Status Pending PolicyStat ID 19160247

Origination	08/2005	Policy Area	Patient Financial Services
Approved	N/A		
Last Revised	11 /2025		

SAN GORGONIO
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Charity Care and Financial Assistance

Policy:
San Gorgonio Memorial Hospital (SGMH) is committed to ensuring that all patients have access to necessary healthcare, regardless of their financial circumstances.
In accordance with California Health & Safety Code §127405:
(a) Each hospital shall maintain written discount payment and charity care policies.
(b) Each hospital shall limit expected payment for services provided to a financially qualified patient to no more than the amounts generally billed to insured patients.
Each hospital shall provide patients with a plain language summary of its charity care and discount payment policies and include it with billing statements.
Each hospital shall provide, without discrimination, charity care or discounted payments to financially qualified patients who meet the hospital's eligibility criteria.
Each hospital shall make applications, policies, and plain language summaries available on its website, by mail, and in conspicuous public locations in the hospital, including admissions and emergency departments.
Hospitals shall ensure these materials are available in English, Spanish, and other languages that meet the threshold for translation under state law.
Definitions:
Financially Qualified Patient: An uninsured or underinsured patient with documented household income at or below 400% of the Federal Poverty Level (FPL).
Charity Care (Free Care): Hospital services provided at no cost to patients with household income at or below 200% FPL.

Discounted Care: Reduced charges for patients with household income between 201%-400% FPL.
High Medical Costs: Annual out-of-pocket medical expenses that exceed 10% of the patient's household income.
Emergency Medical Condition: As defined by EMTALA, a condition manifesting by acute symptoms of sufficient severity that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health.
Procedure:
Eligibility Criteria
A. Income Level:
less than 200% FPL-> Eligible for Charity Care (100% write-off).
201%-400% FPL-> Eligible for Discounted Care (sliding scale discount).

8. High Medical Costs: Patients whose out-of-pocket medical expenses exceed 10% of their household income are eligible for financial assistance, regardless of insurance status.
Insurance Status: Both uninsured and under-insured patients may qualify.
The Director of Patient Financial Services, or designated representative, will approve applications which meet the annual Federal poverty guidelines, based on the sliding scale and will apply the appropriate discount/adjustment to the patient account.
The charity adjustment should be applied to all eligible existing accounts based on date received and dates of service.
Charity care adjustments of less than $10,000 may be approved by the Director of Patient Financial Services. Charity care adjustments greater than $10,000 must be approved by either the Chief Financial Officer (CFO) or the Chief Executive Officer (CEO), or their delegate.
If the patient is found to have a financial liability after the charity care determination, a reasonable payment plan may be set up for the balance of the account and will take into consideration the patient family's income and essential living
expenses. Extended payment plans will be offered interest free and may be assigned to a outside contractor for follow-up. If the hospital and patient cannot agree on the payment plan, the hospital shall create a reasonable payment plan, where the monthly payments are not more than 10% of the patient's monthly family income, excluding deductions for essential living expenses.
The hospital will approve or deny a completed application within 30 days of receipt of the charity care application and supporting documentation, and the patient and/or responsible party/family will be notified of the decision.
If the application is denied in total, the patient may request an additional review within 30 days

of the denial.
An additional review based on information supplied from patient will be done by the Director of Patient Financial Services, and the Chief Financial Officer may review appeals, as deemed appropriate.
Approved applications will remain valid for 3 months following the approval date in the event of additional medical expenses incurred by the patient at San Gorgonio Memorial Hospital. After 90 days, the information may be re-verified with recent check stubs, and applicable patient certification documents, as is necessary. Once determination that the financial information has not substantially changed the application may be used for an additional 90 day period.
All applications and supporting documentation will be retained within the patient's electronic health record for the minimally required period of time.
A Charity Care Log will be maintained according to state guidelines for use in cost reporting and audit purposes.
Scope of Services Covered
This policy applies to:
Emergency medical care.
Medically necessary inpatient and outpatient hospital services.
Elective procedures not deemed medically necessary may be excluded.
As required by the Health and Safety Code section 127405(a)(1)(B) An emergency physician, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level.
Application Process
Access to Applications:
Applications are available at Registration, Patient Financial Services, by mail upon request, and on the Hospital's website.
Applications are provided in English, Spanish, and other prevalent languages in the community.
Required Documentation:
Proof of income (tax returns, pay stubs, benefit statements). Family size and residency information.
Insurance coverage details, if applicable.

Review and Determination:

Financial counselors will review applications promptly.
Determination letters will be sent in writing within 30 days of receiving all required documentation.
Appeals may be submitted within 30 days of denial.

