Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
DISTRICT OPERATIONS

ISSUE DATE:	**09/96**	**SUBJECT:**	**Charity Care, Uncompensated Care, Community Service**
REVISION DATE:	**08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15, 06/17, 02/22, 03/22, 7/2025**	**POLICY NUMBER:**	**8610-285**

Department Approval:	**08/25**
Administrative Policies and Procedures Committee Approval:	**08/22**
Finance, Operations and Planning Committee Approval:	**08/22**
Board of Directors Approval:	**08/22**

A. **PURPOSE:**

1. The purpose of this policy is to explain who can get help with their hospital bill and how to apply for help. This is for people who do not have health insurance or whose insurance does not cover all of their medical needs. Tri-City Medical Center (TCMC) has set rules and guidelines for how patients may apply to get help paying their bills. This help may be full Charity Care or Discounted Payment Program.
2. California's Fair Pricing Law requires hospitals to follow rules for giving discounts to patients and charity care to eligible patients. Hospitals must also have written policies explaining how they offer these discounts. This policy goes beyond what the law requires**.**

B. **POLICY:**

1. TCMC is committed to providing quality healthcare to everyone in the community. We offer Financial Assistance (Charity Care) for eligible patients who cannot pay for services that are medically needed. This help may be free or discounted if you can show financial hardship (you don't have enough money) or if your medical bills are very high.
2. All patients will be treated fairly and respectfully, no matter how much money they have, regardless of race, creed, color, sexual orientation, gender identity, immigrant status, where they come from religious affiliation, disability or age.
3. TCMC's Business Office staff can help you understand your options and help you apply for health programs at the city, state and federal level. If you do not have insurance or have limited coverage, we will inform you about our charity care and discount payment programs.
4. If you want financial help, you or your legal representative must give us information about your health benefit coverage that is insurance, financial status and important documentation which is necessary to determine your status relative to Tri-City Medical Center's Charity Care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided to us, will be confidential and your dignity will be maintained during this process.
5. Emergency room physicians that provide emergency care in a hospital must also give discounts to uninsured patients or patients with high medical bills at or below 400 percent of the federal poverty level. This statement shall not be taken to enforce any additional responsibilities upon Tri-City Medical Center.

6. All collection agencies working on behalf of Tri-City Medical Center shall comply with the California Fair Pricing Law.
7. Without the completion of an application for financial assistance, Tri-City Medical Center, at its discretion, may approve financial assistance outside the scope of this policy. Discretionary full or discounted payment adjustments include, but are not limited to, a history of non-payment on the patient account balance, where referral to an outside collection agency would not result in a payment on the patient account, the social situation of the patient, and patients/guarantors who cannot be located**.**

C. **KEY DEFINITIONS AND ELIGIBILITY (WHO CAN GET HELP):**

1. Charity Care - means 100% free medical care for medically necessary services provided at Tri-City Medical Center.
2. Discounted Payment Program – means any charge for care that is reduced but not free.
    a. Special Circumstance Charity Care – If you do not fit other rules but have a tough situation, such as bankruptcy and not having a home, you may still get help.
    b. The following may qualify for special circumstance Charity Care:
        i. Bankruptcy: Patients who are in bankruptcy or have recently finished bankruptcy.
        ii. Homeless / Unhoused: Patients with no home address or place to live, or when they hospital cannot reach them even after trying.
        iii. Deceased Without Estate: Patients who have died and do not have an estate (money or property left behind) or third-party coverage.
        iv. MediCal / Medicaid Denials: Patients who should be covered by MediCal or Medicaid usually assumed to qualify for full Charity Care, especially if:
            1) Their coverage is limited or restricted
            2) The hospital gets a denial for Treatment Authorization Request (AR), medical necessity, or bills (including if the bills were filed too late e.g., untimely filing)
        v. Exceeding Length-of-Stay Limits: When patients on MediCal / Medicaid or other state or county programs are charged for days in the hospital that are over the allowed limit.
        vi. Non-Covered Services for MediCal / Medicaid Eligible: Services that are not paid for under Medical or Medicaid, for patients who are otherwise eligible.
        vii. Non-Contracted Insurance: Patients whose insurance is not accepted at the hospital such as:
            1) Medicaid from another state
3. Insurance companies not partnered with the hospital who then deny the patient's claim. These categories are common in California hospitals, but they don't cover every possible situation. Other cases may also qualify, depending on the hospital's own rules and decisions.
4. Federal Poverty Level (FPL) – The amount the government sets as a measure of low income.
5. High Medical Cost Patient – If your out-of-pocket medical bills are more than 10% (ten percent) of your family income, or if your family earns 400% (four hundred percent) or less of the FPL. An insured patient with high medical costs (coinsurance, deductible, and/or reached a lifetime limit, non-covered relating to services not medically necessary)
    a. High Medical Cost Indicator:

i. Annual out-of-pocket costs incurred by the patient, at Tri-City Medical Center, that is more than 10% of the patient's family income in the prior 12 months.
ii. Annual out-of-pocket medical expenses by the patient that more than 10% 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.
iii. Annual family income that is not more than 400% of the annual poverty level.

6. Medically Necessary – Healthcare service that is reasonable and necessary to either:
   a. Protect life
   b. Prevent significant illness or significant disability,
   c. To alleviate severe pain
   d. To prevent diagnose or treat an illness, injury, condition or disease, the symptoms of an illness, injury, condition or disease
   e. Meets accepted standards of medicine
7. Patient's Family and Determination of Family Income
   a. Adults Patients: Patients over 18 years of age. The patient family includes their spouse or domestic partner and dependent children under 21 years of age (whether living at home or not) as well as dependent children of any age if disabled.
   b. For Patients:
      i. Under 18 years of age or 18-20 years of age or
      ii. Who are 18 to 20 years of age and are a dependent child, the patient's parents or caretaker relative, if those children are disabled.
8. Documentation of family income shall be limited to 6 recent pay stubs or Tax Return Form 1040 for the current year. The patient's assets or the assets of the patient's family may not be considered.
9. Reasonable Payment Formula - Monthly payments that are not more than 10% of a patient's family income for a month, after subtracting costs for basic needs.
   a. "Essential living expenses" means the costs of the following**:** rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
10. Self-Pay / Uninsured Patient - Someone with no insurance for their bill. Self-Pay patient is a patient who does not have third-party coverage from a health insurer, health care service plan, Federal healthcare program, workers' compensation, medical savings account, or other coverage for all or any part of the bill, including claims against third parties covered by insurance, automobile insurance or other insurance as determined and documented by TCMC.
11. Third Party Coverage – Any insurance or program that help pay your bill, like policy of insurance or other prepaid coverage purchased for protection against certain events, such as health, automobile and general liability insurance.
12. High Medical Cost Charity Care - Refers to a write-off of a High Medical Cost Patient's remaining financial responsibility after payment is made by a third-party source of payment for Medically Necessary Services (e.g., not a Self-Pay Patient), that relieves them of their financial obligation for Medically Necessary Services

D. **DISCOUNT TABLE FOR MEDICALLY NECESSARY SERVICES:**

Income Level Based on Federal Poverty Level	Discount Amount Medically Necessary Services
Up to 400% of FPL	100% Discount
401% to 500% FPL	75% Discount
Over 500% of FPL	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

a. Everyone registered without insurance will be registered as a self-pay or MediCal / Medicaid-pending patient, and a MediCal / Medicaid application should be taken.
b. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Financial Assistance Application Form (FAAF).
c. If the patient does not qualify for charity or MediCal / Medicaid, payment will be required in advance of the service.
d. If a charity determination is made and partial payment is required, payment is due in advance of service.
e. Charity determinations over $25,000 require the approval of the Chief Financial Officer or their designee.

