Financial Assistance Policy

POLICY

Cottage Health's mission is to provide superior health care for and improve the health of our communities through a commitment to our core values of excellence, integrity, and compassion. As part of this mission, Cottage Health is pleased to offer a Financial Assistance program to patients unable to pay for emergency or medically necessary care.

This Patient Financial Assistance Policy (Policy) establishes eligibility requirements and the application process for patient Financial Assistance, also known as charity or discount care, at Cottage Health hospitals. This Policy is consistent with Cottage Health's values of excellence, integrity, and compassion and is compliant with all State and Federal laws.

Cottage Health provides, without discrimination, care for emergency medical conditions within the meaning of the Emergency Medical Treatment and Labor Act ("EMTALA") to individuals, regardless of their ability to pay for services. This provision applies to care for emergency medical conditions, within the meaning of EMTALA; please refer to ED Policy "EMTALA – Transfer Policy."

SCOPE

Services Covered

This Policy covers technical and facility fees for emergency and other medically necessary care provided at the following Cottage Health hospital and hospital-based facilities:

- Santa Barbara Cottage Hospital;
- Santa Ynez Valley Cottage Hospital;
- Goleta Valley Cottage Hospital; and
- Hospital-Based Clinics

This policy also covers professional fees for the Santa Ynez Valley Cardiology Clinic, Santa Ynez Valley Primary Care and Cottage Clinical Associates.

Services Not Covered

Physician Fees Not Covered

This Policy does not cover physician fees (also known as "professional fees") for emergency, and other medically necessary care provided by physicians and certain other medical providers who treat patients seen at Cottage Health facilities that are not billed by Cottage Health. Additionally, service provided at Cottage Urgent Care is not covered under this policy.

More specifically, this policy does not cover professional fees for emergency and other medically necessary care provided by the following types of physicians:

- Emergency Department physicians
- Hospitalists
- Internists
- Radiologists and Radiology groups
- Anesthesiologists and Anesthesia groups
- Pathology

Additionally, this policy does not cover professional fees for emergency, urgent care, and other medically necessary care provided by the following hospital departments:

- Cardiovascular Services
- Family Practice
- Internal Medicine
- Neurology/Neurosurgery
- OB/GYN
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pediatrics
- Psychiatry
- Pulmonary/Critical Care
- General Surgery
- Urology

These health care providers bill separately from Cottage Health, and this Policy does not apply to their charges. Payment for professional fees billed by these health care providers is the patient's responsibility and does not qualify for a discount or charity care adjustment under this Policy. This Policy only applies to the technical and facility fees for emergency and other medically necessary care provided at a Cottage Health hospital or hospital-based facility.

Although emergency physicians are not covered by this Policy, under California law, an emergency physician who provides emergency medical services in a hospital that provides emergency care is required by law to provide discounts to: (1) uninsured patients who are at or below 400% of the federal poverty level, and (2) Patients With High Medical Costs (as defined below) who are at or below 400% of the federal poverty level. This requirement does not impose additional obligations upon Cottage Health. Patients can seek additional information about this requirement directly from the emergency physician who provided care.

Additional Services Not Covered

Cosmetic surgeries are generally considered to be elective procedures that are non-emergent and not Medically Necessary Care (as defined below) and are excluded from this policy. Services offered at Cottage Residential Center ("CRC") and the Comprehensive Outpatient Program Experience ("COPE") are also excluded from this policy. Please refer to Policy 8560.74, "Financial Assistance for Non-Urgent Services" for details regarding assistance available to patients of the CRC and COPE programs. Services provided by Pacific Diagnostic Laboratories in freestanding clinics off-campus are also excluded. Additionally, any services provided in freestanding clinics that are not licensed as a service of the hospital are excluded. Services provided at a Cottage Urgent Care are excluded from this policy.

DEFINITIONS

Amounts Generally Billed, or "AGB": An amount calculated using the methodology described in this Policy that sets a limit on the amount Cottage Health may charge for emergency and medically necessary care provided by a Cottage Health hospital facility to a patient eligible for Financial Assistance based on the eligibility criteria outlined in this Policy. Under this Policy, AGB only applies to patients eligible for Financial Assistance discounts, because Cottage Health writes off 100% of the amount patients are personally responsible for paying when they demonstrate a household income of equal to or less than 500% of the federal poverty level.

Extraordinary Collection Activities (ECAs): Actions that Cottage Health may take to collect a bill, including: (1) actions that require a legal or judicial process; or (2) reporting adverse information to credit reporting agencies or credit bureaus.

