



FINANCIAL ASSISTANCE POLICY

EASTERN PLUMAS HEALTH CARE BUSINESS OFFICE - EFFECTIVE: 5/12/2025

1. Purpose

This policy describes Eastern Plumas Health Care's Financial Assistance (Charity Care and Discounted Care) policy. Eastern Plumas Health Care ("EPHC") provides Financial Assistance to patients and families when they are unable to pay all or part of their medical bill, based on the standards below. This policy describes how EPHC reviews a patient's financial resources to determine if Financial Assistance can be provided. The intent of this policy is to comply with applicable federal, state and local laws and regulations. EPHC does not discriminate and is fair in reviewing and assessing eligibility for Financial Assistance for community members who may be in need of financial help.

2. Overview

EPHC is committed to providing Financial Assistance to patients of the hospital district who seek needed healthcare services but have limited, or no means, to pay for that care. Financial Assistance is comprised of Charity Care (free care) and Discounted Care. EPHC determines eligibility for Financial Assistance based on: (1) Family Income, (2) type of service requested, (3) the availability of other health coverage/insurance, and (4) whether the patient has high medical costs or expenses. This policy describes the eligibility criteria and the level of Financial Assistance that will be offered to patients meeting specified criteria.

Charity Care and Discounted Care are not substitutes for personal responsibility. Patients are encouraged to cooperate with the EPHC procedures for obtaining Financial Assistance.

Persons must help pay for the cost of their care based on their ability to pay.

All patients will be notified of the Financial Assistance Policy and how to access the Financial Assistance Application. Patients may request Financial Assistance by submitting an application with supporting documentation, as applicable. EPHC will apply the standards in this policy to make a determination on each application for Financial Assistance and shall notify each applicant of its determination. Applicants dissatisfied with the determination can appeal the determination to EPHC. The collection of any remaining patient financial responsibility shall be subject to the EPHC's Billing and Collections Policy.

EPHC provides, without discrimination, care for emergency medical conditions to individuals regardless of whether they are eligible for assistance under this policy, as detailed in Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations (or any successor regulations).

3. Who is covered under this Financial Assistance Policy

Financial assistance is available to uninsured or underinsured individuals experiencing high medical expenses or costs who have a household income at or below 400% of the federal poverty guidelines.

4. What's covered under this Financial Assistance Policy

Financial Assistance pursuant to this Policy includes health care services provided at EPHC. These health care services include the services of physicians who render services at EPHC, including emergency room physicians. EPHC's emergency physicians are required to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the Federal Poverty Level, pursuant to California law and this policy.

Please note that some services are excluded from this policy, such as care that is not Medically Necessary or purchases from EPHC's retail operations, such as gift shops and cafeteria.

5. Applying for Financial Assistance

a. Access to Financial Assistance Policy and Application

EPHC makes information about its Financial Assistance Policy and Application available through numerous means in compliance with applicable state and federal laws and regulations. Information about this policy is available on the hospital's website home page and on any website where the patient pays a bill or accesses information about the patient's account, posted in hospital areas that are accessible to the public, such as the emergency department, on each billing statement, and by plain language summaries provided to all patients. Hospital personnel shall direct patients, guardians, or family members who request Financial Assistance or information about Financial Assistance, or who the hospital personnel believe may be eligible for Financial Assistance to Patient Financial Services Department to receive a paper copy of this Policy and an application form.

An explanation of EPHC's Financial Assistance Policy and the related application form are available at <https://www.ephc.org>

b. Other Forms of Health Coverage

EPHC shall make all reasonable efforts to obtain from the patient or the patient's representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient.

Patients may be able to access affordable insurance options, including:

- Private health insurance, including coverage offered through the California Health Benefit Exchange.
- Medicare
- The Medicaid program, the California Children's Services program, or other state-funded programs designed to provide health coverage.

If a patient applied or has a pending application for another health coverage program at the same time that the patient applies for Financial Assistance, neither application will stop eligibility for the other program.

