

**Mountain Communities Healthcare District Trinity Hospital
Financial Assistance (Charity and Discount Care) Policy
Version 3, Effective October 01, 2025**

Policy Statement

The purpose of this policy is to establish guidelines for financial assistance for charity and discount care available at Mountain Communities Healthcare District, (herein referred to as MCHD).

Policy Interpretation and Implementation

This policy was interpreted and implemented in accordance with California Code of Regulations, Title 22, Division 7, Chapter 9.2, Hospital Fair Billing Program, California Health and Safety Code, Division 7, Part 2, Chapter 2.5, Hospital Fair Pricing Policies, and with National Health Service Corps (NHSC) program guidelines for Rural Health Clinics.

It is MCHD'S policy to provide patients, regardless of ability to pay, with understandable written information regarding Financial Assistance and to provide income-based Financial Assistance (Charity Care and Discount Care).

This policy applies to Mountain Communities Health Care District dba Trinity Hospital, Trinity Hospital Swing Bed, Trinity Community Health Clinic and Hayfork Community Health Clinic, and provider fees that are billed by MCHD for these facilities.

This policy does not apply to Mountain Communities Healthcare District dba Trinity Skilled Nursing Facility, or to provider services sent to and billed from separate outside providers. Examples of bills a patient may receive from outside providers are labs or pathology tests that cannot be performed in-house that are sent out for analysis to an outside laboratory.

Definitions

Charity Care means free care.

Discount Payment means charges are reduced but not free.

Eligible Charges means all MCHD facility and provider charges, including emergency physician fees. The only exclusions to eligible charges are send-out diagnostic testing and specialist fees. Emergency physicians, who provide emergency medical services in a hospital that provide emergency care are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the federal poverty level.

Eligible Patient means a patient, whether insured or not insured, that has a family income that does not exceed 400% of the federal poverty level.

Essential Living Expenses means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Federal Poverty Level (FPL) means the measure of income level published annually by the United States Department of Health and Human Services (HHS).

Financial Assistance means financial support provided to individuals and families based on their income levels.

Healthcare Services means all preventive, emergency, and medically necessary services that MCHD is licensed to provide, for the facilities listed under the Scope of this document.

Insured Patient means a patient who has a third-party source of payment for a portion of their medical expenses, including patients who are covered by Medi-Cal/Medicaid.

Medicare Interim Reimbursement Rates means a rate sheet supplied by Medicare indicating the reimbursement rates for outpatient hospital visits (based on percent of charges), per diem rates for inpatient and swing bed patients and all-inclusive rate for clinics. These rates are updated periodically. The date of service will be used to determine which Medicare Interim rate sheet will be used.

Out-of-Pocket Cost Expenses means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

Patient Responsibility means the amount that an Insured Patient is responsible for paying out-of-pocket after the patient's third-party coverage has determined the amount of the patient's benefits.

Primary Language of Healthcare's Service Area means a language used by the lessor of 1,000 people or 5% of the community served by the healthcare based upon the most recent community health needs assessment performed by healthcare.

Reasonable Payment Plan means monthly payments that are not more than 10% of a patient's family income for a month, excluding deductions for essential living expenses.

Self-Pay/Uninsured Patient means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance as determined and documented by the healthcare. Self-pay patients may include charity care patients.

Sliding Scale Fee means a payment model that adjusts healthcare costs based on a patient's income and family size. The sliding scale fee is based on the Federal Poverty Level table and is updated annually.

Determining Eligibility Types

During the application process, MCHD shall use the eligibility criteria below to determine the type of financial assistance, as explained below.

Private Pay Full Charity: A self-pay patient with a family income at or below 100% of the Federal Poverty Level, at the time of first billing. This means care is completely free for eligible charges with no nominal fee.

Private Pay Discount Care: A self-pay patient with a family income between 101% up to and including 400% of the Federal Poverty Level at the time of first billing. A discount will be applied according to MCHD's sliding fee scale in effect at the time of first billing. Patient responsibility will be reduced to Medicare interim reimbursement rates for eligible charges.