Family Members: Under California law, a patient's family for persons 18 years and older are a spouse or domestic partner and dependent children under 21 years of age, whether living at home or not. For persons under 18, a patient's family is defined as parents, caretaker relatives, and other children less than 21 years of age of the parent or caretaker. For those 18 and over, number of Family Members should directly correspond with the number of dependents listed on the current year tax return. If the current year tax return is not available, or if current Number of Family Members is not the same as the number listed on the current year tax return, the patient or responsible party must provide one or more of the following documents to demonstrate change in Number of Family Members:

- birth certificate
- federal immigration documents
- guardianship documents

Federal Poverty Level (FPL): A uniform measure of income that is adjusted for inflation, published annually by the United States Department of Health and Human Services, and used by Cottage Health to determine eligibility for Financial Assistance under this Policy.

Financial Assistance: Charity (free) or discounted care provided to individuals who cannot afford to pay all or a portion of their hospital medical bills. Eligibility for Financial Assistance is determined based on the criteria identified in this Policy.

Gross Charges: Cottage Health's full, established price for medical care that it consistently and uniformly charged to patients before applying any contractual allowances, discounts, or deductions.

Guarantor: Patient or other individual responsible for payment of the patient's care.

High Medical Costs: Under California law, for an individual whose family income does not exceed 400% FPL: (a) annual out-of-pocket costs incurred by the individual at Cottage Health that exceed the lesser of 10% of the patient's family income in the prior 12 months or 10% of the patient's current family income; or (b) annual out-of-pocket expenses that exceed 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.

Household Income: The patient/responsible party's gross income, as well as the gross income of other adults listed as members of the patient/responsible party's household on the relevant tax return. Acceptable income source documents are listed under "Financial Assistance Application Process," below.

Medically Indigent: Guarantors whom Cottage Health has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the financial assistance policy. Medical bills and liabilities considered in this determination include those from organizations outside of Cottage Health.

Medically Necessary Care: A medical service or treatment that is absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

Monetary Assets: Intangible assets that include cash, stocks, bonds, savings accounts, and other bank accounts, but exclude retirement or deferred compensation plans qualified under the Internal Revenue Code, nonqualified deferred compensation plans, or any real property or tangible assets. The first ten thousand dollars ($10,000) of a patient's Monetary Assets and 50% of a patient's Monetary Assets over the first ten thousand dollars ($10,000) are excluded for purposes of determining eligibility for Financial Assistance. For deceased patients, Monetary Assets include assets of the deceased person's estate.

Primary Language: A language used by the lesser of 1,000 people or 5% of the community served by a Cottage Health hospital facility based upon the most recent Community Health Needs Assessment performed by the hospital facility.

FINANCIAL ASSISTANCE AVAILABLE

Eligibility Requirements

Eligibility for Financial Assistance is based on the following criteria:

- For 100% Financial Assistance, often referred to as "charity care," Cottage Health will consider household income, family size, and monetary assets. Patients with a Household Income equal to or less than 500% of FPL are eligible for 100% Financial Assistance. This satisfies the requirement under California law that patients whose family income does not exceed 400% FPL and who (a) are self-pay, or (b) have High Medical Costs, shall be eligible for charity care or discounted payments and shall not pay more than what the hospital would expect to receive from providing services to a government payor; these patients are eligible for 100% Financial Assistance.
- Discounted care is available for patients with a Household Income above 500% FPL up to 700% FPL, taking into consideration Number of Family Members (and not considering Monetary Assets). Discount percentages based on Household Income and Number of Family Members are consistent with annual FPL sliding scale guidelines and are attached and incorporated into this Policy as Attachment A, Patient Financial Assistance Calculation Form. Discounts are taken off of the patient's out-of-pocket financial responsibility. If the application of the AGB percentage leads to a lower patient financial responsibility than the discounts achieved through Attachment A, the AGB discount will apply.
- 100% financial assistance or discounted care is available for guarantors who demonstrate they are Medically Indigent. Monetary Assets may be considered in arriving at this determination. Cottage Health has sole discretion when determining a guarantor's status as being Medically Indigent.
- Patients who receive direct payment for medical care through an indemnity, Medicare Supplement, or a civil settlement or judgment due to a third party's liability may not seek Financial Assistance for the care covered by such direct payment.
- Patients who have insurance who refuse to provide sufficient information to their insurance carrier, resulting in the insurance carrier denying a claim for treatment, may not seek Financial Assistance for the costs of the denied care.
- Patients who request that Cottage Health not bill the patient's insurance carrier and who choose to pay for such services out-of-pocket as a self-pay patient may not seek Financial Assistance for the services paid out-of-pocket.
- Patients who are eligible for FPL-qualified programs such as Medi-Cal, Medicaid, and other government- sponsored low-income assistance programs, are deemed to be eligible for financial assistance. Therefore, such patients are eligible for financial assistance under this policy when the programs deny payment and then deem the charges billable to the patient. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Specifically included as eligible are charges related to the following:
    - Denied services
    - Non-covered services
    - Treatment Authorization Request (TAR) denials
    - Denials due to restricted coverage
    - Medicaid claims (including out of state Medicaid claims) with "no payment"
    - Any service provided to a Medicaid eligible patient with no coverage and no payment
    - Share of cost for Medicaid members are eligible for financial assistance
    - Patient has an active Medicaid plan or is eligible for Medicaid
- Patients with out-of-network (non-contracted) third-party coverage who wish to obtain non-emergent hospital-based services at Cottage Health will not be eligible for financial assistance unless a Single Case Agreement is negotiated with the out-of-network provider in advance of service.
    - This provision does not apply to care for emergency medical conditions, within the meaning of EMTALA; please refer to ED policy "EMTALA – Transfer Policy."
    - This provision does not apply to patients who have insurance through a payor that is out-of- network due to ongoing contractual negotiations.
- **Discovery of Patient Financial Assistance Eligibility During Collections** – While Cottage Health strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. Cottage Health collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Cottage Health will reverse the account out of bad debt and document the respective discount in charges as charity care.

- **Policy Updates for Access to Healthcare Crisis Situations** – During a public emergency, Cottage Health may declare an Access to Healthcare Crisis and adjust its financial assistance policy to meet the needs of the community in crisis. These situations may include, but are not limited to, public health emergencies and natural disasters. If an Access to Healthcare Crisis is applicable, Cottage Health will attach an addendum to the policy. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy.
- **Non-Covered/Denied Charges for All Coverages** - Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, Santa Ynez Valley Cottage Hospital, and Cottage Clinical Associates. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.
- **Presumptive Charity Care** - Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates a financial hardship. The reason for presumptive eligibility will be reflected in the transaction code used to adjudicate the patient's claim. Additional patient notes may be included. Examples of these exceptions where documentation requirements are waived include, but are not limited to:
    - An independent credit-based financial assessment tool indicates indigence
    - Is actively receiving benefits from government assistance programs, i.e.: CALFRESH, School Meals Program, SNAP, WIC, TANF
    - Determination of patient financial assistance eligibility by Vice President, Revenue Cycle

Financial Assistance is available to all patients who satisfy the eligibility requirements outlined in this Policy, after all private health insurance payments have been applied. Patients eligible for Financial Assistance may include patients who are eligible for Medi-Cal but whose eligibility dates do not cover the entirety of the care they receive. Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services who are eligible.

If a student applying for assistance is claimed as a dependent on the family tax return, then the entire family income must be considered in determining eligibility for Financial Assistance.

For deceased guarantors, refer to policy "8545.08 Deceased Patients" to determine any changes to the guarantor based upon legal transfer of assets and whether they are subject to Probate. If Cottage is not able to identify a surviving spouse or identifiable assets for deceased guarantors, or identify a new guarantor based upon a legal transfer of liabilities such as in the case of a patient who is a minor child, presumptive charity will be awarded, and the outstanding balance will be written-off as such. If a deceased patient has a surviving spouse, and the surviving spouse has elected to forego formal Probate, the surviving spouse may apply for Financial Assistance, in which case the eligibility requirements outlined in this Policy are applicable.

Patients who are eligible for Financial Assistance under this Policy will not be charged more than Amounts Generally Billed.

Basis for Calculating Amounts Generally Billed (AGB)

Patients determined to be eligible for Financial Assistance will not be charged – meaning, such patients will not be personally responsible for paying – more than Amounts Generally Billed (AGB) to individuals who have insurance for emergency or other medically necessary care, after all deductions, discounts, and insurance reimbursements have been applied.

In accordance with applicable law, Cottage Health utilizes the "look-back method" for calculating AGB. Specifically, Cottage Health divides the sum of the amounts of all Cottage Health claims for all medical care that has been allowed by Medicare fee-for-service and all private health insurers during a prior 12-month period by the sum of the Gross Charges for those claims. Claims used in the calculation depend on whether the claim was allowed by a health insurer during the 12-month period, not whether the care resulting in the claim was provided during that 12-month period.