Financial Assistance does not relieve the patient or guarantor's responsibility to ensure payment for health care services. EPHC encourages patients to cooperate with

EPHC to find other sources of payment, or coverage, from public and/or private payment programs. The patient or guarantor is responsible for meeting the conditions of coverage of their insurance or health plan if they have third-party insurance or health plan.

c. Application Process

To be considered for Financial Assistance under this policy, a patient or guarantor must submit a true, accurate, and complete confidential Financial Assistance Application by mail or in person.

The Financial Assistance Application may be completed in writing or orally (or a combination of both), either of which may be completed by or with the assistance of a staff or management member of the Patient Financial Services Department. For both Charity Care and Discounted Care, the Financial Assistance Application must be accompanied with one of the following forms of documentation of income:

- Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed, or
- Recent pay stubs from within the 6 months before or after the patient is first billed (or in preservice when the Application is submitted)

A patient, or patient's legal representative, who requests Discounted Care or Charity Care, shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. EPHC may consider the failure to provide this information in making its determination. These documents provided for the Application will only be used in reaching a determination of Financial Assistance and will not be used for collection activities.

An individual is considered to have submitted a complete Financial Assistance Application if he or she provides information and documentation sufficient for the hospital facility to determine whether the individual is eligible for Financial Assistance. An Application is incomplete if he or she provides some, but insufficient, information and documentation to determine eligibility for Financial Assistance.

d. Notification of Financial Assistance Determination

Once EPHC has reviewed the Financial Assistance Application and has made a determination based on the eligibility requirements stated below, the facility shall notify the individual in writing by mail of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

e. Effect of Financial Assistance Determination

If found eligible for Financial Assistance, whether Charity Care or Discounted Care, EPHC shall provide the individual with a billing statement that states the amount the individual now owes for the care, how that amount was determined, and how the individual can get information regarding the Financial Assistance offered for the care.

If found eligible for Discounted Care, the patient may enter into an extended payment plan to allow payment over time. The hospital and the patient shall negotiate the terms of the payment plan and take into consideration the patient's Family Income and Essential Living Expenses. If the hospital and the patient cannot agree on the payment plan, the hospital shall create a payment plan where monthly payments will not be

more than 10 percent of a patient's Family Income for a month, excluding deductions for Essential Living Expenses.

If appropriate, EPHC shall refund the individual any amount over \$5.00 he or she has paid for the care (whether to EPHC or any other party to whom EPHC has referred the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying after Financial Assistance has been applied plus interest. The hospital shall make any refunds under this section within 30 days of the determination of eligibility for Financial Assistance. Any interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, EPHC may choose not to reimburse the patient if EPHC determines the patient would have qualified for financial assistance at the time the patient was first billed and it has either (i) been five years or more since the last payment to the hospital, assignee, or debt buyer or (ii) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.

The Financial Assistance approval and any adjustment to the amount owed will be applied to all eligible patient account balances, including those received before the application approval date. For bills received after the Financial Assistance is approved, a new Financial Assistance Application will need to be filled out if the patient is seeking Financial Assistance for those bills.

f. Appeal of Financial Assistance Determination

Patients may submit a written request for reconsideration to EPHC Patient Financial Services Department. Such an appeal should demonstrate that the individual either:

- Believes their Financial Assistance Application was not approved according to this policy; or
- Disagrees with the way the policy was applied to their case

Appeal must be submitted within 30 days of the date of the decision letter. The Financial Officer or his or her designee will be the final level of appeal.

g. How to Ask for Help

A patient may request assistance with understanding the medical bill or in applying for Financial Assistance by visiting the Patient Financial Services Department in person at 500 First Ave Portola, CA, 96122 or by calling 530-832-6500. Patient Financial Services Department is open Monday through Friday from 8:00 am to 4:00 pm, except holidays.

