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Policy Title: Financial Assistance Policy aka Sponsor Care and Discount Payment policy		Policy # AD-1030
Department: Patient Business Services		
Target Audience: Patients & Hospital Staff		
Policy Lead: Director, Revenue Cycle		
Effective date: Month/Year: 1/2022		Next Review Date: Month/Year: 1/2027

PURPOSE

Community Hospital of the Monterey Peninsula (Community Hospital) provides financial assistance to eligible patients who cannot pay all or part of their hospital bill. This policy explains who may qualify, which services are covered, how to apply, how eligibility decisions are made, how discounts are calculated, and how a patient may appeal a decision.

SCOPE

This policy applies to emergency and medically necessary services provided and billed by Community Hospital and to services of participating hospital-based providers identified by Community Hospital. It applies to current and prospective patients, uninsured patients, and insured patients with high medical costs or other eligible patient responsibility amounts. A current list of participating and nonparticipating providers is available on the hospital website and from Patient Business Services.

California emergency physicians who provide emergency services at the hospital must provide discounts to uninsured patients and patients with high medical costs whose family income is at or below 400% of the Federal Poverty Level (FPL), as required by California law. Emergency physician services billed separately from Community Hospital may be subject to the physician group's separate financial assistance process.

DEFINITIONS

Amount Generally Billed (AGB): The amount generally billed to patients who have insurance coverage for emergency or medically necessary care. Community Hospital calculates AGB using the prospective Medicare method described in 26 C.F.R. § 1.501(r)-5(b)(4). Patients may request the current AGB calculation from Patient Business Services.

Charity Care / Sponsored Care: Free care. The patient receives a 100% discount on the eligible amount owed for covered services.

Discount Payment: A reduction of the amount the patient owes, but not free care.

Disabled: A person who meets the disability standard applicable under federal or California law for purposes of determining family composition and financial assistance eligibility.

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Eligibility Qualification Period: The period during which an approved financial assistance determination applies. Unless a shorter period is required because of a documented change in circumstances, an approval applies for 12 months and to eligible outstanding accounts for covered services received before the application date. Patients may request reevaluation whenever their financial circumstances change.

Emergency Medical Condition: A medical condition within the meaning of the Emergency Medical Treatment and Labor Act and other applicable law.

Family: For a patient age 18 or older, except a dependent patient age 18 through 20, family includes the patient, the patient's spouse or registered domestic partner, dependent children under age 21, and dependent children of any age who are disabled, whether living at home or not. For a patient under age 18, or a dependent patient age 18 through 20, family includes the patient's parent or parents, caretaker relatives, and the parent's or caretaker relative's other dependent children under age 21 or of any age if disabled. A person claimed as a dependent under applicable tax rules may be included when determining eligibility.

Family Income: Income received by members of the patient's family before taxes. It may include earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance cash payments, veterans' payments, survivor or disability benefits, pensions, retirement income, interest, dividends, rents, royalties, income from estates or trusts, alimony, child support, and other cash income. Noncash benefits, such as Medi-Cal, Medicare, food benefits, housing assistance, school meals, foster-care payments, and disaster-relief assistance, are not counted as income. Community Hospital may annualize current income and will use reasonable current information when income has materially changed.

Federal Poverty Level (FPL): Income guidelines published annually by the federal government and used with family size to determine eligibility.

Financial Assistance: Sponsored Care, Discount Payment, Presumptive Charity Care, and other assistance provided under this policy.

Guarantor: A person who has legal financial responsibility for a patient's healthcare services.

High Medical Costs: For an insured patient, annual out-of-pocket costs incurred at Community Hospital that exceed the lesser of 10% of the patient's current family income or 10% of the patient's family income during the prior 12 months. A patient may also qualify when annual out-of-pocket medical expenses paid by the patient or family

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exceed 10% of family income and the patient provides reasonable documentation of those expenses.

Insured Patient: A patient who has commercial, governmental, employer-sponsored, or other third-party health coverage.

Medically Necessary: Services that a qualified healthcare professional determines are needed to diagnose or treat a medical condition and are consistent with generally accepted standards of care.

Monetary Assets: Cash, savings, investments, and similar assets. Community Hospital does not use monetary assets to decide eligibility under this policy.

Presumptive Charity Care: Financial assistance approved without a completed application when reliable information supports the patient's eligibility or financial hardship.

Uninsured Patient: A patient who has no third-party coverage for the services at issue.

POLICY

Community Hospital provides financial assistance for emergency and medically necessary hospital care. Every patient will be treated with dignity and respect. This policy is applied without discrimination based on race, color, national origin, citizenship, religion, sex, gender identity, sexual orientation, age, disability, or any other status protected by law.