When including allowed claims in calculating its AGB percentage(s), Cottage Health includes the full amount that has been allowed by the health insurer, including both the amount the insurer will pay or reimburse and the amount (if any) the patient (or the patient's guarantor) is personally responsible for paying in the form of co-payments, co- insurance, and deductibles, regardless of whether or when the full amount allowed is actually paid and disregarding any discounts applied to the patient's portion.

Cottage Health hospital facilities each utilize a different Medicare provider agreement and each calculate their own AGB percentage for their facility based on claims and Gross Charges for all such hospital facilities. Such AGB percentage is available, in writing and free of charge, on Cottage Health's website at www.cottagehealth.org/FAP. Patients may also request a paper copy of Cottage Health's AGB, to be mailed without charge, by submitting a request by email to CottageBilling@sbch.org, by calling 805-687-6510, or by submitting a request in writing to one of the following:

Cottage Health Business Office, 6550 Hollister Avenue, Goleta, CA 93117
Santa Barbara Cottage Hospital, 400 W. Pueblo St. Santa Barbara, CA 93105
Goleta Valley Cottage Hospital, 351 S. Patterson Ave., Goleta, CA 93111
Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd., Solvang, CA 93463

FINANCIAL ASSISTANCE APPLICATION PROCESS

Process

To be considered for Financial Assistance eligibility, an individual must submit a complete Financial Assistance Policy Application (FAP Application) and all required documentation during the Application Period. The Application Period terminates on the later of:

1) the 240th day after the date the first post-discharge billing statement was provided; or
2) the deadline provided in Cottage Health's notice of ECAs.

An individual who submits a FAP Application may be required to submit copies of the following documentation, as applicable:

- tax returns and supporting schedules (previous one (1) years)
- statements from all bank and investment accounts covered by this Policy (previous three (3) months)
- pay stubs from all employment (previous three (3) months)
- most recent Form W-2 or unemployment statement
- Social Security benefits statement (if applicable)
- driver's license or photo identification
- In some cases, birth certificate, federal immigration documents and/or guardianship documents

Patients may be denied Financial Assistance if they do not produce a complete FAP Application and the required documentation during the Application Period. (See "Submission of Applications During the Notification and Application Periods," below, for a further description of complete and incomplete FAP Applications.)

When a patient applies or has a pending application for another health care program at the same time the patient applies for Financial Assistance, neither application precludes eligibility from the other program. Patients are eligible to apply for Financial Assistance under this Policy at any point during the Application Period.

Information About Financial Assistance and Help With the FAP Application

The patient or any person involved in the care of the patient, including a family member or provider, can express financial concerns at any point during the patient's care. Inquiries regarding financial assistance should be directed to the Cottage Health Business Office.

Representatives are available to provide information about the FAP and to assist patients with completing the FAP Application, in person or by telephone, as follows:

Cottage Health Business Office
In Person: 6550 Hollister Avenue, Goleta, CA 93117
Telephone: 805-879-8963
Hours: 8:00am–4:00pm, Monday–Friday

Disputing a Financial Assistance Determination

In the event of a dispute regarding a determination of Financial Assistance or review of an FAP Application, the affected individual may request a review by Cottage Health's Vice President of Revenue Cycle. This request for review may be emailed to CottageBilling@sbch.org or submitted by telephone at 805-879-8926.

ACTIONS TAKEN IN EVENT OF NONPAYMENT

Notification and Application Periods

Cottage Health shall notify patients of the availability of Financial Assistance under this Policy and the process for patients to apply to receive such assistance by including notice on all patient billing statements. Cottage Health shall not engage in ECAs before making a reasonable effort, as required by state and federal law, to determine whether a patient is eligible for Financial Assistance under this Policy. For a period of at least 180 days following the date of the first post-discharge billing statement, which is referred to as the "Notification Period," Cottage Health will not engage in ECAs to collect amounts due.

At least 30 days before initiating ECAs, Cottage Health will:

1) Furnish written notice to the patient that provides information on the availability of Financial Assistance under this Policy, a copy of our Financial Assistance Application, the specific ECAs Cottage Health intends to take in the event of nonpayment including the name of the agency, and a deadline for the initiation of such ECAs, as well as the statement required pursuant to California law regarding fair debt collection practices and Federal Trade Commission enforcement;
2) Provide a written plain language summary (Plain Language Summary) of this Policy; and
3) Make reasonable efforts to orally notify the patient about this Policy and how the patient can obtain assistance with the FAP Application before ECAs are initiated.

