole data source in determination of an appropriate level of consideration for payment assistance and would require other information or circumstances to support determination. Additionally, PARO may be used to validate financial and demographic information provided by the patient during the Payment Assistance eligibility process.

Patient With High Medical Costs: An under-insured person whose household income does not exceed 350% of the FPL, who does not receive a discounted rate

from the hospital as a result of his or her third-party coverage **and** meets one of the three (3) criteria listed below:

1. Annual out-of-pocket costs incurred by the individual at the hospital exceed 10% of the patient's household income, in the prior 12 months;
2. Annual out-of-pocket medical expenses exceed 10% of patient's household income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's household in the prior 12 months; and
3. Meets a lower level determined by the hospital in accordance with the hospital's payment assistance policy.

People in Household/Patient's Household: The Payment Assistance application form (see Attachment three) requests specific information about people in the guarantor's household, including name, date of birth, income, employer and employer phone number. Consistent with Medicaid and California State guidelines, the applicant may only include people who meet the following criteria as part of their household:

For persons 18 years of age and older:

1. Spouse or registered domestic partner;
2. Dependent children under 21 years of age, whether living at home or not;
3. The separate children of either unmarried parent or of the parent or stepparent; and
4. If there are no children, household member means a single person or a married couple.

For persons under 18 years of age:

1. The parents married or unmarried of sibling children;
2. The stepparents of the sibling children; and
3. A caretaker relative or child under 21 years of age of the parent or caretaker relative.

Qualified Monetary Assets: The Payment Assistance application form requests specific information regarding Qualified Monetary Assets. For purposes of the application, qualified monetary assets would include the following:

1. **Savings** – For purposes of the application, qualified savings would include any cash equivalents held by a member of the household **excluding** any amounts held in tax exempt accounts, retirement, deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans such as a 401K savings account, 403B savings account or IRA savings account.
2. **Other Monetary Assets(s)** – This amount would be the estimated fair market value of any other “real” assets that are readily convertible to cash held by a member of the household.

DISCOUNT CALCULATION PROCESS

1. The Uniform Patient Fee Schedule will be used to determine a patient's payment assistance allowance. All discounts referenced below and patient responsibilities are based upon total charges and are calculated independently of the Uninsured Patient Discount.
 - a. Patients whose household income is at or below 200% of the FPL are eligible to receive free care (100% discount)
 - b. Patients whose household income is above 200% but no more than 350% of the FPL are eligible to receive services at the highest average rate that Gateways would receive for providing services from any other government-sponsored health program of health benefits in which the hospital participates, whichever is greater.
 - c. Patients whose household income is above 350%, but no more than 500% of the FPL, are eligible to receive services at 135% of the highest average rate Gateways would receive for providing services to any other government-sponsored health program of health benefits in which Gateways participates.
 - d. Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Gateways.

The 2020 poverty guidelines are in effect as of January 15, 2020
The Federal Register notice for the 2020 Poverty Guidelines published January 17, 2020

FAMILY SIZE	100%	200%	350%	500%
1	\$12,760	\$25,520	\$ 44,660	\$ 63,800
2	\$17,240	\$34,480	\$ 60,340	\$ 86,200
3	\$21,720	\$43,440	\$ 76,020	\$108,600
4	\$26,200	\$52,400	\$ 91,700	\$131,000
5	\$30,680	\$61,360	\$107,380	\$153,400
6	\$35,160	\$70,320	\$123,060	\$175,800
7	\$39,640	\$79,280	\$138,740	\$198,200
8	\$44,120	\$88,240	\$154,420	\$220,600

Note: For households with more than eight (8) members ad \$4,480 per member.

2. Additional discounts may be available for patients meeting hardship Criteria and patients with high medical costs:

- a. **Hardship Criteria:** In addition to the payment assistance discounts based upon the sliding scale described above, those patients whose liability after the initial discount is in excess of 15% of their annual income, including excess of qualified monetary assets, shall be given an additional discount for all amounts over the 15% threshold.
 - b. **Patient With High Medical Costs:** If a patient meets all of the criteria as defined in Section III above for a *patient with high medical costs*, the maximum allowable payment for the service, including the amount paid insurance, is limited to the estimated amount that the highest government payor would have paid for the services.
 - (i) If insurance has paid more than the estimated payment rate of the highest government payor, than the entire amount of the patient responsibility would be classified as a charity adjustment and no additional collections would occur.
 - (ii) If the insurance has paid less than the amount from the highest government payor, the amount of the patient responsibility that is over the estimated highest government rate would be classified as a charity care adjustment and the facility would be allowed to collect on the remaining balance.
3. Patients will be allowed to settle their accounts through a schedule of regular payments up to 30 months if they have applied for and are granted payment assistance. Such payment plan schedules shall be interest free. Extended interest free payment plans may be offered to patients not qualified for payment assistance on a case-by-case basis at the discretion of Gateways.
 4. Gateways maintains the discretion to increase the amount of the payment assistance discount above and beyond the calculated amounts outlined in Section 1 through 3 above. For these cases, Gateways will document the circumstances and/or rationale used to justify additional discounts.
 5. Documentation to support payment assistance adjustments and applicable calculations will be maintained by Gateways.

