Debt Collection Policy

Kindred Hospital Rancho

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Patients who do not meet the financial indigence criteria shall be billed privately. All such bills shall be subject to the below Section V. Patients who are eligible for Medicare Part B benefits shall be responsible for the coinsurance amounts in addition to amounts not covered under Part-B.

Section V

Hospital's Business Office staff shall evaluate each self-Pay accounts to determine whether they should be sent to legal counsel or to IVAR (a third-party collection vendor). IVAR generates statements and performs collection efforts for a period of 180 days.

Prior to commencing any collection activities, the Hospital or IVAR will provide the patient with a notice that advises the patient that nonprofit credit counseling services may be available in the area, and contains the following statement:

> State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov.

This notice must be included with any document indicating that the commencement of collection activities may occur.

Before assigning a bill to collections, or selling patient debt to a debt buyer, the Hospital shall send the patient a notice with all of the following information:

(1) The date or dates of service of the bill that is being assigned to collections or sold.

(2) The name of the entity to which the bill is being assigned or sold.

(3) A statement informing the patient how to obtain an itemized bill from the hospital.

(4) The name and plan type of the health coverage for the patient on record with the Hospital at the time of services, or a statement that the hospital does not have that information.

(5) An application for the Hospital's charity care and financial assistance.

(6) The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

If an account is deemed uncollectable it shall be returned to the CBO 180 days after being placed with IVAR and written-off. Bad debt will only be sold to third parties pursuant to a written agreement containing the conditions identified in 501(r) (6) and AB 1020, including those requirements set forth in sections 127400 *et seq.* of the California Health & Safety Code, and the terms of this policy, including the standards for an extended payment plan found in section III.D.

In no event shall bad debt of a patient be sold to a third party unless the patient has been found ineligible for financial assistance or the patient has not responded to any attempts to bill or offer financial assistance for 180 days. If a patient is found to be eligible for Medi-Cal after the patient's bad debt has been sold to a third party, the Hospital must notify the third party and instruct it to cease collection efforts and notify the patient that such steps were taken.

In no event shall a third party to which any bad debt has been sold use wage garnishment or a sale of a patient's primary residence as a means of collecting bad debt, except as expressly permitted under California Health & Safety Code section 127425(h)(2).

Neither Hospital nor any third party to which any bad debt has been sold will report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment until 180 days have passed since initial billing. (This time period shall be extended if the patient has a pending appeal for third-party coverage of the services.) If the Hospital learns during or after such a 180-day period that the patient is eligible for Medicaid, any information previously sent to a consumer reporting agency must be corrected within 30 days.