Eastern Plumas Health Care
"People Helping People"

CHARITY CARE POLICY
EASTERN PLUMAS HEALTH CARE
BUSINESS OFFICE
EFFECTIVE: 10/2023

I. POLICY STATEMENT

It is the policy of Eastern Plumas Health Care to identify charity care that is provided to patients according to the guidelines of this policy. Charity care is defined as health care services provided at no charge or at a reduced charge to patients who do not have or cannot obtain adequate financial resources or other means to pay for their care. This is in contrast to a bad debt which is defined as a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by their actions an unwillingness to resolve the bill. Partial and full charity care will be based solely on ability to pay and will not be abridged on the basis of age, sex, race, creed, disability, or national origin. Classification of healthcare services as charity care will only be made in those cases when a reasonable effort has been made to seek other financial resources, but classification can occur at any time. Classification of healthcare services as charity care will not be made for non-medically necessary services (i.e., cosmetic surgery, patient convenience hospital days and services, etc.)

II. PURPOSE

The purpose of this policy is to define the eligibility criteria for charity care assistance and provide administrative guidelines for the identification and classification of patient accounts as charity care.

III. ELIGIBILITY

The following categories of patient accounts will be classified for charity care:

Category A – As defined in Assembly Bill 1020 "Uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level…shall be eligible to apply for participation under a hospital's charity care policy or discount payment policy." This includes (not limited to):

a. Emergency room patients without a payment source. Individuals in this category have no job, no mailing address/or residence, *and* no insurance. These patients may meet the qualification guidelines for medical assistance such as Medicare, Medi-Cal or Covered California but do not have the inclination to follow through on the necessary eligibility processes. Collection efforts would be fruitless. Approval for write-off usually takes place after the service has been rendered.

b. Patients who do not qualify for Medicare, Medi-Cal, Covered California or other assistance programs and are financially unable to pay all or part of the hospital bill. Typically, individuals and families in this category may be partially covered by health insurance and seek charity care assistance after insurance has paid. Patients must complete the attached application form and their adjusted family income must fall within the financial criteria to receive charity care, see income criteria table below. Families whose income exceeds the income criteria may still qualify for charity care with a cost share. Charity care approval can take place at any time including prior to service.

c. Indigent/uncollectible situations that normally occur after service has been rendered.

d. Current Medicare, Medi-Cal or Covered California recipients who are requesting Charity Care for a prior hospitalization which was not covered by the program. This situation normally occurs in cases where a patient does not meet the financial eligibility criteria for either program for the month of hospital service, but subsequently after discharge (weeks, months) the patient's financial condition deteriorates and therefore becomes eligible for assistance for future hospitalizations. Medicare, Medi-Cal or Covered California will not retroactively qualify applicants for prior periods.

e. Confirmed "Other County" Medi-Cal/Medicaid patients whose county is not contracted with Eastern Plumas Health Care.

Category B- A deceased patient having no estate.

IV. PROCEDURAL GUIDELINES

a. The patient financial advocate who receives a request for charity care or determines a patient's account(s) should be considered for charity care should thoroughly research and document on the financial file folder all relevant facts. Care should be taken that reasonable efforts have been made to seek alternative financial resources. Efforts should be made to secure approval or denial prior to admission.
b. For purposes of this determination, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility as defined in AB 1020.
c. The charity care request (Charity Care Application and/or documentation on the financial file jacket) should be forwarded through the levels of management to the lowest level able to authorize the charity care write-off amount (see write-off matrix below).
d. Authorized employees must sign their approval or denial and reason for determination on the file. Authorized employees must assure that reasonable efforts have been made to assure that alternative resources are not available to cover the cost of the hospitalization.

e. The file should then be returned to the Patient Financial Advocate to process the write-off and send the Eligibility Determination Notice to the patient.
f. The Patient Financial Advocate files (approvals only) and eligibility determination (approvals and denials) are to be archived for no less than five years. These records are to be archived in such a manner as to assure easy accessibility.

V. DISPUTES

In the event of a dispute a patient may seek further review from the CEO and/or CFO.

WRITE-OFF MATRIX

	Estimated of Actual Amount
Hospital Administrator/ Chief Executive Officer Chief Financial Officer	Above $10,000
Patient Financial Services Manager	To $10,000
Amounts shown are maximum per account(s) if combined	

Income Criteria for All States except Alaska and Hawaii
Effective 01/15/2024

Size of Family Unit	2023 Federal Poverty Guideline	EPHC Poverty Guideline *(400% OF FED POVERTY GUIDELINE)*
1	$15,060	$58,320
2	$20,440	$78,880
3	$25,820	$99,440
4	$31,200	$120,000
5	$36,580	$140,560
6	$41,960	$161,120
7	$47,340	$181,680
8	$52,720	$202,240

For family units over 8 members, add $5,380.00 (EPHC Poverty Guidelines) for each additional member.

Eastern Plumas Health Care
"People Helping People"

500 East First Ave.
Portola, CA, 96122
Phone: (530) 832-6568
Fax: (530) 832-1105

Date: _____

Re: Account # _____

Dear _____,

We have received your request for a possible charity care write-off. For us to process your request we will need the enclosed form completed and returned to our business office within **30 business days** along with all or part of the accompanying information:

a) Copies of your prior three months bank statements.
b) Copy of your last Federal Income Tax return filed.
c) Copies of your prior three months' paycheck stubs.

Upon receipt of the above information, you will be notified of our decision. Should you require further clarification or have any questions, please contact me at (530) 832-6568.