IV. GUIDELINES / PROCEDURES

A. FINANCIAL SCREENING

Financial screening is the process of evaluating a client or a responsible party's ability to pay for services. This includes their ability to personally contribute; their ability to access third party benefits; and their ability to qualify for benefit from social welfare programs.

The UMDAP (Uniform Method of Determining Ability to Pay) liability is based on a sliding scale fee and applies to services extended to the client and dependent family members. It is valid for a period of one year. UMDAP liability amounts can be adjusted should the client's financial condition improve during the liability period. Under no circumstances will a client be billed the UMDAP liability amount if the client has not incurred that amount in actual services. The client is responsible for the actual cost of care or the annual liability amount, whichever is less.

There is only *one* annual UMDAP liability period regardless of the number of providers of service within any country in the State of California in which a client is treated. Subsequent providers must accept the UMDAP liability sliding scale fee established by the previous provider for the remainder of the UMDAP liability period. The UMDAP liability period is a twelve-month period that constitutes a client's fiscal year. The UMDAP liability sliding scale fee is re-evaluated for every twelve-month period.

The objective of the financial screening interview is to obtain complete and accurate billing information on each client/payor. All third party billing sources are identified and clients appropriately referred to social welfare programs for which they are potentially eligible. All clients are questioned as to their eligibility for Medi-Cal and third party payor benefits and Gateways ensures benefits are maximized.

Client/payors have the right to refuse to provide financial information, however if the client/payor refuses to cooperate with the billing of third party payors or refuses to provide any required information, the client/payor shall be liable for the actual charges of services received.

The financial screener will base the financial interview on obtaining the information required to complete the Patient Financial Information (PFI) Form. (See Attachment One).

Consistent with the goal of Los Angeles County Department of Mental Health, Gateways interviews all clients seen in Gateways' mental health system at the time of their first visit. In case of emergency, measures are taken to obtain basic billing information, e.g., name, address, telephone number and Social Security Number. If this goal is not attained at that time, the interview takes place as soon as possible during a subsequent visit, or prior to discharge from inpatient care.

In the absence of adequate information to determine the UMDAP liability amount, the client should be billed the actual cost of care. The actual cost of care amount can be rescinded once the information is provided.

B. UNIFORM METHOD OF DETERMINING ABILITY TO PAY (UMDAP)

The State of California Department of Mental Health requires that all Short/Doyle providers employ the UMDAP System when assessing the ability of a client/payor to personally pay for services rendered. The UMDAP System was developed to establish a reasonable, equitable and uniform methodology for that assessment.

Third party benefits are separate and aside. They apply first to the actual cost of care, then to the annual UMDAP liability. Third party payments do not lessen the established UMDAP liability except in instances when the third party payment and the UMDAP liability combined, exceed the actual cost of care.

See the following examples:

The actual cost of care is \$1,000 and the UMDAP liability amount is \$100. If the client has insurance that paid \$500, nothing is applied against the UMDAP liability amount because the amount paid by the insurance did not reach or go below the UMDAP liability of \$100.

Actual Cost of Care	\$1,000
Minus Insurance Payment	- 500
Balance =	\$ 500

(The balance amount will be funded by the UMDAP liability amount of \$100 and county general funds of \$100. The UMDAP liability amount is used before county general funds.)

The actual cost of care is \$1,000 and the UMDAP liability amount is \$100. If the client has insurance that paid \$950, then \$50 would be applied to the UMDAP liability. The client would be liable for the remaining \$50 balance.

Actual Cost of Care	\$1,000
Minus Insurance Payment	<u>- 950</u>
Balance =	\$ 50

(The balance amount will be funded by the UMDAP liability amount of \$50 without using county general funds.)

If additional services were received during the annual liability Period, the same formula would apply.

