SOUTHERN INYO HEALTHCARE DISTRICT

POLICY/PROCEDURE

TITLE: **Charity Care, Deposit and Discount Payment**

DEPARTMENT: **Business Office**

SCOPE: FINANCIAL PERSONNEL

POLICY: The Business Office will maintain an understandable, written financial assistance policy for low-income uninsured and underinsured patients, addressing the hospital's charity care, deposit and discount payment policy.

The written charity care, deposit and discount payment policy will be in compliance with AB 774.

Uninsured patients, as well as insured patients with high medical costs, are eligible to apply under the policy if their family income is at or below 250 percent of the federal poverty level.

The charity care, deposit and discount payment policy will state the process used to determine whether a patient is eligible for charity care or a discounted payment.

Underinsured patients, such as those with high-deductible consumer-driven health plans, are eligible to apply under the District's policy. To be eligible, patients must incur out-of-pocket costs that exceed 10 percent of their family income in the prior 12 months.

A patient applying must make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the patient fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that grounds for disqualification.

PROCEDURE:

If a patient or hospital staff member considers that the patient may be eligible for charity care or discounted payment, they will provide the patient with a Financial Statement form and request that it be returned to the Financial Counselor for eligibility determination.

The Financial Counselor will review all Financial Statements submitted for eligibility determination for either charity care or discount payment as soon as reasonably possible, but in all cases prior to instituting any collection practices other than the initial deposit requirements as specified in the deposit schedule. (attached)

In determining eligibility for charity care, the financial counselor will require all relevant income information from the patient to verify possible eligibility. (This includes, but is not limited to Income Tax Returns, W-2's, recent pay stubs and bank statements) This information may not be used for collection activities.

Notice

Business services staff will provide patients with a written notice about the availability of the discount payment and charity care policy. This notice will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, the emergency department, billing office, admitting office, rural health clinic, retail pharmacy and other outpatient locations. This notice will be in English and other languages as required by Insurance Code 12693.30.

Eligibility

In determining eligibility for charity care, business services staff will consider the income and monetary assets of the patient. However, they will not include any of the various retirement or deferred-compensation plans that an applicant may have, the first $10,000 of an applicant's monetary assets, and 50 percent of any amount over the first $10,000 in determining eligibility.

Billing Requirements

Business services staff will make all reasonable efforts to obtain information from the patient about whether private or public health insurance might fully or partially cover the charges for care, including private health insurance, Medicare, Medi-Cal, Healthy Families, or other state or federally funded programs.

When a patient is billed who has not provided proof of coverage by a third party at the time the care was rendered or upon discharge, the business services staff will include as part of that billing process a "clear and conspicuous" notice of the following:

- A statement of charges for services rendered;
- A statement that, if the consumer does not have health insurance coverage, the consumer may be eligible for Medicare, Healthy Families Medi-Cal or charity care;
- A statement indicating how patients may obtain applications for the Medi-Cal and the Healthy Families Program and that the Hospital will assist in obtaining these applications;
- Information regarding the financially qualified patient and charity care application process, 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 a discounted payment or charity care.

B. The name and number of the then current patient financial counselor and the business office for further information about the hospital's discount payment and charity care policy, and how to apply for assistance.

Payment Plan

If a patient tries to qualify for the SIHD charity care or discount payment and attempts in good faith to settle an outstanding bill by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, SIHD will not send the bill to a collection agency unless that agency agrees to comply with the requirements of AB 774.

SIHD will not use wage garnishments or liens on primary residences as a means of collecting debt from eligible patients. However, an unaffiliated collection agency may obtain a court order authorizing wage garnishment.

Any extended payment plan offered by SIHD to assist patients eligible under the charity care and deposit and discount payment policy, or any other policy adopted by SIHD for assisting low-income patients will be interest free.

Before commencing collection activities, SIHD will provide the patient with a clear and conspicuous written notice regarding the patient's rights under state and federal fair debt collection rules. The notice must include a statement that the Federal Trade Commission enforces these requirements.