Insured Patient Full Charity Care: An insured patient with a family income at or below 100% of the Federal Poverty Level, at the time of first billing. Patient responsibility after insurance or third-party payer reimbursement is completely free for Eligible Charges with no nominal fee.

Insured Patient Discount Care: A patient with a family income between 101% up to and including 400% of the Federal Poverty Level, at the time of first billing. A discount will be applied to the patient's responsibility remaining after insurance or third-party payer reimbursement. The discount will be applied according to MCHD's sliding fee scale in effect at the time of first billing.

Calculating Family Income

- **Patient's Family Size:** The patient's family size shall be determined as follows:
 - For persons 18 years of age and older, spouse, domestic partners, dependent children under 21 years of age, or any age if disabled, whether living at home or not.
 - For person under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.
- **Proof of Family Income:** Patient shall only be required to provide pay stubs or tax returns as proof of income when applying for financial assistance. Family income is annual earnings of all members of the patient family from the prior twelve (12) months or prior tax year as shown by recent pay stubs or income tax returns, less payments made for alimony and child support. Recent tax returns are tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed. Recent Pay Stubs are pay stubs within a 6-month period before or after the patient was first billed by the healthcare facility, or in the case of preservice, when the application is submitted. Income included in this calculation is income such as, salaries, wages, and retirement income. Monetary assets are not to be included in the calculation for family income. MCHD may validate income by using external presumptive eligibility service providers, provided that such service only determines eligibility using only information permitted by this policy. Collected income information for Financial Assistance applications shall not be used for debt collection activities.

- **Calculating Family Income for Expired Patients:** Expired patients, with no surviving spouse, may be deemed to have no income for purposes of calculation of family income. Documentation of income is not required for expired patients. The surviving spouse of an expired patient may apply for Financial Assistance.
- **Calculating Family Income as a Percentage of FPL:** After determining family income, MCHD shall use the MCHD Sliding Scale Fee table during the time of first billing as the guide for eligibility and the amount of charity or discount.
- **Special Circumstance: Benefits Exhausted During Inpatient Stay:** When an Insured Patient's third-party coverage pays only a portion of the expected reimbursement for the patient's stay because the patient exhausted their benefits during the stay, the hospital should collect from the patient the balance of the expected reimbursement that would have been due from the third-party coverage if the benefits were not exhausted. MCHD shall not pursue from the patient any amount more than the amount that would have been due from the third-party coverage if the benefits were not exhausted, plus the patient's share of cost or coinsurance. A patient who exceeded their benefit cap during a stay is eligible to apply for Financial Assistance.
- **Medi-Cal/Medicaid Denied Patient Days and Non-covered Services:** Medi-Cal/Medicaid patients are eligible for charity care write-offs related to denied charges and non-covered services. These Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid patients are to be classified as charity, including share of cost.

Financial Assistance Exclusions/Disqualification

The following are circumstances in which Financial Assistance is not available under this policy:

- **Payer pays patient directly:** MCHD may require a patient or guarantor to pay the facility the entire amount of reimbursement sent directly to the patient or guarantor by a third-party payer for that service.
- **Information falsification:** MCHD may refuse to award Financial Assistance to patients who falsify information regarding family income, household size, or other information in their eligibility application.
- **Diagnostic test send-out services and specialists:** Outside contracted services, such as send-out laboratories, or specialist services are not covered under this policy. These providers will send a separate bill. Many healthcare providers offer charity care programs. Patients should inquire directly with the outside service provider about their charity program.