Additional Services Actual Cost of Care	\$1,200
Minus Insurance Payment	<u>- 1,100</u>
Balance =	\$ 100

(The balance amount will be funded by the UMDAP liability amount of \$50 *[the remaining UMDAP balance from the original \$100]* and \$50 county general funds. The UMDAP liability is used before the county general funds.)

C. COMPLETING THE PATIENT FINANCIAL INFORMATION (PFI FORM- (SEE ATTACHMENT ONE))

The PFI is used to capture client/payor financial information in order to determine a client's ability to pay. It is used to identify and document third party payor sources for billing purposes. All information recorded on the PFI is confidential (Welfare and Institutions Code, Section 5328).

Each provider should provide a photocopy of the PFI when requested. In lieu of obtaining a photocopy of a current PFI, a provider may complete a PFI with the information obtained from the Integrated System (IS), retaining the current annual UMDAP liability period and indicating on the PFI that the information was obtained from the IS. Subsequent providers must accept the UMDAP liability sliding scale fee established by a previous provider for the remainder of the UMDAP liability period, however, all information must be confirmed by the client that it is still current.

D. SHARE OF COST MEDI-CAL (SOC)

In addition to providing coverage to individuals who receive cash assistance from the government, Gateways' Medi-Cal Program offers health care coverage to individuals and families who have incomes too high to qualify for welfare, but too low to afford health care costs. Medi-Cal requires some of these recipients to contribute to their health care by paying a share of the cost of the services they receive. Share of Cost (SOC) is a term that refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to offer assistance.

Share of Cost (SOC) clients are not eligible to receive Medi-Cal benefits until their monthly SOC dollar amount has been cleared or certified online. Services provided to SOC clients will not be billed to Medi-Cal unless the SOC has been cleared. The SOC cannot be cleared unless services are provided. The SOC can only be cleared through the State's MEDS online system. Once the SOC has been cleared and certified, the balance above the SOC and all subsequent services for that month may be billed to Medi-Cal.

GATEWAYS' POLICY AND RULES ON SOC CLAIMING

1. Clearing of SOC

- Service providers shall clear or certify the SOC as soon as services are provided.
- All services rendered by a provider must be properly documented and meet the "medical necessity" requirement.
- Service providers shall not provide services for the sole purpose of meeting or clearing the SOC in order to qualify clients for Medi-Cal benefits; nor shall providers bill a third party payor or the Medi-Cal program for those services.
- The cost of service that may be reimbursed through another third party such as Medicare or private insurance shall not be used to clear the SOC. The dollar amount paid by Medicare or other third party must be deducted from the cost of care and the balance used to clear SOC.
- **CROSSOVER OR THIRD PARTY BILLING:** Providers are to bill Medicare and/or other third party such as private insurance for the actual cost of care as services are provided. However, the cost of service that may be reimbursed through another third party (such as Medicare and/or Private Insurance) should not be used to clear the SOC. The service provider must deduct the dollar amount paid by Medicare and/or other third party from the actual cost of care and then use only the balance to clear the SO.

2. Client Billing

- **UMDAP LIABILITY DETERMINATION:** Service providers are to bill the client either the monthly SOC or Annual Liability (not to exceed the actual cost of care), whichever is less, therefore, it is necessary to apply UMDAP during the financial screening of a SOC

client to determine their annual liability (also referred to as UMDAP liability amount).

- **FINANCIAL OBLIGATION AGREEMENT**: Service providers are to collect from SOC clients, the client's obligation toward the cost of their care as services are rendered. Service providers may collect payments from the client on the date the services are rendered, or allow the client to pay at a later date or through an installment plan. Financial obligation agreements are between the service provider and the client and should be in writing (see Attachment 4), signed by both parties for their protection. The hospital will make every effort to work collaboratively with the patient, allowing the patient up to twenty-four months to pay for services.
- **MEDI/MEDI SOC CLIENTS**: For client with Medicare and Medi-Cal with SOC, service providers should wait until the Medicare remittance is received, then proceed to collect from clients the SOC, UMDAP liability, or Medicare deductible plus co-payment, whichever is least.
- **SOC RE-EVALUATION**: Client who claim they cannot pay their Medi-Cal SOC are referred to DPSS for SOC re-evaluation.
- **COLLECTION & RECORDING OF FEES**: The client fee card is used to record individually all money transaction pertaining to a client account. The client fee card is used as (1) a ledger to document client charges, payments and adjustments, and (2) when photocopies, the monthly billing invoice. A separate client fee card must be maintained for each billed revenue source, i.e., client fee, Medicare, insurance, etc. Until the cumulative cost of care is equal to or beyond the UMDAP liability amount, all payments, regardless of payment source, must be posted to the patient fee card. This involves some duplication of posting, however, it is necessary to ensure overpayments do not occur.