Sincerely,

April Shepherd
Patient Financial Service Coordinator
Eastern Plumas Health Care

Eastern Plumas Health Care
"People Helping People"

CHARITY CARE FINANCIAL STATEMENT

Date of Request: _____ Birthdate: _____

Patient's Name: _____ Telephone No.: _____

Social Security Number: _____

Address: _____

Account #: _____ Dates of Service: _____

Marital Status: _____ Name of Spouse: _____

Employer: _____ Last Day Worked: _____

Spouse's Employer: _____ Last Day Worked: _____

Do you have? Medicaid _____Medicare _____Other Insurance _____

Gross Annual Family Income: Self: $_____

Spouse: $_____

Other: $_____

Total: $_____

Number of Dependents Supported on Income (Include Self): _____

Provider of Financial Information (If other than patient or guarantor):

Name: _____

Address: _____

DO NOT COMPLETE (To be completed by Hospital Personnel only).

This document was received on: _____

By: _____ Title: _____

Eastern Plumas Health Care
"People Helping People"

CHARITY CARE FINANCIAL STATEMENT

Patient Full Name		Birthdate	Social Security Number
Physical Address			
Mailing Address (if different)			Telephone Number
Patient Employer Name			
Employer Address			Employer Phone Number
Patients Previous Employer (if within two Years		Position	Years of Employment?
Salary, Wages, or Commissions Earned			
Weekly:	Bi-Weekly:	Semi-Monthly:	Monthly:
Other Income Per Month		Source of Other Income	
Spouse Full Name		Birthdate	Social Security Number
Spouse Employer Name			Employer Phone Number
Employer Address			
Numbers of Members in Family			
Name	Relationship	Age	Gender

Bank Name		Branch	
Checking Account Number		Saving Account Number/ Loan Number(s)	
Do you Rent or Own a Home?		Monthly Payment	
Description of Real Estate Owned	Value	Amount Owed	
Make, Model and Year of Vehicle Owned		Amount Owed	
Make, Model and Year of Vehicle		Amount Owed	
List All Debts (attach additional sheets if necessary)			
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment
Creditor	Address	Balance Owing	Monthly Payment

I UNDERSTAND THAT THE INFORMATION WHICH I SUBMIT IS SUBJECT TO VERIFICATION BY EASTERN PLUMAS HEALTH CARE AND SUBJECT TO REVIEW BY GOVERNMENTAL AGENCIES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature: _____ Date: _____Time: _____

Printed Name: _____

Eastern Plumas Health Care
"People Helping People"

ELIGIBILITY DETERMINATION FOR CHARITY CARE PROGRAM

Eastern Plumas Health Care has conducted an eligibility determination for EPHC Charity Care Program for:

_____

Patient's Name Account Number Date(s) of Service

The request of Charity Care Program assistance was made by the patient or on behalf of the patient on _____. This determination was completed on: _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for Charity Care has been approved for services rendered on _____with a share cost of $_____. Before the final adjustment can be made to your account our office needs to be informed as to how your share of cost will be satisfied. Please contact one of the principals appearing at the bottom of this letter to make arrangements.

_____ Your request for Charity Care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____

_____

_____

_____ Your request for Charity Care has been denied because:

_____

_____

_____

If you have any question on this determination, please contact:

_____

April Shepherd
Patient Financial Service Coordinator
Eastern Plumas Health Care
(530) 832-6568

Eastern Plumas Health Care
"People Helping People"

APPROVAL FOR CHARITY CARE

Patient Name:	MRN:

Account Number(s)	Amount
	$
	$
	$
	$
	$
	$
	$
Total	$

ACCOUNT REPRESENTATIVE CHECK LIST:

Does patient meet income criteria?	Yes	No
Is proof of income Attached? (Bank statements, prior year's tax return, paycheck stubs)	Yes	No
Account attached?	Yes	No
Notes in computer system?	Yes	No
Write off sheet attached?	Yes	No

_____ _____

Account Representative Signature Date

Adjustment: Approved _____ Denied _____ By: _____

Patient Financial Services Manager /CEO

Eastern Plumas Health Care
"People Helping People"

SUMMARY OF CHARITY CARE

Patient Name:	Date of Approval:		
EPHC AGI: $			
Family Members:			
Has the patient provided?			
Tax Return	Yes	No	AGI: $
Check Stubs	Yes	No	AGI: $
Bank Statements	Yes	No	AGI: $
Application	Yes	No	AGI: $
Manager Approval Initials:			
Return to April Shepherd for following			
Notes in Computer		Completed:	
Application to Scanning		Completed:	
Mail Letter to Patient		Completed:	
Payment Plan on Balance to Patient (If Applicable)		Completed:	
Notes: _____ _____ _____ _____ _____			

Date: _____

Patient Name: _____

Address: _____***City:*** _____***State:*** _____***Zip Code:***_____

Dear: _____,

Eastern Plumas Health Care is proud of its mission to provide quality patient care to all we serve.

Your account(s) are seriously past due and need immediate attention. We will be referring these account(s) to National Business Factors in the next 30 days from the above date. You may reach NBF Collections at 775-883-3700 after the above date. In the event you need an itemized bill regarding your account(s) listed, please call 530-832-6568 for assistance.

For your convenience, you may pay your account(s) with a credit card by calling 530-832-6568 or online at www.ephc.org

It is important to let us know that you are having trouble paying this bill(s). Eastern Plumas Health Care has a financial Assistance program that you may qualify for, we have enclosed an application. If you would like to apply, please complete the application, and return with the requested documentation in 10 business days.

Date of Service	Account Number	Insurance/Self Pay	Amount
		Total Balance Due	

Sincerely,

April Shepherd
Patient Financial Service Coordinator
530-832-6568

Rev. 11/13/2023