



<b>Department(s)</b>	Compliance		
<b>Reference #</b>	4632	<b>Version #</b>	4
<b>Subject</b>	Community Care Financial Assistance and Discount Payment Program		
<b>Date published</b>	04/24/2025		
<b>Scope of Policy (Identifies the entities that are covered under the policy)</b>			
<b>X</b>	All Orchard Hospital entities	Medical Specialty Center	Orchard Hospital
	Medical Specialty Center (Oroville)		

## COMMUNITY CARE FINANCIAL ASSISTANCE POLICY

### **POLICY:**

Overview: Orchard Hospital is committed to providing medical care to all patients, regardless of their financial circumstances. In recognition of financial hardships, OH offers a Financial Assistance Program to reduce or eliminate medical bills for patients who meet specific eligibility criteria.

**Program Description:** The Financial Assistance Program is designed to provide relief from medical expenses for eligible individuals who are uninsured, underinsured, or experiencing high medical costs relative to their income. The program covers medically necessary services provided by OH, ensuring that no patient faces an undue financial burden for essential healthcare.

Eligibility Criteria: Eligibility for financial assistance is based on the patient's family income, insurance status, and medical costs, as outlined below:

### **Free Care:(previous Charity Care)**

1. Patients whose family income is at or below 400% of the Federal Poverty Level (FPL); and,
2. No third-party payor.

### **Discount Payment:**

1. Uninsured patients or insured patients with high medical costs whose income is at or below 400% of the Federal Poverty Level (FPL)

**Extended payment plan to allow payment of the discounted price overtime:** The hospital and the patient will negotiate the terms of the payment plan and take into consideration of the patient's family income and essential living expenses. If the two



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If the parties cannot agree on the plan, the hospital will create a reasonable payment plan. Where monthly pay is not more than 10% of the patient’s family income and essential living expenses.

The granting of charity care or discounted payments shall be based on an individualized determination of financial need and will NOT take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Eligible patients may have payments adjusted on a sliding fee scale, in accordance with financial needs as determined by the FPL in effect at the time of the determination. The basis for the amounts charged for qualified patients is as follows:

1. Patients whose family income is at or below 400% of the FPL may receive free care.
2. Patients whose family income is at or above 400% of the FPL but no more than 600% of the FPL are eligible to receive services at discounted rates.
3. Patients whose family income exceeds 600% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness.
4. Any expected payments from those eligible patients would not exceed the payments that would be expected from Medicare or Medi-Cal, whichever is greater. If there is no established payment for the service under Medicare or Medi-Cal, the hospital, may establish an appropriate discount payment.

**Special Circumstances:**

- a. Patients who have filed for bankruptcy or are deceased with no remaining estate are automatically eligible for full financial assistance.
- b. Patients facing extraordinary financial hardships, such as job loss, may also qualify for assistance.
- c. Emergency Room Physicians are required by law to provide discounts for patients



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who are uninsured or whose family income is at or below 400% of FPL.

**PROCEDURE:**

1. Pre-Admission

a. The hospital will make reasonable efforts to obtain from the patient or the patient’s representative information about whether private or public health insurance may fully or partially cover the charges for services provided by the hospital to the patient, including, but not limited to:

- Private health insurance (including insurance offered through the state health benefit exchange).
- Medicare; and,
- Medi-Cal or other state-funded health coverage programs.

b. The hospital will provide all patients without insurance with a written estimate of the amount the hospital will require patients to pay for the healthcare services provided.

2. Patient Admission

a. Upon admission (within 3 days of admission), the patient or the representative will be provided with written documents about the financial assistance policy (i.e., discounted payment and charity care) of the hospital, which will include but is not limited to:

- A statement indicating that if the patient lacks or has inadequate insurance and meets certain low- and moderate-income requirements that the patient may qualify for discounted payments or charity care.
- A telephone number from which the patient may obtain information about discounted payments or charity care and how to apply for that assistance.

b. If the patient is not conscious or able to receive the notice during admission



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process, the notice will be provided at the latest during the discharge process or via United States Postal Mail within 72 hours of providing the services, and include:

- Eligibility criteria contact information for the hospital administrator where they may obtain additional information about the hospital policies.
- The Internet address for Health Consumer Alliance (<https://healthconsumer.org>).

c. In addition, the hospital's policy regarding discounted payment and charity services will be posted in location(s) that are visible to the public, such as the admissions office and hospital lobby in addition to the hospital's website.

d. These notices will be made available in at least English and Spanish to meet the primary languages spoken in the community. For any patient who is unable to understand the information in the written formats available, the information will be provided by reading the information to the patient utilizing language or an auditory interpreter services.

e. Patients admitted to the hospital who do not have coverage by third-party payer or those that request a discounted price or charity care will receive an application and assistance in completing the application for the Medi-Cal program or other state- or county health-funded health coverage program.

### 3. Application Process

a. Patients seeking financial assistance must complete the Financial Assistance Application through OH Patient Financial Services Department. The following steps outline the process:



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b. Submission

1. Applications can be submitted before, during, or after receiving care.
2. Supporting documentation must accompany the application.

c. For purposes of determining eligibility for Discount and Charity Care, documentation of income shall be limited to:

1. Federal Income Tax Return (Form 1040) for patients and spouses or domestic partner from the year the patient was first billed or 12 months prior to the patient's first billing.
2. Three months' pay stubs from within the 6 months before or after the patient is first billed (or in preservice when the Application is submitted).

d. Timeline:

- Once the application is received, patients have three weeks (21 days) to Submit all required documentation.

OH's Patient Financial Services Department reviews all applications. Eligibility is based on income, family size, and medical expenses. Patients will receive a written determination within 30 days of submitting a completed application.

**Note:** information obtained through the financial application process will NOT be used in the collection activities.

**Assistance:** The Patient Financial Services Department is available to assist patients with completing the application, including providing translations as needed.

**Validity:** Approved applications are valid for 180 days. Patients may reapply or update their application if their financial situation changes.



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**Appeal Process:** Patients may appeal a denied application by submitting a written appeal to the Patient Financial Services Department within 30 days of the decision. Appeals will be reviewed by the Director of Revenue Cycle, with final determination made within 30 days of the appeal.

**4. Debt collections:**

a. Patient Financial Services shall enforce its cash collection program if the patient is found ineligible for financial assistance, or the patient has not responded to any Attempts to bill or offer financial assistance for 180 days. OH, shall not commence civil actions against a patient for non-payment at any time 180 days after billing. If a patient has a pending appeal for coverage of services, OH shall not commence civil action against the patient for non-payment at any time 180 days after the Patient appeal is completed.

**REFERENCES:**

The processes and procedures described above are designed to comply with CA SB 1276 (Chapter 758, Statutes of 2014), CA AB 774 (Statutes of 2006) and SB 350 (Chapter 347, Statutes of 2007).

Questions regarding SB 1276, AB 774 and SB 350 can be addressed by the Patient Financial Counselor or by California’s Office of Statewide Health Planning and Development’s website, at



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<http://www.oshpd.ca.gov/hid/products/hospitals/fairpricing/index.html>.

<http://aspe.hhs.gov/poverty/14poverty.shtml>