Communication and Notice
Consistent with HSC §127405(c), (e), and (f):
A plain language summary of this policy will be included in billing statements.
Copies of the policy, summary, and application will be posted in Admissions, Emergency, and Patient Financial Services areas.
All materials will be available on the Hospital's website and by mail upon request.

Materials will be translated into English, Spanish, and all other languages required under state law.

Payment Plans
Patients not qualifying for full charity care will be offered interest-free extended payment plans, consistent with state law.
Responsibilities
Patient Financial Services Department: Administers the program, reviews applications, and makes eligibility determinations.
Chief Financial Officer (CFO): Oversees compliance and reports charity care activity to the Board.
Board of Directors: Approves this policy and all subsequent revisions.

Regulatory Reference(s):
California Health & Safety Code §§127400-127446
0 §127405(a): Written policy requirement
0 §127405(b): Limitation on expected payments
0 §127405(c): Requirement for plain language summary with billing statements
0 §127405(d): Obligation to provide free or discounted care to financially qualified patients
0 §127405(e): Public availability of policy, application, and plain language summary
0 §127405(f): Language access requirements

§127405(a)(1)(B) Health and Safety Code section

Title 22, California Code of Regulations, §§96050-96051.6

Attachments

 Patient Notice of Financial Assistance .docx
 Pover!Y level sliding scale 2025.xlsx

Approval Signatures

Step Description	Approver	Date
Policy & Procedure Committee	Gayle Freude: Director Med/ Surg/CM and SW and P&P Chairperson	Pending
	Mayda Cox: Director Financial Services	11/2025

History

Comment by Cox, Mayda: Director Financial Services on 10/20/2025, 2:03PM EDT

corrected additional changed required by HCAI

Draft saved by Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson on 10/22/2025, 3:58PM EDT
Sent for re-approval by Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson on 10/22/ 2025, 3:58PM EDT

Changed workflow to include District Board approval

I **Approved by Cox, Mayda: Director Financial Services** on 10/22/2025, 3:59PM EDT

approved changes

Approved by Freude, Gayle: Director Med/Surg/CM and SW and P&P Chairperson on 10/22/2025,

4:01PM EDT

Draft saved by Cox, Mayda: Director Financial Services on 11/24/2025, 1:25PM EST

Edited by Cox, Mayda: Director Financial Services on 11/24/2025, 1:27PM EST

added additional changes requested by HCAI

Approved by Cox, Mayda: Director Financial Services on 11/24/2025, 1:27PM EST

Annual2025 POVERTY GUIDELINES: 48 CONTIGUOUS STATES				
Household *I* Family **Size**	Up to 200% of Federal Poverty Guideline	> 200% and up to 300% of Federal Poverty Guideline	> 300% and up to 400% of Federal Poverty Guideline	> 400% of Federal **Poverty** Guideline
1	$ 31,299.96	$ **46,950.00**	$ **50,862.48**	$ **62,600.04**
2	$ **42,300.00**	$ **63,450.00**	$ 68,737.56	$ **84,600.00**
3	$ **53,300.04**	$ **79,950.00**	$ **86,612.52**	$ 106,599.96
4	$ **64,299.96**	S **96,450.00**	$ 104,487.48	$ **128,600.04**
5	$ 75,300.00	S **112,950.00**	$ **122,362.56**	$ 150,600.00
6	$ **86,300.04**	S **129,450.00**	$ **140,237.52**	$ 172,599.96
7	$ 97,299.96	$ **145,950.00**	$ **158,112.48**	$ **194,600.04**
8	$ **108,300.00**	$ **162,450.00**	$ 175,987.56	$ **216,600.00**
9	$ **119,300.04**	$ 178,950.00	$ **193,862.52**	$ **238,599.96**
10	$ **130,299.96**	$ 195,450.00	$ 179,162.52	$ **260,600.04**
Patient Payment Responsibility	0% of patient bill willbeowed	Patient will owe 50% of Medicare allowed payment amount. NOTE: That would be either the Diagnosis Related Grouping (DRG) amount if Inpatient stay, or the Ambulatory Procedure Coded amount if Outpatient visit.	Patient willowe75%of Medicare allowed payment amount. NOTE: That would be either the Diagnosis Related Grouping (DRG) amount if Inpatient stay, or the Ambulatory Procedure Coded amount if Outpatient visit.	Patient will owe 125% of Medicare allowed payment amount. NOTE: That would be either the Diagnosis Related Grouping (DRG) amount if Inpatient stay, or the Ambulatory Procedure Coded amount if Outpatient visit.

Note for more than 10 family members please add $5,380 per person.

Effective January 1, 2025 **Reference:** .l:!!ms:/ /www.tederalregister.gov