

SOUTHERN INYO HOSPITAL POLICY/PROCEDURE

SUBJECT: FINANCIAL ASSISTANCE AND CHARITY CARE	EFFECTIVE DATE: July 1, 2025
MANUAL: Policy and Procedures	Charity Care – Low Income Uninsured or Underinsured
APPROVED BY:	DATE:

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 financial assistance and charity care programs.

Uninsured patients, as well as insured patients with out-of-pocket costs (any expenses for medical care that are not reimbursed by medical insurance or health program) are eligible to apply under the policy if their family income is at or below 400 percent of the federal poverty level.

Financial Assistance and Charity Care will state the process used to determine whether a patient is eligible. The policy will be following AB 2297 and SB 1061.

A patient who is applying must make every reasonable effort to provide the hospital with documentation of income and/or 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.

To ensure low-income, uninsured, and under-insured patients' and families' financial capacity does not prevent them from seeking or receiving medical treatment. Southern Inyo Hospital provides medically necessary financial assistance and charity care to all eligible patients pursuant to the guidance in this policy. The Financial Assistance and Charity Care Policy is designed to satisfy the requirements of Section 501(r) of the Internal Revenue Code, California Health & Safety Code sections 127400 – 127466 et seq., and the Department of Health and Human Services Office Inspector General guidance regarding financial assistance to uninsured and underinsured patients.

This policy is intended to:

- Define the forms of available Financial Assistance and the associated eligibility criteria;
- Establish the processes that patients shall follow in applying for Financial Assistance and the process the hospital will follow in reviewing applications for Financial Assistance;
- Provide a means of review in the event of a dispute over a Financial Assistance determination;
- Provide administrative and accounting guidelines to assist with identifying, classifying, and reporting Financial Assistance;
- Establish the process that Southern Inyo Hospital shall follow to provide patients an estimate of financial responsibility for services; and,
- Define the discounts available to patients for hospital inpatient and outpatient services performed at Southern Inyo Hospital.

This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between Southern Inyo Hospital and a third-party payer, nor is it intended to provide discounts to a non-contracted third-party payer or other entities that are legally responsible for making payment on behalf of a beneficiary, covered person, or insured.

PROCEDURE:

If a patient or hospital staff member considers that the patient may be eligible for financial assistance or Charity care, they will provide the patient with a Financial Statement form and request that it be returned to the Business Office for eligibility determination.

The Business office Director will review all Financial Statements submitted for eligibility determination for either financial assistance, full charity care or partial charity care as soon as possible, but in all cases prior to instituting any collection practices other than the initial

deposit requirements as specified in the deposit schedule. (See Below)

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	30%	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 SPEAKING TO THE DIRECTOR OF PATIENT FINANCIAL SERVICES.

DIRECTOR OF PFS

OFFICE: (760) 876 – 5501 FAX: (760) 876 - 4388

EMAIL: kgarcia@sihd.org

ELIGIBILITY:

In determining eligibility for Charity Care or Financial Assistance, business office Director will consider the income and income tax of previous year in determining eligibility.

DEFINITIONS:

- Covered Services: Covered Services are all services that are deemed medically necessary. Those services that are “Elective Services Requiring Prior Administrative Approval.” As defined below, are not covered services.
- Elective Services Requiring Prior Administrative Approval: Due to their unique nature, certain non-emergent services require administrative approval before admission and treatment. Typically, patients seeking complex, specialized, or high-cost services – such as experimental procedure – must obtain administrative approval before receiving care. Patients requesting these services are not eligible for Full Charity Care, Partial Charity Care, or High Medical Cost Charity Care unless the hospital administration grants an exception. Exceptions will only be considered for Inyo County residents.
- Southern Inyo Hospital will establish a process for Inyo County residents to apply for prior administrative approval. If an eligible patient receives service requiring prior approval without obtaining it, they will qualify for Partial Charity Care or High Medical Cost Charity Care if eligible. Otherwise, they will receive an Uninsured Patient Discount.
- Uninsured Patient: An uninsured patient is a patient who has no source of payment for any portion of their medical expenses, including, without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability, or whose benefits under insurance have been exhausted prior to the admission. Patients without coverage may be screened for eligibility for state or federal government programs.
- Primary Language of Southern Inyo Hospital service area: The primary language of Southern Inyo Hospital local population is English.
- Family Income: Family income is annual family earnings from the prior 12 months or prior tax year, as shown by recent pay stubs or income tax returns, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year to date family income, taking into consideration current earning rates.
- High Medical Cost: Includes either of the following:
 - Annual out – of – pocket costs incurred by the individual at the hospital that exceeds **the lesser of** 10 percent of the patient’s current family income **or** family income in the prior 12 months.

- Annual out – of – pocket expenses that exceed 10 percent 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.
- Out – of – pocket costs and expenses mean any expended for medical care that are not reimbursed by insurance of a health coverage program, such as Medicare copays or Medi-cal cost sharing.