Attachments: Charity Criteria
Sliding Scale
Deposit Schedule

Reference: AB 774

APPROVAL	DATE	APPROVAL	DATE
Department/Division Manager		Interdisciplinary Team	N/A
Unit Medical Director (if applicable)	N/A	Governing Board	10-7-19
Medical Staff Committee (if applicable)	N/A	Administration	10-4-19
Reviewed By:		Reviewed By:	
Reviewed By:		Reviewed By:	

SOUTHERN INYO HEALTHCARE DISTRICT

HOSPITAL AND CLINIC CHARITY CRITERIA

FAMILY UNIT	MONTHLY INCOME
	A
1	2,602
2	3,523
3	4,444
4	5,365
5	6,285
6	7,206
7	8,127
8	9,048
9	9,969
10	10,890

Patient Owes:

RHC	$20.00	
Lab	$10.00	
Xray	$15.00	
U.S	$15.00	
CT	$30.00	
OP Serv	$25.00	
Rehab(PT,OT)	$20.00	per visit
Surg/Proc	$50.00	
CRNA	$50.00	
Phy-Surg	$400.00	
E/R	$50.00	
Phy-ER	$50.00	
Acute Care	$50.00	daily
Swing	$50.00	daily

EFFECTIVE: 1/1/2019

SOUTHERN INYO HEALTHCARE DISTRICT

DEPOSIT SCHEDULE:

Hospital Admission	$ 3,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Skilled Nursing	$ 8,000.00	Or the verifiable Co-pay requirement from the primary insurer.
Outpatients / Clinics	$ 100.00	Or the verifiable Co-pay requirement from the primary insurer.
Emergency Room	$ 200.00	Or the verifiable Co-pay requirement from the primary insurer.

AVAILABLE DISCOUNTS: **MULTIPLE DISCOUNT TYPES WILL NOT BE COMBINED**

Cash / Uninsured Hospital Services	30%	Based on all charges. Pay arrangements may be made based on amount due.
Cash / Uninsured Rural Health Clinic Services	50%	Based on all charges. Pay arrangements may be made based on amount due
Sliding Scale		Sliding scale discount based on 250% of the currently posted "Poverty Guidelines" (see sliding scale schedule)
Employee & Board	50%	Applicable to the patient's personal liability portion of the hospital's charges; not to include patient deductible and or co-pay's.
Administrative Allowance		From time -to-time the CEO may grant a special discount when warranted by special circumstances. Such discounts or allowances will only be granted upon written authorization from the CEO/CFO to the Business Office Manager or Controller.

Acceptable payment arrangements may be made by seeing the Financial Counselor.

Revised: 9/1/2019

Southern Inyo Healthcare District
Financial Assistance
Notification of Eligibility Determination

Southern Inyo Healthcare District has conducted an eligibility determination for financial assistance for:

_____	_____	_____
Patient's Name	account number	date(s) of service

The request for financial assistance was made by the patient or on behalf of the patient on _____.

Based on the information provided by the patient or on behalf of the patient, the following determination has been made:

___ Your request for financial assistance has been approved for all outpatient services provided at Southern Inyo Healthcare District.

You are approved for _____% financial assistance for the current calendar year, expiring on December 31, 20__. It is your responsibility to fill out a new application including documentation of family size and income before the December 31 expiration date.

___ You are approved for _____% catastrophic event financial assistance for the account number(s) and date(s) of service listed above only.

___ Your request for financial assistance is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

___ Your request for financial assistance has been denied because:

Reason: _____
_____
_____
_____

If you have any questions on this decision, please contact:

_____
Patient Financial Assistance
Southern Inyo Healthcare District
(760) 876-5501 Ext. 2271

Poverty Guidelines, all states (except Alaska and Hawaii)