- Patients may request assistance before, during, or after care. There is no deadline for applying for charity care or discounted payment.
- Eligibility is based on family income and family size. Monetary assets are not considered.
- Patients may be informed about Medi-Cal, Medicare, Covered California, or other coverage. Applying for those programs is encouraged but is not required before Community Hospital screens a patient for or provides financial assistance.
- A pending application for another coverage program will not delay the hospital's financial assistance review.
- When a patient qualifies for more than one program, Community Hospital applies the greatest assistance available under this policy.

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Financial Assistance Programs

Sponsored Care (Charity Care)

Patients with family income at or below 300% FPL may qualify for a 100% discount on the eligible amount they owe for covered services.

Discount Payment Program

Uninsured patients and insured patients with high medical costs whose family income is at or below 400% FPL are eligible for discounted payment. For patients from 301% through 400% FPL, Community Hospital limits the expected payment for covered services to the amount it would expect, in good faith, to receive from Medicare or Medi-Cal, whichever is greater. The patient will never be charged more than AGB for covered emergency or medically necessary care. The award letter will show the charges, calculation, discount, and remaining patient responsibility.

Assistance Above 400% FPL

Community Hospital may approve assistance above 400% FPL based on the patient's circumstances and approved hospital terms. Under the current program design, eligible patients above 400% but below 500% FPL may receive a 25% discount and an interest-free payment plan. This discretionary assistance does not reduce the assistance available to patients at or below 400% FPL.

PROCEDURE

1. Identify Potential Eligibility

- The care was emergency care or medically necessary care provided and billed by Community Hospital or a participating hospital-based provider.
- The patient is uninsured, or the patient is insured and has high medical costs or another eligible patient responsibility amount.
- The patient's family income meets the applicable program limit.

Financial assistance may apply to patient amounts not reimbursed by insurance or another health coverage program, including Medicare copayments or Medi-Cal cost sharing, when allowed by law.

2. Make Applications Available

Patients may apply before, during, or after care. Applications and assistance are available from Patient Access, Patient Business Services, registration areas, and the

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hospital website. Community Hospital will provide free language assistance and reasonable help completing the application.

1. Complete the financial assistance application or ask staff for assistance.
2. Provide recent pay stubs or a recent income tax return, if available.
3. If standard documents are unavailable, provide other reasonable information showing current family income. Community Hospital will not require a specific alternative document when reasonable information is available.
4. Return the application to Patient Access before or during care, or to Patient Business Services after care.

An incomplete application will remain available for completion. Community Hospital will make reasonable efforts to obtain missing information. The timing of an application will not by itself be used to deny assistance.

3. Review Eligibility

- Determine family size using the definition in this policy.
- Determine current family income and compare it with the current FPL.
- For an insured patient, apply the High Medical Costs test using the lower of current family income or family income during the prior 12 months.
- Confirm that the services are emergency or medically necessary and covered by this policy.
- Review income documents and other reasonable information. Do not consider monetary assets.

Community Hospital will send a written determination that explains the assistance approved, the calculation used, any remaining amount owed, the effective qualification period, or the reason for denial. The notice will explain how to request review or appeal.

4. Presumptive Charity Care

Community Hospital may approve financial assistance without a completed application when reliable information supports eligibility or hardship. Examples include:

- Enrollment in CalFresh, CalWORKs, WIC, General Assistance, or another means-tested public benefit program.
- Homelessness or lack of a permanent address.
- A prior financial assistance approval within the past six months.
- Active Medicaid coverage or documented Medicaid eligibility, when appropriate.
- A deceased patient with no surviving spouse and no estate.
- A reliable third-party screening result or other information supporting financial hardship.

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A third-party screening tool may not use monetary assets. It may not shift valid insurance or third-party payment responsibility to the patient while claim processing, coordination of benefits, or third-party liability remains unresolved. Community Hospital will notify the patient of a presumptive determination. If presumptive assistance is less than 100%, the patient may submit an application or additional information for greater assistance.

5. Payment Plans

Every patient approved for Discount Payment may request an interest-free extended payment plan. Community Hospital and the patient will negotiate the plan based on family income and essential living expenses. If the parties cannot agree, the monthly payment will not exceed 10% of the patient's monthly family income after essential living expenses. If payments are missed for 90 consecutive days, Community Hospital will attempt to contact the patient and renegotiate the plan before ending it or beginning permitted collection activity.