2. Application - Except in those instances where Tri-City Medical Center has determined that minimal application and documentation requirements apply, in order to qualify for Charity Care, a FAAF should be completed.
   a. Family Members – Patient will be required to provide the number of family members in their household as defined in this policy
   b. Income Calculation
      i. For adult patients, this includes the combined gross income of the patient and their spouse or domestic partner.
      ii. For minor patients, this includes income from the patient (if any), and from their parent(s), legal guardian, or domestic partner of a parent or guardian.
   c. Income verification – Patients will be required to verify the income set forth in the FAAF. Income documentation will include Tax Return Form 1040, 6 recent paycheck stubs, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, MediCal / Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.
   d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:
      i. Expired patients: Expired patients may be deemed to have no income.
      ii. Written Attestation: Patient can sign the FAAF attesting to the accuracy of the income information provided.
      iii. Verbal Attestation: Tri-City Medical Center financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.

3. Patients who choose not to provide the financial information requested by a Tri-City Medical Center financial counselor will be informed that their application for Charity Care cannot proceed without this information. If they do not comply, no further consideration will be given to their Charity Care request, and standard Accounts Receivable follow-up will continue.
4. Extended Payment Plans, without interest charges, will be made available and negotiated between Tri-City Medical Center and the patient to allow the patient who is eligible for Discount Payment Program to pay over an extended period of time. If Tri-City Medical Center and the patient cannot agree to a payment plan, Tri-City Medical Center will use the "reasonable payment plan" formula to determine the payment plan.
5. California Health Benefit Exchange – Tri-City Medical Center will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third-party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or County-funded health coverage program.
6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for Charity Care or a discounted payment program, neither the Charity Care, discounted payment program, nor health care coverage program applications preclude eligibility for the other program.
7. All internal and external collection activity will be based on the written procedures contained herein. Tri-City Medical Center will maintain a written agreement from any external agency that collects debt that the external agency will adhere to Tri-City Medical Center's standards and practices. Specifically, the external collection agency will comply with the definition and application of Tri-City Medical Center's reasonable payment plan, defined herein.

E. **ELIGIBILITY PERIOD (HOW LONG THE HELP LASTS):**

1. The financial help (Financial Assistance adjustment) will be used for all medical bills that qualify**,** including bills received before the application approval dates.
2. The financial assistance approval is good for 180 days, after the approval is granted
3. For bills received after 180 days from when the financial assistance is approved, a separate Financial Assistance Application will need to be filled out if the patient is seeking financial assistance to pay those bills.

F. **NOTIFICATION**

1. Timeframe - There is no fixed deadline for making charity care decisions (determination). Sometimes, financial help is given after a bill goes to collections.
   a. In some cases, a patient eligible for Charity Care may not be identified prior to the initiation of collection action.
   b. TCMCs collection agencies shall be made aware of this procedure so that the agencies know to refer back to Tri-City Medical Center patient accounts which may be eligible for Charity Care.
2. Once a full or Discount Payment Program determination has been made, a written notification will be sent to the patient that is advising them of Tri-City Medical Center's decision.

G. **COMMUNICATION:**

1. Patient:

a. When you register at the hospital, or soon after, you will get written information about Charity Care programs and contact details if you need more information. This information is also on Tri-City Medical Center's website and at your request.
b. All patient statements to people without insurance will include information about how to get help and other insurance options. This information will be provided in your main language.
c. Notices about charity care are posted clearly where patients register.

2. Postings and Other Notices – Information about Charity Care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

H. **FORMS/RELATED DOCUMENTS:**

1. Patient Financial Assistant Form - Sample

I. **REFERENCE:**

1. California Health and Safety Code, Section 127400, et. Seq
2. Affordable Care Act provisions, IRC §501

Tri-City Medical Center

Financial Assistance Application Form

Financial Assistance (Charity Care) is available to you if you don't have the resources to pay your hospital expenses and don't qualify for any government programs. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability after their insurance has paid will be screened for charity care. If you need assistance in completing the form please (760) 940-5912.