E. SUMMARY OF ELIGIBILITY CRITERIA

Gateways is committed to providing payment assistance for psychiatric services to those deemed eligible. Gateways will assess patients prior to services being rendered, when possible, and after services are rendered, if not already done so, to determine eligibility for financial assistance. It is an expectation that the patient/guarantor will cooperate and supply all necessary information required to make a determination for financial assistance eligibility. Applicants are required to fully cooperate by applying for any public or private assistance program for which they may be eligible prior to their evaluation for payment assistance.

1. Eligibility for payment assistance will be considered for those individuals who are uninsured or underinsured, ineligible for any government program, have high medical costs as defined above, and are unable to pay for their care.
2. For all persons presenting to the hospital for emergency services, payment assistance will be considered after the rendering of service if there is a documented need. Future consideration will be given if, after billing, patients are unable to pay.
3. The hospital will make all reasonable efforts to explain the benefits of Medicaid and other public and private programs to all uninsured patients at the time of registration. Potentially eligible patients will be asked to apply for such programs, and the hospital will provide the applications.
4. If a patient is unable to provide all required documentation for obvious reasons (e.g., homeless), the facility may categorize write-offs associated with the patient's account(s) as charity, consistent with internal facility procedures (i.e., local authorization Policy) and must document the rationale for the decision.
5. In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, i.e., existing eligibility for Medicaid or PARO score, these sources of information can be used to support and/or validate the decision for qualifying a patient for a full or partial Payment Assistance Discount.
6. Eligibility for Payment Assistance for non-residents of the hospital's service area shall be evaluated by the facility on a case- by-case basis based upon approved hospital services needed and financial need of patient.

V **PAYMENT ASSISTANCE PROGRAM APPLICATION PROCESS**

1. Government Program Eligibility Screening Process
 - a. Gateways shall first make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, any of the following:
 - (i) Private health insurance
 - (ii) Medi-Care

(iii) The Medi-Cal program, the Healthy Families Program, the California Children's Services program, or other state-funded programs designed to provide health coverage.

b. If the uninsured patient does not indicate coverage by a third-party, or requests a discounted price or charity care then Gateways shall provide an application for the Medicaid program, the Healthy Families Program or other governmental program to the patient and explain the benefits of the program(s). This application shall be provided prior to discharge if the patient has been admitted and within a reasonable amount of time to patients receiving emergency or out-patient care.

2. Payment Assistance Application Process.

- a. At the time of registration, if appropriate or when possible, an authorized facility representative shall explain the Payment Assistance program eligibility requirements to uninsured patients and ask potentially eligible patients/guarantors to apply.
- b. Gateways shall provide a Payment Assistance Application to any interested patient and any patient that may meet the criteria either at the point of service or during the collection process.
- c. If an Uninsured Patient does not complete the application within 30 days of sending the application, Gateways shall issue a standard form letter with the application attached and make one phone call over a one month period following delivery of the application notifying the patient that the application has not been received and that the failure to provide the executed application will result in no payment assistance to the patient and that collection action may result.
- d. Gateways will require applicants to provide documentation to substantiate the information included in the application. In the event that the patient can't provide all of these documents, the authorized hospital designee may waive some or all of the documentation requirements in situations where the patient/guarantor is not capable of meeting these requirements. Rationale for this waiver must be documented.
- e. The patient/guarantor will be asked to return the completed form within thirty (30) days of receipt for financial assistance consideration.
- f. At minimum, the need for payment assistance shall be re-evaluated if the last financial evaluation was completed more than 12 months prior. However, Gateways retains the discretion to require patient to complete a new application at any time additional information relevant to the eligibility of the patient for Payment Assistance becomes known.
- g. Obtained documentation may not be used for collection activities.
- h. Gateways may require waivers or releases from the patient or the patient's family authorizing Gateways to obtain account information from other mental health providers, financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value.

- i. Gateways personnel will also offer potentially eligible patients a summary document explaining both the Gateways Uninsured Patient Discount Policy and the Patient Payment Assistance Policy. The patient will also be provided with a Payment Assistance application and instructions for completion in the primary language of the patient.
- j. Delivery of the summary and application should occur at the earliest point that patients are identified as Uninsured. Timing will depend upon whether or not identification is made at the time of service, during the billing process, or during the collection process.
 - (i) It is preferred, but not required, that a request for payment assistance and a determination of financial need occur prior to rendering of services. In accordance with EMTALA regulations, patients will be screened or potential payment assistance referral following rendering of services in emergency situations.
 - (ii) A household member, close friend or associate of the patient may request consideration for Payment Assistance. A referral may also be initiated by any member of the medical or facility staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, religious sponsors, vendors or others who may be aware of the potential need for payment assistance consideration.
 - (iii) To apply for payment assistance, a Payment Assistance Application is given to a patient by a member of the patient financial Service Department (Admitting/Registration Financial Counseling, Insurance Verification, etc.) or associated Payment Assistance.

3. Payment Assistance Review Process

- a. Information supplied on the completed application will be used by authorized representatives of Patient Financial Services in the evaluation of the patient's financial situation.
- b. A decision shall be made regarding the patient's ability to pay for services provided which may result in full or partial waiver of payment.
- c. The patient/guarantor will be notified in writing of approval/denial of the payment assistance request within 30 days of receipt of completed application.
- d. If a patient/guarantor feels that a denial for payment assistance was made in error, he/she will be instructed to provide additional information that may assist Gateways in reconsidering the request. (Sample letters are included in Attachment 5 & 6).

VI. SIGNATURE AND WRITTEN COMMUNICATION

Gateways will comply with the following signage and written communication requirements:

- a. Post in patient admitting areas a summary of its Payment Assistance Policy, including a simple statement that Uninsured Patients with annual household income of less than \$250,000 will be expected to pay at a reduced rate and that they may qualify for free or further reduced cost medical care by filling out an application for payment Assistance.
- b. Provide brochures explaining the Payment Assistance policy in the Admission & Discharge In-Patient, Out-Patient waiting rooms, pharmacy, and in patient financial services offices located in the main facility and satellite locations.
- c. Ensure that signs posted in the admitting areas and brochures are printed in appropriate languages as may be required under applicable law.
- d. Insert terms in its agreements with every collection agency to which Gateways refers accounts to require the agency to provide a telephone number Uninsured Patients can call to request Payment Assistance, and offer customer service telephone number with a voicemail option for call backs and bilingual customer service representatives available to communicate in languages other than English as may be required by applicable law.

VII. TRAINING

Gateways shall provide training to relevant staff personnel regarding Payment Assistance availability and how to sufficiently communicate that availability to patients. The following are the guidelines for the required training for both new and existing staff.

- a. Gateways will designate appropriate staff and provide them with sufficient training to conduct the following:
 - (i) Distribute information and assist patient with their obligations for fully completing required applications.
 - (ii) Provide information on how to apply for Payment Assistance and government assistance programs, including local, state, and federal health care programs such as Medicaid.
 - (iii) Assist patient as they complete eligibility documentation for assistance, including providing all required residency, household income, and qualified assets verification; providing all necessary documentation relating to Medicaid enrollment or the denial of Medicaid enrollment; and informing the hospital of changes in household income and/or insurance status.
 - (iv) Assist eligible patients with settling their accounts through a schedule of regular payments if determined eligible to do so by Gateways' Patient Payment Assistance Policy.

All new hire training for admitting and registration staff shall contain information on the availability, eligibility and application process for Payment Assistance.

VIII. APPEAL/DISPUTE PROCESS

Communication to all patients who are denied Payment Assistance must be in writing (see Attachment Six for example). The communication must contain the reason for the denial and a contact name and number at Gateways.

**LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYER FINANCIAL INFORMATION**

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME	SS #	EMH CLIENT ID #
2	MIDDLE NAME	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP
			SPOUSE NAME

THIRD PARTY INFORMATION

3	NO THIRD PARTY PAYER <input type="checkbox"/>			
4	MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL COUNTY CODE / AID CODE / CIN #	MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REFERRED
5	SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE
6	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO	HEALTHY FAMILIES CIN #
7	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE #	LIFETIME AUTHORIZATION SIGNED <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO
8	HMO/PPO <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF CARRIER	GROUP / POLICY / ID #	NAME OF INSURED
9	CARRIER ADDRESS	ASSIGNMENT / RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		

PAYER REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYER	RELATION TO CLIENT	DOB	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> SP	PAYER SOCIAL #
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #
12	SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER:				PAYER SS #
13	EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED
14	EMPLOYER'S ADDRESS (include City, State & Zip Code)				TEL #
15	SPOUSE	ADDRESS (include City, State & Zip Code)			SPOUSE'S SS #
16	SPOUSE'S EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED
17	SPOUSE'S EMPLOYER'S ADDRESS (include City, State & Zip Code)				TEL #
18	NEAREST RELATIVE / RELATIONSHIP	ADDRESS (include City, State & Zip Code)			TEL #

UMDAP LIABILITY DETERMINATION

19	LIQUID ASSETS	20	ALLOWABLE EXPENSES	21	ADJUSTED MONTHLY INCOME
	Savings \$ _____		Court ordered obligations paid monthly \$ _____		Gross Monthly Family Income \$ _____
	Checking Accounts \$ _____		Monthly child care payments (necessary for employment) \$ _____		Self/Payer \$ _____
	IRA, CD, Market value of stocks, bonds and mutual funds \$ _____		Monthly dependent support payments \$ _____		Spouse \$ _____
	TOTAL LIQUID ASSETS \$ _____		Monthly medical expense payments \$ _____		Other \$ _____
	Less Asset Allowance \$ _____		Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____		TOTAL HOUSEHOLD INCOME \$ _____
	Net Asset Valuation \$ _____		Total Allowable Expenses \$ _____		TOTAL FROM BOX 19 \$ _____
	Monthly Asset Valuation (Divide Net Asset by 12) \$ _____		VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO		SUBTOTAL \$ _____
	VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO				LESS TOTAL FROM BOX 20 \$ _____
22	Number Dependent on Adjusted Monthly Income (Client included)	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD	Payment Plan \$ _____ per month for 1 2 3 4 5 6 months.	
23		FROM	TO		
	PROVIDER OF FINANCIAL INFORMATION Name and Address (if Other than Patient or Responsible Person)				

OTHER

24	PRIOR MENTAL HEALTH TREATMENT DURING THE CURRENT ANNUAL CHARGE PERIOD <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
26	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
27	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER			PROVIDER NAME AND NUMBER
	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22.			
	SIGNATURE OF CLIENT OR RESPONSIBLE PERSON			DATE

MH 281 Rev. 02/11/2011



**UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES**
Effective October 1, 1989



MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDIC-AL ELIGIBLE AREA				
0- 569	38	40	42	44	46
570- 599	40	42	44	46	48
600- 649	42	44	46	48	50
650- 699	50	52	54	56	58
700- 749	56	58	60	62	64
750- 799	63	65	67	69	71
800- 849	71	73	75	77	79
850- 899	79	81	83	85	87
900- 949	89	91	93	95	97
950- 999	99	101	103	105	107
1000-1049	111	113	115	117	119
1050-1099	125	127	129	131	133
1100-1149	140	142	144	146	148
1150-1199	156	158	160	162	164
1200-1249	177	179	181	183	185
1250-1299	200	202	204	206	208
1300-1349	226	228	230	232	234
1350-1399	255	257	259	261	263
1400-1449	288	290	292	294	296
1450-1499	326	328	330	332	334
1500-1549	368	370	372	374	376
1550-1599	416	418	420	422	424
1600-1649	470	472	474	476	478
1650-1699	531	533	535	537	539
1700-1749	600	602	604	606	608
1750-1799	678	680	682	684	686
1800-1849	752	754	756	758	760
1850-1899	835	837	839	841	843
1900-1949	927	929	931	933	935

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456

Above \$4200 Add \$400 for each \$100 additional income.

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (See back page).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/1989

Uniform Patient Fee Schedule
 Community Mental Health Services
 Attachment C to DMH Notice 98-13
 Effective October 1, 1989

Monthly Adjusted Gross Income*	Persons Dependent on Income Annual Deductibles					Monthly Adjusted Gross Income*	Persons Dependent on Income Annual Deductibles				
	1	2	3	4	5 or more		1	2	3	4	5 or more
	Medi-Cal Eligible Area**					1950 - 1999	1029	926	833	750	675
0 - 569	37	33	30	27	24	2000 - 2049	1142	1028	925	833	750
570 - 599	40	36	32	29	26	2050 - 2099	1268	1141	1027	924	932
600 - 649	45	40	36	32	29	2100 - 2149	1407	1266	1139	1025	923
650 - 699	50	45	41	37	33	2150 - 2199	1562	1406	1265	1139	1025
700 - 749	56	50	45	41	37	2200 - 2249	1734	1561	1405	1265	1139
750 - 799	63	57	51	46	41	2250 - 2299	1925	1733	1560	1404	1264
800 - 849	71	64	58	52	47	2300 - 2349	2136	1922	1730	1557	1401
850 - 899	79	71	64	58	52	2350 - 2399	2371	2134	1921	1729	1556
900 - 949	89	80	72	65	49	2400 - 2449	2632	2369	2132	1919	1727
950 - 999	99	90	80	72	65	2450 - 2499	2922	2630	2367	2130	1917
1000 - 1049	111	100	90	81	73	2500 - 2599	3275	2948	2653	2388	2149
1050 - 1099	125	112	101	91	82	2600 - 2699	3482	3134	2821	2359	2285
1100 - 1149	140	126	113	102	92	2700 - 2799	3695	3326	2993	2694	2425
1150 - 1199	156	140	126	113	102	2800 - 2899	3915	3524	3172	2855	2570
1200 - 1249	177	159	143	129	116	2900 - 2999	4139	3725	3353	3018	2716
1250 - 1299	200	180	162	146	131	3000 - 3099	4370	3933	3540	3186	2867
1300 - 1349	228	203	183	165	149	3100 - 3199	4607	4146	3731	3358	3022
1350 - 1399	255	230	207	186	167	3200 - 3299	4850	4365	3929	3536	3182
1400 - 1449	288	259	233	210	189	3300 - 3399	5099	4589	4130	3717	3345
1450 - 1499	326	293	264	238	214	3400 - 3499	5458	4912	4421	3979	3581
1500 - 1549	368	331	298	268	241	3500 - 3599	5830	5247	4722	4250	3825
1550 - 1599	416	374	337	303	273	3600 - 3699	6214	5693	5036	4532	4079
1600 - 1649	470	423	381	343	309	3700 - 3799	6610	5949	5354	4819	4337
1650 - 1699	531	478	430	387	348	3800 - 3899	7018	6316	5684	5116	4604
1700 - 1749	600	540	486	437	393	3900 - 3999	7438	6694	6025	5423	4881
1750 - 1799	678	610	549	494	445	4000 - 4099	7870	7083	6375	5738	5164
1800 - 1849	752	677	609	548	493	4100 - 4199	8314	7483	6735	6062	5456
1850 - 1899	835	752	677	609	548	Above \$4200 add \$400 for each \$100 additional income.					
1900 - 1949	927	834	751	676	608						

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (see back page)

The above information was provided by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/29/89

Quick Reference

Medi-Cal Eligibility

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU	1 - \$602	3 - \$934	6 - \$1,417	9 - \$1,825
	2 - \$750	4 - \$1,100	7 - \$1,550	10 - \$1,959
	2 - \$934 (Adults)	5 - \$1,259	8 - \$1,692	

Asset allowances for 1989 are:

Persons	1 - 2000	4 - 3300	7 - 3750
	2 - 3000	5 - 3450	8 - 3900
	3 - 3150	6 - 3600	9 - 4050

Aid categories commonly found in community mental health are:

Refugee: First 18 months in the U.S.	Disabled: Meeting federal definition of disability
Aged: 65 years of age and over	AFDC: Aid to Family with Dependent Children

Medi-Cal Share-of-Cost

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-year old man would be eligible for Medi-Cal except that his income is too high. He has a \$1000 medical bill. He meets the low asset levels, but his income from retirement is \$1000 per month. His income is \$1000 minus the standard \$20 disregard and the \$24.90 payment for the Medicare Part B, leaving a "net" of \$955.10. His "share-of-cost" for Medi-Cal is \$955.10 minus \$602 ("need level") or \$353.10. Medi-Cal will pay the remainder of the \$1000 medical bill for that month and other months when he obligates the share of cost. He has to submit a Medi-Cal form MC-177 each month he obligates a share of cost above \$353.10. His eligibility will be predetermined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

10/20/89

Gateways Hospital and Mental Health Center

CHARITY / DISCOUNT CARE ELIGIBILITY DETERMINATION

GENERAL				
Guarantor Name:				
Address:				
City:	State:	Zip:	Country:	
Phone ()	How Long at this address?			
Method of Verification:	Power bill	Water bill	Drivers License	Other
Previous Address:				
Eligibility Requirements for Charity or Discout Care				
Social Security Number:			Date of Birth:	
Place of Employment:				
Length of Employment:				
If not employed, what is your source of income?				
Gross income per month:			Number of dependents:	
Spouse's Name:				
Spouse's Place of Employment:				
How long:				
Gross income per month:			Total Gross Income per month:	
Verified by tax return: (year)			Do you have health insurance?	
If so what type of insurance and with whom?				
Effective Date:			Is a copy of card available?	
MEDICAL ELIGIBILITY				
Have you applied for Medi-cal or any other government assistance Y or N If so when?				
Were you denied assistance? Y or N If denied why?				
Applicants Signature:			Date:	
Applicants Signature:			Date:	



GATEWAYS HOSPITAL
AND MENTAL HEALTH CENTER

1891 Effie Street
Los Angeles, CA 90026
Phone 323.644.2000
Fax 323.666.1417

Financial Obligation Agreement

California Welfare and Institutions Code requires that a person receiving mental health services at a Los Angeles County operated or contracted facility will be responsible for the cost of those services in accordance with their ability to pay.

Annual Liability = \$ _____ based on income and/or Medi-Cal without Share of Cost.

- Or -

Based on the fee schedule issued by the State of California your annual liability for the period of _____ to _____ will be \$ _____ or the actual cost of care, whichever is less.

You are required to notify this office immediately if there is a change in your financial situation including but not limited to a change in employment status, income, cash assistance (e.g., SSI, SSDI, General Relief (GR), etc.), Medi-Cal or other healthcare coverage such as Medicare or private/group insurance. Failure to notify this office of any change in your financial situation could lead to client responsibility for the full cost of the care received from this program.

We have agreed to allow you to make monthly payments to pay off this debt. You have agreed to pay \$ _____ per month for _____ month. Your first payment is due by _____ and thereafter on the _____ of each month. In the event your annual liability exceeds the actual cost of care you may discontinue your monthly payments once the actual cost of care has been paid in full.

Delinquent accounts may be referred to our Collection Agency for further action.

Client Signature

Date

Clinic Representative

Date

Patient's Name - _____

GATEWAYS HOSPITAL AND MHC
1891 EFFIE ST., LOS ANGELES, CA 90026
(323) 644-2000

U | OU | M-CARE | M-CAL | M-CALX | FI | CHMPS | PHP

DATE _____
 MIS NUMBER _____

Client

Responsible Person

Address

City, State, Zip

THIS STATEMENT INCLUDES ALL
 CHARGES AND CREDITS THROUGH _____

AMOUNT
 NOW DUE

Please Enter
 Amount Paid

RETURN TOP PORTION WITH YOUR PAYMENT

SERVICES

PAYMENT DUE

MONTH	SERVICES PROVIDED*					COST OF CARE THIS MONTH	AMOUNT DUE LAST MONTH	PAYMENTS AND ADJUSTMENTS	PAYMENT PLAN AMOUNT DUE THIS MONTH **	TOTAL AMOUNT DUE THIS MONTH
	I	G	M	P	TOTAL U/S					
										\$ -
										\$ -
										\$ -
										\$ -
										\$ -
										\$ -
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UMDAP PERIOD

***PAYMENT PLAN

_____ TO _____
 ANNUAL LIABILITY _____

DATE	AMOUNT	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a question or problem about this statement, please call or visit the clinic office as soon as possible.

Service Codes	Pmt & Adj. Codes
I - Individual	C - Champus
G - Group	E - Error
M - Medication	I - Insurance
P - Psych-Emergency	M - Medicare
	P - Patient
	T - Therapeutic
	U - Umdap

Make your Check or Money Order Payable To:
GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER

Please Do Not Send Cash
 -----Thank You-----



GATEWAYS HOSPITAL
AND MENTAL HEALTH CENTER

1891 Effie Street
Los Angeles, CA 90026
Phone 323. 644. 2000
Fax 323. 666.1417

Discharge of Financial Obligation Agreement

In consideration of full payment by _____, referred to as the Maker, in the amount of _____ Dollars (\$_____) on the ___ day of _____, 20____, I, _____ of Gateways Hospital and Mental Health Center, referred to as the Holder, release and discharge the Maker from any costs of obligations under the Financial Obligation Agreement dated the ___ day of _____, 20____.

The Holder agrees to release all parties connected to the original Financial Obligation Agreement including, if any, co-signers and guarantors.

IN WITNESS WHEREOF, the Holder has executed this Agreement as of the day and year first above written.

Holder's Signature _____ Date: _____

Print Name: _____

Maker's Signature _____ Date: _____

Print Name: _____