FEDERAL POVERTY GUIDELINES:

The measure of income levels published annually by the United States Department of Health and Human Services and is used by hospitals to determine eligibility for financial assistance. These guidelines are available at:

<https://aspe.hhs.gov/topics/povertyeconomicmobility/poverty-guidelines>

2025 FPL Calculation Chart (Monthly Values) Enclosure 1

Family Size	100% FPL		MONTHLY FPL VALUES (Rounded up to next higher dollar)										
	Annual FPL	Monthly FPL	60%	100%	108%	109%	114%	120%	128%	133%	135%	138%	142%
1	15650	1305	783	1305	1410	1423	1488	1566	1671	1736	1762	1801	1854
2	21150	1763	1058	1763	1905	1922	2010	2116	2257	2345	2381	2433	2504
2 Adults	21150	1763	1058	1763	1905	1922	2010	2116	2257	2345	2381	2433	2504
3	26650	2221	1333	2221	2399	2421	2532	2666	2843	2954	2999	3065	3154
4	32150	2680	1608	2680	2895	2922	3056	3216	3431	3565	3618	3699	3806
5	37650	3138	1883	3138	3390	3421	3578	3766	4017	4174	4237	4331	4456
6	43150	3596	2158	3596	3884	3920	4100	4316	4603	4783	4855	4963	5107
7	48650	4055	2433	4055	4380	4420	4623	4866	5191	5394	5475	5596	5759
8	54150	4513	2708	4513	4875	4920	5145	5416	5777	6003	6093	6228	6409
9	59650	4971	2983	4971	5369	5419	5667	5966	6363	6612	6711	6860	7059
10	65150	5430	3258	5430	5865	5919	6191	6516	6951	7222	7331	7494	7711
11	70650	5888	3533	5888	6360	6418	6713	7066	7537	7832	7949	8126	8361
12	76150	6346	3808	6346	6854	6918	7235	7616	8123	8441	8568	8758	9012
Ea Add'l	5500	459	276	459	496	501	524	551	588	611	620	634	652

Family Size	100% FPL		MONTHLY FPL VALUES (Rounded up to next higher dollar)											
	Annual FPL	Monthly FPL	150%	160%	185%	200%	202%	208%	213%	250%	266%	322%	400%	600%
1	15650	1305	1958	2088	2415	2610	2637	2715	2780	3263	3472	4203	5220	7830
2	21150	1763	2645	2821	3262	3526	3562	3668	3756	4408	4690	5677	7052	10578
2 Adults	21150	1763	2645	2821	3262	3526	3562	3668	3756	4408	4690	5677	7052	10578
3	26650	2221	3332	3554	4109	4442	4487	4620	4731	5553	5908	7152	8884	13326
4	32150	2680	4020	4288	4958	5360	5414	5575	5709	6700	7129	8630	10720	16080
5	37650	3138	4707	5021	5806	6276	6339	6528	6684	7845	8348	10105	12552	18828
6	43150	3596	5394	5754	6653	7192	7264	7480	7660	8990	9566	11580	14384	21576
7	48650	4055	6083	6488	7502	8110	8192	8435	8638	10138	10787	13058	16220	24330
8	54150	4513	6770	7221	8350	9026	9117	9388	9613	11283	12005	14532	18052	27078
9	59650	4971	7457	7954	9197	9942	10042	10340	10589	12428	13223	16007	19884	29826
10	65150	5430	8145	8688	10046	10860	10969	11295	11566	13575	14444	17485	21720	32580
11	70650	5888	8832	9421	10893	11776	11894	12248	12542	14720	15663	18960	23552	35328
12	76150	6346	9519	10154	11741	12692	12819	13200	13517	15865	16881	20435	25384	38076
Ea Add'l	5500	459	689	735	850	918	928	955	978	1148	1221	1478	1836	2754

BILLING REQUIREMENTS:

Business office Director 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 free 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 free 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 any charge for care that is reduced but not free payment or free care.
 - b. The name and number of the then current patient financial counselor and the business office for further information about the hospital’s financial assistance and charity care policy, and how to apply for assistance.

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

HOMELESS PATIENTS:

Emergency room patients without a payment source may be classified as in need of financial assistance if they do not have a job, mailing address, residence or insurance. Consideration must be given to classifying (Emergency Room Only) patients who do not or cannot provide adequate information as to their financial status.

SOUTHERN INYO HEALTHCARE EMPLOYEES

Southern Inyo Healthcare Employees may apply for Financial Assistance or qualify for the standards employee discount but may not qualify for both.