Application Process

1. A patient may apply, at any time, for financial assistance.
2. MCHD shall make all reasonable efforts to obtain from the patient or their representative information about whether private or public health insurance may fully or partially cover the charges for care rendered by MCHD to a patient.
3. Patients seeking Financial Assistance are not required to apply for Medicare, Medi-Cal, or any other insurance coverage. However, patients may be screened by MCHD for the Medicaid eligibility, with the authorization of the patient or patient guardian. All patients should be encouraged to investigate their potential eligibility for government program assistance if they have not already done so.
4. Patients may request assistance with completing the application for financial assistance in person at the MCHD Trinity Hospital, located at 60 Easter Avenue, Weaverville, CA 96093, over the phone at 530-623-5541 ext. 3217, or by mail at P.O. Box 1229, Weaverville, CA 96093. A copy of the application is also available [Mountain Communities Healthcare District Pricing Transparency](http://www.mcmedical.org/price-transparency) web page. (www.mcmedical.org/price-transparency).
5. Patients should mail applications for Financial Assistance to MCHD, P.O. Box 1229, Weaverville, CA 96093 Attn: Financial Counselor, or bring the application into the Financial Counselor or patient registration location at 60 Easter Avenue, Weaverville, CA 96093.

Financial Assistance Determination Process

1. MCHD will consider each application for Financial Assistance regardless of ability to pay and grant Financial Assistance when the patient meets the eligibility criteria set forth in the Eligibility section of this policy.
2. Patients also may apply for governmental program assistance, which may be prudent if the patients require ongoing services.
3. Employees should assist patients in determining if they are eligible for any governmental or other assistance, or if a patient is eligible to enroll with plans in the California Health Benefit Exchange (i.e., Covered California), if the patient agrees.
4. If a patient applies or has a pending application for another health coverage program while they apply for Financial Assistance, the application for coverage under another health coverage program shall not preclude the patient's eligibility for Financial Assistance.
5. Once a full charity care or discounted care determination has been made by the Financial Counselor, a notification form will be sent to the applicant advising them of the results of the charity/discount care decision.
6. Once an application is approved, a patient is presumed to be eligible for Financial Assistance for a period of one year after MCHD issues notification of the decision to the patient. After one (1) year, patients must re-apply for Financial Assistance.
7. If the Financial Assistance determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest in the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health and Safety Code section 127440.

Dispute Process

A patient may seek review of any decision by MCHD to deny Financial Assistance by notifying the Director of Revenue Cycle at MCHD or designee, of the basis of the dispute and the desired relief. Patients may submit the dispute orally, by calling 530-623-0278, or writing to P.O. Box 1229, Weaverville, CA 96093. The Director of Revenue Cycle at MCHD or designee shall review the patient's dispute as soon as possible and inform the patient of any decision in writing. Procedures for disputes can be found in MCHD's Billing and Financial Assistance Dispute Policy.

Availability of Financial Assistance Information

Languages: This policy shall be available in the Primary Language(s) of MCHD's Service Area. In addition, a tagline sheet with a statement for language assistance of, at least, the top fifteen languages in California as determined by the Department of Healthcare Services. The tagline sheet shall be included with policy notifications and communications, the first bill and with the final letter sent to the patient before the patient is sent to collections.

Information Provided to Patients During the Provision of Healthcare Services

- **Preadmission or Registration:** During preadmission or registration (or as soon thereafter as practicable) facilities shall provide all patients with a copy of a plain language summary of the Financial Assistance policy which also contains information regarding their right to request an estimate of their financial responsibility for services. All healthcare providers shall identify the department that patients can visit to receive information about, and assistance with applying for Financial Assistance.
- **Financial Counselors/Discharge Planners:** Patients who may be Self-Pay Patients shall be assigned financial counselors and/or discharge planners who shall visit with the patients in person at the healthcare. Financial counselors/discharge planners shall give such patients a Financial Assistance application, as well as contact information for healthcare personnel who can provide additional information about this Financial Assistance policy and assist with the application process.
- **Emergency Services:** In the case of emergency services, healthcare facilities shall provide all patients with a plain language summary of the Financial Assistance policy as soon as practicable after stabilization of the patient's emergency medical condition or upon discharge. In cases where the plain language summary cannot be given to the patient before discharge, the notice will be mailed to the patient within 72 hours of providing services.
- **Recording the Notice:** After supplying a patient with the Notice of Financial Assistance, registration personnel will place a label on the copy of the Notice and scan the notice into the patient's medical record.

- **Medicaid Applications:** All private pay patients will be given a Medi-Cal/Covered California application, screened for Healthcare Presumptive Eligibility, if patient agrees, or any other applicable application to help them with healthcare affordability.