6. Collections and Later Discovery of Eligibility

- Community Hospital follows AD-1031 and applicable federal and California patient-protection laws.
- Collection activity will be suspended while a financial assistance application or appeal is under review or while required additional information is being timely provided.
- Community Hospital will not begin prohibited civil action or adverse collection activity before the waiting period required by law.
- Patient debt will not be sold unless all statutory conditions are met.
- If Community Hospital or a collection agency later learns that a patient may qualify, the account will be returned for review. If approved, the hospital will apply the appropriate adjustment and reverse related bad-debt classification as required.

7. Refunds

If a patient paid more than the amount due after financial assistance is applied, Community Hospital will refund the excess when required by law. Applicable interest begins on the date Community Hospital received the payment. Community Hospital will issue the refund within 30 days after eligibility and the refund amount are determined. Refunds of \$5.00 or less are not required unless otherwise required by law. Community

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Hospital is not required to reimburse a payment when five years or more have passed since the patient's last payment, unless otherwise required by law.

8. Appeal or Dispute

A patient may request review by sending a written request and any additional information to Patient Business Services. Community Hospital will not deny review solely because the request was made after 30 days.

- The Customer Service Supervisor completes the first review.
- If the decision changes, Patient Business Services updates the application and account.
- If the original decision remains, the Director of Revenue Cycle or designee completes a second review and sends a written response.

Patients who believe financial assistance was wrongly denied may also contact the California Hospital Bill Complaint Program.

9. Patient Notification and Access

Community Hospital will make financial assistance information available through the hospital website, registration and intake locations, the emergency department, Patient Business Services, discharge notices or after-visit summaries, billing statements, conspicuous hospital postings, telephone assistance, the plain-language summary, and required translated materials and taglines.

Free language help and aids for people with disabilities are available, including interpreters and documents in braille, large print, audio, and accessible electronic formats. Patient-facing documents must use a sans serif font of at least 12 points, logical heading structure, correct accessibility tags, and a logical reading order.

- Before or during care: Patient Access, (831) 625-4910.
- After care: Patient Business Services, (831) 625-4922.
- Patient Business Services office: 23625 Holman Highway, Monterey, CA 93942, Monday through Friday, 8:00 a.m. to 4:30 p.m.
- Health Consumer Alliance: 888-804-3536; healthconsumer.org.
- Hospital Bill Complaint Program: HospitalBillComplaint.hcai.ca.gov. This state program reviews hospital decisions about whether a patient qualifies for help paying a hospital bill.

10. Policy Maintenance and HCAI Submission

Community Hospital will review this policy at least annually and submit it to the California Department of Health Care Access and Information every two years or

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whenever a significant change requires submission. Clean and marked-up versions and related patient-facing materials will be submitted when required. The discharge notice and required tagline sheet must include English and the top 15 languages required by 22 CCR § 96051.1(b), including Thai.

STAKEHOLDERS

- Director, Revenue Cycle
- Patient Access
- Patient Business Services
- Hospital registration areas
- Compliance and Legal
- Quality Department
- Participating hospital-based providers
- Patients and guarantors

RELATED DOCUMENTS/LINKS

- AD-1029, Sponsored Care and Discount Payment Program
- AD-1031, Collection Policy
- Financial assistance application
- Plain-language summary
- HCAI-required discharge notice and tagline sheet
- Participating and nonparticipating provider list
- Hospital website financial assistance resources
- Current AGB calculation

REGULATORY

- California Health and Safety Code sections 127400 through 127446, as amended.
- Title 22, California Code of Regulations sections 96051 through 96051.37.
- Internal Revenue Code section 501(r) and related regulations, including 26 C.F.R. § 1.501(r)-5.
- Emergency Medical Treatment and Labor Act, as applicable.

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REFERENCES

- California Department of Health Care Access and Information, Updated Compliance Determination and Revision 2 Compliance Review Report dated February 12, 2026.
- Federal Poverty Guidelines, updated annually.
- Community Hospital's adopted AGB methodology.
- Stanford Health Care Financial Assistance Policy, used as an organizational and readability benchmark only.

APPENDIX

Appendix A: Patient contact information, current FPL tables, provider lists, AGB calculation, translations, and other patient-facing materials are maintained as controlled related documents. They must remain consistent with this policy and current legal requirements.

POLICY ADMINISTRATIVE TABLE

CONTENTS	DESCRIPTION
Approving Committee(s) Authority:	Director of RCM & CFO
Approved by:	CFO
Revision History:	Reformatted into CHOMP Quality Department template and revised to address HCAI financial assistance policy requirements. [Insert approval date/version.]
Key Words:	Financial assistance; Sponsored Care; charity care; Discount Payment; high medical costs; FPL; HCAI; patient billing