SPECIAL CIRCUMSTANCES:

- A. Responsible party of deceased patients without estate or third-party coverage will be eligible for financial assistance.
- B. Patients who are in bankruptcy or recently completed bankruptcy may be eligible for assistance.
- C. In rare occasions, the patients' individual circumstances may be such that while they do not have the ability to pay their hospital or clinic bill. In these situations, with the approval of Administrative, part or all of their cost of care may be written off to charity care.

POSTINGS AND OTHER NOTICES:

Information about Financial Assistance shall also be provided through clearly and conspicuously posted notices in locations that are visible to the public, including but not limited to the emergency department, billing office, admitting office, and other hospital outpatient service settings. This information shall also be available at [https:// www.sihd.org](https://www.sihd.org)

OTHER:**A.) BILLING AND COLLECTIONS POLICY:**

A separate Billing and Collections Policy describes actions Southern Inyo Hospital may take in the event of nonpayment.

B.) WHERE TO OBTAIN COPIES:

This Financial Assistance Policy, the Financial Assistance application, and the Billing and Collections Policy are available by calling Patient Financial Services at (760) 876 – 5501 and request a copy by mail or email or downloading online at <https://www.sihg.org> . Copies of policies and applications are also available in the Admissions areas and the Billing Office of Southern Inyo Hospital. English and Spanish translations are available at all locations.

C.) LANGUAGES:

all notices and communications provided shall be available in English and any other languages representing of 5% of the service populations and a manner consistent with all applicable federal and state laws and regulations.

D.) RECORDKEEPING:

Records relating to financial assistance must be readily accessible. Southern Inyo Hospital must maintain information regarding the number of uninsured patients who have received services, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied, and the reasons for the denial. In addition, notes relating to each financial assistance application and approval or denied should be entered into the patient's account.

E.) NO MISREPRESENTATION:

Southern Inyo Hospital or it's agents shall not misrepresent this policy to its patients or its patients' guarantors in any way.

F.) EMERGENCY PHYSICIANS:

An emergency physician, as defined in California Health and Safety Code § 127450, who provides emergency medical services at Southern Inyo Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.

G.) SUBMISSION TO HCAI:

Southern Inyo Hospital shall upload copies of this Financial Assistance Policy to the Department of Health Care Access and information, or “HCAI”. The policy shall be submitted in the manner and frequency prescribed by HCAI.

H.) PATIENT CONFIDENTIALITY:

All patient financial information obtained for the purpose of determining charity care, patient discounts, and billing and collections are required to be kept in strict confidence. Disclosure of such information is limited to those participating in the evaluation of a patient’s eligibility for financial assistance. Unauthorized disclosure of a patient’s confidential financial information is strictly prohibited and subject to disciplinary action to be determined by the CEO.

I.) CONTACT FOR INFORMATION AND ASSISTANCE:

Additional information from the Billing Department:

☐ Calling: (760) 876 – 5501

☐ Visiting the Business Office at Southern Inyo Hospital at 501 E. Locust St.
Lone Pine, California 93545

J.) SHOPPABLE SERVICES: The link to our Patient Price Estimator can be found at:

<http://www.sihd.org>

NOTICE OF DETERMINATION:

A.) TIMELINE FOR DETERMINATION: While it is desirable to determine the amount of financial assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent; in other cases, further investigation is required to determine eligibility. In some cases, a patient eligible for Financial Assistance may not have been identified before initiating external collection action. Southern Inyo Hospital external collection agency shall be

made aware of this policy so that the agency knows to refer back to the hospital patient accounts that may be eligible for Financial Assistance.

B.) NOTIFICATION LETTER: Once a Full or Partial Charity Care or High Medical Cost Charity Cost determination has been made, a “Charity Notification Letter” will be sent to each applicant advising them of Southern Inyo Hospital’s decision.

C.) DISPUTE RESOLUTION: In the event of a dispute over the application of this policy, a patient may seek review from the hospital by notifying the Southern Inyo Hospital CEO, Compliance (760) 876 – 5501, or designee at (760) 876 – 5501 ex.2207, of the basis of any dispute and the desired relief. Written communication should be submitted within thirty (30) days of the patient’s notice of the circumstances, giving rise to the dispute. The CEO or designee shall review concerns and inform the patient of any decision in writing.

REFERENCE:

1. California Health and Safety Code Section 127400-127446
2. CA AB 1020
3. Title 22 of the California Code of Regulations (CCR) section 96040-96051.37, et seq.)
4. California Senate Bill 1061 (SB 1061)
5. Hospital Fair Pricing Act (AB 774)
6. Fair Debt Collection Practices Act (FDCPA)
7. Fair Credit Reporting Act (FDRA)
8. No Surprises Act
9. Medicare CMS Manual 15: The Provider Reimbursement Manual.

RECORD RETENTION AND DESTRUCTION:

Maintain all patient accounting records for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Billing and Collection
2. Price Transparency
3. Credit Balance Refund Processing
4. Prompt Pay Discount

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