After conclusion of the Notification Period and satisfaction of the notice provisions outlined in this section, Cottage Health may initiate ECAs to collect amounts due.

If Cottage Health receives a complete FAP Application during the Application Period, Cottage Health will suspend any ECAs that have been initiated and make a determination of the individual's eligibility for Financial Assistance.

If Cottage Health receives an incomplete FAP Application during the Application Period, Cottage Health will suspend any ECAs that have been initiated and provide a reasonable opportunity for the patient to submit a complete FAP Application by notifying the patient of the requirements for completing the FAP Application and providing contact information for the Cottage Health Business Office.

Cottage Health's Vice President of Revenue Cycle or designee shall determine, on a case-by-case basis, whether Cottage Health has made reasonable efforts to determine whether a patient is eligible for Financial Assistance under this Policy and whether Cottage Health may initiate ECAs.

Charity Care Adjustments

Patients who do not submit a complete FAP Application, but who are projected, based on an initial financial screening, to have a Household Income of 500% FPL or less, may qualify for a charity care adjustment under this Policy. Such initial financial screening shall use information generally available to Cottage Health and shall be in Cottage Health's sole discretion. Cottage Health may use information obtained from sources other than the patient, including estimates of an individual's ability to pay based on public and proprietary information, information included in publicly available databases and information provided by third-party vendors who use information included in publicly available databases (e.g., Payment Assistance Rank Ordering, or "PARO"). Throughout the Notification Period, Cottage Health will provide all required notices regarding the availability of Financial Assistance and the opportunity to obtain assistance in completing the FAP Application, as well as a Plain Language Summary and compliant billing statements for any balance due to such individual. Prior to or at the conclusion of the Notification Period, even if the individual has not applied for Financial Assistance, Cottage Health may apply a 100% charity care adjustment to any balance due for patients with a financial screening of 500% FPL or lower.

Cottage Health does not intend to use a determination of eligibility for Financial Assistance utilizing this process as a mechanism to meet Cottage Health's reasonable efforts requirements. Rather, Cottage Health will determine eligibility for Financial Assistance under this Policy only by notifying patients of the Policy and processing FAP Applications. Cottage Health's use of any third-party information for purposes of informing Cottage Health's charity care adjustments does not constitute a presumptive determination of eligibility for Financial Assistance under this Policy. Patients must submit a complete FAP Application during the Application Period to be considered for Financial Assistance.

Payment Plans

Patients may be eligible for an interest-free, extended payment plan, including for payments of the discounted charge. Payment plans shall be offered and negotiated pursuant to the Cottage Health Payment Plan Policy.

Billing and Collections

Separate from initiating ECAs, as described in this Policy, Cottage Health may employ reasonable collection efforts to obtain payment from patients. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by Cottage Health or by any collection agency engaged by Cottage Health. General collection activities may include issuing patient statements, phone calls, emails, and ensuring that statements have been sent to the patient or guarantor.

AVAILABILITY OF FINANCIAL ASSISTANCE INFORMATION

Preadmission or Registration: During the preadmission or registration process (or as soon thereafter as practicable) Cottage Health will provide all patients with a paper copy of the Plain Language Summary of this Policy.

Billing Statements: Cottage Health's billing statements include a Plain Language Summary, including a telephone number for patients to call with questions about Financial Assistance and the website address where patients can obtain additional information. A summary of legal rights is also included in the billing statement.

Public Posting: All Cottage Health hospital facilities conspicuously post signs to notify and inform patients of the Policy in public locations, including, but not limited to, admission areas, waiting rooms, billing offices, emergency rooms, and hospital outpatient service settings. These public notices include information about the patient's right to request an estimate of financial responsibility for services.

Paper Copies: Paper copies of this Policy, the Plain Language Summary, and the FAP Application are available upon request and without charge in the admission areas and emergency rooms at the Cottage Health hospital facilities listed below. Patients may also request paper copies of these materials to be mailed, without charge, by submitting a request by email to CottageBilling@sbch.org, by calling 805-879-8963, or by submitting a request in writing at one of the following:

Cottage Health Business Office, 6550 Hollister Avenue, Goleta, CA 93117
Santa Barbara Cottage Hospital, 400 W. Pueblo St. Santa Barbara, CA 93105
Goleta Valley Cottage Hospital, 351 S. Patterson Ave., Goleta, CA 93111
Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd., Solvang, CA 93463

Website: Copies of this Policy, the Plain Language Summary, and the FAP Application are available on the Cottage Health website at www.cottagehealth.org/FAP.