Instructions for Completing the Application for Financial Assistance:

Financial Assistance Qualifications: All application funding sources must be complied with and determined prior such as Medi-Cal and other state or county programs. Your financial assistance application may be pended if you have applied for another health coverage program at the same time until the outcome for that application has been determined.

Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level.

Patients who are covered by insurance but have (i) family income at or below 400% of the federal poverty level; **and** (ii) medical expenses for themselves or their family (incurred at the hospital affiliate or paid to other providers in the past 12 months) that exceed 10% of the patient's family income.

Patients who are covered by insurance but exhaust their benefits either before or during their stay at the hospital, and have a family income at or below 400% of the federal poverty level.

Proof of Income Required:

Along with your application, please attach the following information or an explanation as to why this information is not available. Missing documentation may delay the process of your application and could result in a denial for financial assistance.

Current employer's six (6) months of recent pay stubs or other statements of income for all family members

Tax Return Form (1040) for current year.

Once completed, the application and supporting documents can be submitted to any registration team member, cashier, or patient financial services team.

Financial Assistance Notification Process:

Once the eligibility process is complete you will receive a financial assistance notification letter in the mail. The form will indicate if you are eligible for full or Discounted Payment Program. You may receive a notification that you are ineligible for financial assistance or that more information is needed to decide e.g., determination.

Sincerely,
Tri-City Medical Center - Financial Assistance Team

Tri-City Medical Center

Financial Assistance Application Form

Application Date: _____

Patient Information

Patient Name (Last, First)	Date of Birth:
Street Address	Phone Number:
City, State, Zip Code	Medical Record or Account Number

Spouse or Parent/Guardian (If patient is less than 18 years old) Information

Name (Last, First)	Date of Birth:
Street Address (if not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Parent Information (If patient is less than 18 years old)

Name (Last, First)	Date of Birth:
Street Address (If not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Additional Questions (Please circle Yes or No)

1. Was the patient a resident of California at the time of service?	Yes	No
2. Did the patient have medical insurance at the time of service?	Yes	No
3. Was the patient an active Medicaid recipient at the time of service?	Yes	No
4. Were your injuries caused by a third party (such as during a car accident or slip and fall?)	Yes	No
5. Do you have other insurance that may apply (such as an auto policy)?	Yes	No
*If you answered Yes to questions 2 or 5, please attach a copy of your insurance or Medicaid card to this application.		

Family Household/Dependents (List the number of family members who live in your home)

Name	Relationship to Patient	Age

Tri-City Medical Center

Monthly Gross Income (List ALL adult income from family members in the household)

Monthly Gross (Before Taxes) Income Sources	Patient	Family Members
Employment/Self Employment	$	$
Social Security	$	$
Disability	$	$
Unemployment	$	$
Pension, Retirement, Annuity	$	$
Alimony/Child Support	$	$
Other	$	$
Total Combined Monthly Income: $		
If you do not have monthly income, please attach a written statement explaining how you or the patient are taking care of your monthly expenses including who provides food, shelter, transportation, etc., and how long you have been without income.		

SIGNATURE

My signature below certified that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant Name **Applicant Signature** **Date**
(Printed Name)

Please send your completed application and required documents to:

Tri-City Medical Center
Patient Accounting
4002 Vista Way | Oceanside, CA 92056
760-940-7329

Tri-City Medical Center

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty Guidelines (100%)	Poverty Guidelines (400%)
1	$0 - $15,650	$62,600
2	$0 - $21,150	$84,600
3	$0 - $26,650	$106,600
4	$0 - $32,150	$128,600
5	$0 - $37,650	$150,600
6	$0 - $43,150	$172,600
7	$0 - $48,650	$194,600
8	$0 - $54,150	$216,600
For families/households with more than 8 persons, add $6,880 for each additional person.		