Information Provided to Patients at Other Times

- **Billing Statements:** MCHD shall bill patients in accordance with the MCHD No Surprise Billing Policy. First correspondence with patients will include a plain language summary of the Financial Assistance policy and a Notice of Debt Collection Rights.
- **Contact Information:** Patients may call 1-530-623-5541 ext)3217 or go to MCHD Financial Counselor office or any MCHD patient registration area, located at 60 Easter Avenue, Weaverville, CA 96093 to obtain additional information about Financial Assistance and assistance with the application process.
- **Upon Request:** MCHD shall provide patients with paper copies of the Financial Assistance Policy, the application for Financial Assistance, the plain language summary of the Financial Assistance Policy, the Medi-Cal/Covered California application, a Notice of Debt Collection Rights, or an estimated cost of services upon request, without charge.

Publicity of Financial Assistance Information

- **Public Posting:** MCHD shall post copies of the Financial Assistance Notification Financial Assistance in a prominent location in the emergency department/outpatient admissions waiting room, other outpatient locations, the rural health clinics, and the billing department. These public notices shall include information about the right to request an estimate of financial responsibility for services.
- **Website:** The Financial Assistance Policy, application for Financial Assistance and plain language summary shall be available in a prominent place on [Mountain Communities Healthcare District Pricing Transparency Web Page](https://www.mcmedical.org/price-transparency) (<https://www.mcmedical.org/price-transparency>). People seeking information about Financial Assistance shall not be required to create an account or provide any personal information before receiving information about Financial Assistance.
- **Mail:** Patients may request a copy of the Financial Assistance Policy, application for Financial Assistance and plain language summary be sent by mail, at no cost to the Patient.

Miscellaneous

- **Recordkeeping:** Records relating to Financial Assistance must be readily accessible. MCHD must maintain information regarding the number of Self-Pay Patients who have received services from MCHD, the number of Financial Assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number of applications denied, and the reasons for denial. In addition, notes relating to a patient's approval or denial for Financial Assistance should be entered into the patient's account. All financial records for money owed to the hospital by a patient or a patient's guarantor must be kept for 5 years.
- **Payment Plans:** Patients may be eligible for a payment plan. Payment plans shall be offered and negotiated per the MCHD Payment Plan Arrangements policy. A Reasonable Payment Plan should be set at a maximum of 10% of the patient's Family Income minus Essential Living Expenses if the patient and the facility cannot agree upon another payment plan.
- **Billing and Collections:** MCHD may employ reasonable collection efforts to obtain payments from patients, including the use of a third-party collection agency. After 180 days of non-payment, non-response, or if an agreement was not agreed upon between the patient and the MCHD, the patient's account may be sent to a collection agency by the Financial Counselor, under the supervision of the Revenue Cycle Director. The collection agency may commence civil action. Medical debt will be excluded from consumer credit reporting. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by MCHD or by any collection agency engaged by MCHD. General collection activities may include issuing patient statements, phone calls, and letters to the patient or guarantor. Affiliates and revenue cycle departments must develop procedures to confirm that patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the patient. MCHD or collection agencies will not engage in any extraordinary collection actions (as defined by the No Surprise Billing policy and the Bad Debt Collections policy for MCHD). Copies of afore mentioned policies may be obtained free of charge on the MCHD website at [Mountain Communities Healthcare District Pricing Transparency Web Page](http://www.mcmedical.org/price-transparency) (www.mcmedical.org/price-transparency), or by calling 530-623-5541 ext. 3217, or within the patient registration areas, patient financial counselor office, or the business services office.
- **Submission to HCAI:** MCHD will submit Financial Assistance policies to the California Department of Health Care Access and Information (HCAI). Information can be located on the [HCAI Hospital Fair Pricing Policy Lookup website](https://hcai.ca.gov/affordability/hospital-fair-billing-program/hospital-fair-pricing-policy-lookup/) (<https://hcai.ca.gov/affordability/hospital-fair-billing-program/hospital-fair-pricing-policy-lookup/>).