MyChart: Patients who have activated a Cottage Health MyChart account can complete a financial assistance through their MyChart account.

Community Awareness: Cottage Health will work with affiliated organizations, physicians, community clinics, and other health care providers to notify members of the community about the availability of Financial Assistance under this Policy.

This Policy, Plain Language Summaries, and FAP Application forms are available on Cottage Health's website at www.cottagehealth.org/FAP and in hard copy form, upon request and without charge, in the primary language(s) of each Cottage Health Hospital Facility's Service Area. In addition, all notices and communications provided pursuant to this Policy will be available in the primary language(s) of each Cottage Health Hospital Facility's Service Area and in a manner consistent with all applicable Federal and State law. For the purposes of this Policy, a Primary Language of Hospital's Service Area is a language used by the lesser of 1,000 people or 5% of the community served by the hospital facility based upon the most recent Community Health Needs Assessment performed by the hospital.

REVIEW OF POLICY

This Policy will be reviewed periodically by the Cottage Health Finance Committee of the Board of Directors and formal approval of any changes will be approved by the Cottage Health Board of Directors.

POLICY REVISION DATE

September 28, 2018. September 27, 2019. June 19, 2020. November 4, 2020. April 2022, May 2023

Attachment A
Patient Financial Assistance Calculation Form 2023

DISCOUNT TABLES 2023

		Family Income Based Upon Number of Family Members							
Federal Poverty Level (FPL) %	Discount %*	1 Person Family	2 Person Family	3 Person Family	4 Person Family	5 Person Family	6 Person Family	7 Person Family	8 Person Family
500%	100%	$72,900	$98,600	$124,300	$150,000	$175,700	$201,400	$227,100	$252,800
510%	95%	$74,358	$100,572	$126,786	$153,000	$179,214	$205,428	$231,642	$257,856
520%	90%	$75,816	$102,544	$129,272	$156,000	$182,728	$209,456	$236,184	$262,912
530%	85%	$77,274	$104,516	$131,758	$159,000	$186,242	$213,484	$240,726	$267,968
540%	80%	$78,732	$106,488	$134,244	$162,000	$189,756	$217,512	$245,268	$273,024
550%	75%	$80,190	$108,460	$136,730	$165,000	$193,270	$221,540	$249,810	$278,080
560%	70%	$81,648	$110,432	$139,216	$168,000	$196,784	$225,568	$254,352	$283,136
570%	65%	$83,106	$112,404	$141,702	$171,000	$200,298	$229,596	$258,894	$288,192
580%	60%	$84,564	$114,376	$144,188	$174,000	$203,812	$233,624	$263,436	$293,248
590%	55%	$86,022	$116,348	$146,674	$177,000	$207,326	$237,562	$267,978	$298,304
600%	50%	$87,480	$118,320	$149,160	$180,000	$210,840	$241,680	$272,520	$303,360
610%	45%	$88,938	$120,292	$151,646	$183,000	$214,354	$245,708	$277,062	$308,416
620%	40%	$90,396	$122,264	$154,132	$186,000	$217,868	$249,736	$281,604	$313,472
630%	35%	$91,854	$124,236	$156,618	$189,000	$221,382	$253,764	$286,146	$318,528
640%	30%	$93,312	$126,208	$159,104	$192,000	$224,896	$257,792	$290,688	$323,584
650%	25%	$94,770	$128,180	$161,590	$195,000	$228,410	$261,820	$295,230	$328,640
660%	20%	$96,228	$130,152	$164,076	$198,000	$231,924	$265,848	$299,772	$333,696
670%	15%	$97,686	$132,124	$166,562	$201,000	$235,438	$269,876	$304,314	$338,752
680%	10%	$99,144	$134,096	$169,048	$204,000	$238,952	$273,904	$308,856	$343,808
690%	5%	$100,602	$136,068	$171,534	$207,000	$242,466	$277,932	$313,398	$348,864
700%	0%	$102,060	$138,040	$174,020	$210,000	$245,980	$281,960	$317,940	$353,920

* Discounts are applied toward patient out-of-pocket financial responsibility for Cottage Health bill.
Annual family income levels up to the stated dollar value are eligible for the corresponding discount.

Effective 01/27/2023

Cottage Health
GOLETA VALLEY | SANTA BARBARA | SANTA YNEZ VALLEY