Additionally, there are free consumer advocacy organizations that will help the patient understand the billing and payment process. The patient may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

6. Eligibility

The level of Financial Assistance, such as Charity Care (no charge to the patient) or Discounted Care (a discount to the patient) is based on several factors: Family Income, the patient's insurance plan, whether the patient had high medical costs or expenses and the type of services the patient received. Different discount policies apply based on the Family Income level and insurance status of the patient.

EPHC authorizes Financial Assistance as set forth in this Policy. EPHC will limit charges to a patient eligible for Financial Assistance to the amount of payment the

hospital would expect, in good faith, to receive for providing services from Medicare or Medi-Cal, whichever is greater.

Non-covered and denied services and related services provided to Medicaid-eligible beneficiaries are considered a form of Charity Care. Medicaid beneficiaries are not responsible for any form of patient financial liability besides “Share of Cost.” Examples of this include but are not limited to services provided to Medicaid beneficiaries with restricted Medicaid, Medicaid pending accounts, Medicaid of other indigent care program denials, charges related to days exceeding length-of-stay limits, Medicaid claims (including out-of-state Medicaid claims) with “no payments,” and any service provided to a Medicaid-eligible patient with no coverage and no payment.

Table 1: Patient Financial Assistance Eligibility

Household Income	Uninsured Patients -Patient Responsibility	Insured Patients with High Medical Costs- Patient Responsibility
Below 200% of the Federal Poverty Level	Zero (Full Charity)	Zero (Full Charity)
200% to 400% of the Federal Poverty Level	Medicare or Medi-Cal Rate (whichever is higher)	Reduction of patient responsibility to Medicare or Medi-Cal Rate (whichever is higher)
> 400% of the Federal Poverty Level	No Discount	No Discount

7. Miscellaneous

Requests and all information collected related to an application for Financial Assistance are subject to applicable privacy law.

8. Definitions

Any terms used in this policy that are not defined below shall reference the definition in California Health and Safety Code section 127400 and Title 22 of the California Code of Regulations section 96051.

a. Application

EPHC’s Financial Assistance Policy

b. Charity Care

Free care provided when the patient is not expected to pay the patient's payment obligation for items and services provided by EPHC. Charity Care is based on financial need.

c. Discounted Care

A deduction from the payment obligations for items and services that is given for cash, prompt, or advanced payment, or to certain categories of patients, e.g., uninsured patients.

d. Emergency Medical Care

The medical screening, examination, and evaluation by a physician and surgeon, or other appropriately licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

e. Essential Living Expenses

expenses like rent or house payment and maintenance, food, household supplies, laundry and cleaning, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, repairs and installment payments, and other extraordinary expenses.

f. Financial Assistance

Charity Care or Discounted Care.

g. Federal Income Tax Return

The Internal Revenue Service (IRS) form/s used to report taxable income. The IRS form must be a copy of the signed and dated forms sent to the IRS.

h. Federal Poverty Level (FPL)

The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority. The existing guidelines can be found at:

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

i. Family

Family is defined as:

- For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not, and
- For persons under 18 years of age or for a dependent child 18 to 20 years of age, parent, caretaker relatives, and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.

j. Family Income

The combined income of the patient seeking Financial Assistance and his/her/their Family as determined under this Policy. Income as used here shall include any sources used to calculate the adjusted gross income, as set forth on line 11 of Form 1040, U.S. Individual Income Tax Return.

k. High Medical Costs

Either of the following:

- Annual out-of-pocket costs incurred by the individual at EPHC that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. Out-of-pocket costs 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.
- Annual out-of-pocket expenses that exceed 10 percent of the patient's family income

or family income in the prior 12 months, 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 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.

l. Medically Necessary Care

A service is “medically necessary” or a “medical necessity” when it is performed in the hospital unless the hospital provides an attestation signed by the referring provider that the hospital services at issue were not medically necessary.

m. Patient Financial Services (PFS) Department

The EPHC department responsible for billing, collecting, and processing payments

n. Policy

EPHC Financial Assistance Policy

o. Self-Pay Patient

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 hospital. Self-Pay patients may include Charity Care patients. Self-Pay Patients are considered “Uninsured Patients” herein.