2019 Annual

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	6,245	$12,490	15,613	16,237	16,612	16,862	17,236	18,735	21,858	23,107	24,980	31,225	37,470	49,960
2	8,455	$16,910	21,138	21,983	22,490	22,829	23,336	25,365	29,593	31,284	33,820	42,275	50,730	67,640
3	10,665	$21,330	26,663	27,729	28,369	28,796	29,435	31,995	37,328	39,461	42,660	53,325	63,990	85,320
4	12,875	$25,750	32,188	33,475	34,248	34,763	35,535	38,625	45,063	47,638	51,500	64,375	77,250	103,000
5	15,085	$30,170	37,713	39,221	40,126	40,730	41,635	45,255	52,798	55,815	60,340	75,425	90,510	120,680
6	17,295	$34,590	43,238	44,967	46,005	46,697	47,734	51,885	60,533	63,992	69,180	86,475	103,770	138,360
7	19,505	$39,010	48,763	50,713	51,883	52,664	53,834	58,515	68,268	72,169	78,020	97,525	117,030	156,040
8	21,715	$43,430	54,288	56,459	57,762	58,631	59,933	65,145	76,003	80,346	86,860	108,575	130,290	173,720
9	23,925	$47,850	59,813	62,205	63,641	64,598	66,033	71,775	83,738	88,523	95,700	119,625	143,550	191,400
10	26,135	$52,270	65,338	67,951	69,519	70,565	72,133	78,405	91,473	96,700	104,540	130,675	156,810	209,080

Poverty Guidelines, all states (except Alaska and Hawaii)

2019 Monthly

Household /Family Size	50%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	250%	300%	400%
1	520	$1,041	1,301	1,353	1,384	1,405	1,436	1,561	1,821	1,926	2,082	2,602	3,123	4,163
2	705	$1,409	1,761	1,832	1,874	1,902	1,945	2,114	2,466	2,607	2,818	3,523	4,228	5,637
3	889	$1,778	2,222	2,311	2,364	2,400	2,453	2,666	3,111	3,288	3,555	4,444	5,333	7,110
4	1,073	$2,146	2,682	2,790	2,854	2,897	2,961	3,219	3,755	3,970	4,292	5,365	6,438	8,583
5	1,257	$2,514	3,143	3,268	3,344	3,394	3,470	3,771	4,400	4,651	5,028	6,285	7,543	10,057
6	1,441	$2,883	3,603	3,747	3,834	3,891	3,978	4,324	5,044	5,333	5,765	7,206	8,648	11,530
7	1,625	$3,251	4,064	4,226	4,324	4,389	4,486	4,876	5,689	6,014	6,502	8,127	9,753	13,003
8	1,810	$3,619	4,524	4,705	4,813	4,886	4,994	5,429	6,334	6,695	7,238	9,048	10,858	14,477
9	1,994	$3,988	4,984	5,184	5,303	5,383	5,503	5,981	6,978	7,377	7,975	9,969	11,963	15,950
10	2,178	$4,356	5,445	5,663	5,793	5,880	6,011	6,534	7,623	8,058	8,712	10,890	13,068	17,423

SLIDING FEE SCALE PROGRAM

Southern Inyo Healthcare District (SIHD) offers our uninsured patients a Sliding Fee Scale Program upon qualification. The application process is simple. One must apply for Medi-Cal before applying for our Sliding Scale Program. Once this is done, a Financial Statement must be filled out showing the monthly income of all members of the patient's household, along with other relevant financial information. Documentation that supports the Financial Statement must also be provided - see the attached requirements.

Eligibility will be based on 250% of the Federal Poverty Guideline. Once eligibility is established, it remains in effect for a maximum of one year or earlier, at the discretion of SIHD. Any changes in a patient's financial information must be reported to SIHD immediately so eligibility can be re-evaluated.

You have been given this information because we believe you may qualify for consideration under this program. Please complete our Financial Statement (attached) and return it to the reception staff immediately. Provide us with your supporting documentation as soon as possible by bringing it to our facility or by mailing it to: P.O. Box 1009 Lone Pine, CA 93545 ATTN: Business Office

You will be notified in writing of our decision as soon as possible after we review your Financial Statement and supporting documentation. Prompt payment for the services you receive is required, whether or not they qualify for a reduction under our Sliding Scale Program.

Contact our Business Office by calling (760) 876-5501, Extension 2231 or 2233, if you have any questions or need assistance concerning this program.

SOUTHERN INYO HEALTHCARE DISTRICT

HOW TO COMPLETE THE FINANCIAL STATEMENT AND PROVIDE SUPPORTING DOCUMENTATION

It is important to complete the Financial Statement in its entirety. Please read and answer every question asked. If the question does not apply to you, write "N/A" for not applicable. If your answer is none, please write "none" so we know you have considered the question. The information requested on this form is to be provided for all members of your household.

If you are working, provide copies of your most recent pay stubs.

If you receive unemployment income, disability income, social security income, retirement and/or pension income, provide copies of the statements showing the amounts you receive. If you receive child support or alimony, provide copies of documentation showing the amounts you receive.

If you are self-employed, provide copies of your most recent income tax return including relevant schedules.

If you receive monies in the form of gifts, assistance, loans or any other unreported compensation, provide a written statement of explanation.

If you have bank accounts, investment or retirement accounts, treasury bills, certificates of deposit, money market funds, stocks, bonds, or other certificates, please provide copies of your most recent monthly or quarterly statements. If you receive income from notes of indebtedness or under a rental contract, provide a copy of the document or contract that details the arrangement.

SOUTHERN INYO HEALTHCARE DISTRICT

Dear Patient,

We need financial information in order to complete your application for our Sliding Scale Program. We need this information within **30 days** from the date that you applied for our program. You will continue to be billed and responsible for **all** Clinic/Hospital charges until this information is received. ***The information must be provided for all members of the household.***

Listed below are some of the most common items that we can use in determining eligibility (Please provide as many as possible).

Financial Statement ***(required)***
Paycheck Stubs (2 months)
Income Tax Returns
Unemployment Income
Any Other Income (CD's, Market Funds, Stocks, etc.)
State Disability Income
Social Security Income (SSI)/Social Security Disability (SSD)
Child Support
General Assistance
Bank Statements (2 months)
Letter of Support (From the person who is helping you)
Golden State Advantage Card (Food Stamp Card)
Medi-Cal Denial Letter ***(**Must have this in order to qualify**)***

If I can be or any assistance or you have any questions, please do not hesitate to contact me.

Thank you for your assistance,

(760) 876-5501 ext. 2231 or 2233

SOUTHERN INYO HEALTHCARE DISTRICT

Financial Statement

Patient Name			Med Rec Number	Account Number
Address	City	State	Zip	How Long?
Telephone Number	If less than one year, Previous Address			

Circle Reason Patient Is Applying

Clinic Appointment	Pre-Admission Arrangements	Hospital Services
Payment Arrangements	Delinquent Account	Collection Letter

Members of Household (including patient): List additional members of household on separate sheet.

	Last Name	First Name	MI	Birthdate	M / S	Social Security Number	Gross Monthly Income
1							
2							
3							
4							
5							
6							

Personal Property. Do you or members of your household have any of the following?:

X	Item	$ Value	X	Item	$ Value
	Checks/Cash (on hand, home, elsewhere)			Certificates of Deposit	
	Treasury Bills			Money Market Funds	
	Notes: Mortgages, Deeds of Trust, etc.			Stocks, Bonds, Certificates	
	Checking Account(s): Bank, Address				
	Savings Account(s): Bank, Address				
	Resources which can be converted to cash (specify):				
	Other:				

Motor Vehicles (include autos, trucks, motorcycles, jet skis, motor homes, boats, trailers):

X	Year	Make	Model	Used for Work?	Owner	$ Value

Other Income:

X	Source	Monthly Amt.	X	Source	Monthly Amt.
	Social Security/ Disability/Unemployment			Dividends/ Interest/ Royalties	
	Pension/Retirement			Child Support / Alimony	
	Rental Income			Self-employment or Business Income	
	Other (specify)				

Living Arrangements: Circle the one that applies

Renting Own/Buying Room with another person Other (explain)

Real Property:

x	*Description*	$ Value

Accident:

Was patient's problem caused by an accident? Yes No	If yes, date of accident: / /
Where did accident occur?	How?
Is patient seeking compensation through an insurance settlement or lawsuit Comment:	Yes No

Circle any of the following that apply to the patient:

Have or Will apply for Medi-cal 65 or Over Blind Pregnant

Other Information:

Provide Address & Phone of any Employer

I declare or affirm that the statements above are true and correct to the best of my knowledge and belief. I understand that withholding information or giving false information will make the patient and/or responsible party liable for payment of all charges for services rendered.

Signature of Patient or Provider of Information:	Date:
Signature of Witness:	Date:

Do Not Write Below this Area for Office Use Only:

Financial Counselors Notes: