STANISLAUS SURGICAL HOSPITAL
A PHYSICIAN-OWNED FACILITY
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Applicability:	*Stanislaus Surgical Hospital*

Charity Care Policy

PURPOSE:

Consistent with Stanislaus Surgical Hospital's (the "Hospital") mission of providing the best quality care for our community of patients, this Charity Care Policy (the "Policy") describes Hospital's policies and procedures related to the provision of charity care to its patients who are unable to pay for all or a portion of their financial obligations to hospital for care rendered. This Policy also describes Hospital's policies and procedures for entering into Payment Plans with patients in order to satisfy patients' financial obligations to Hospital. No referred patient will be denied medically necessary surgical services based on the demonstrated inability to pay for those services.

CHARITY CARE SERVICES:

Non-emergent, medically necessary surgical services, inpatient and outpatient, shall be available to all eligible patients under this Policy.

Specific Exclusions

- Charity care will not be available to patients for services that are not medically necessary, including but not limited to: implants, cosmetic surgery, orthodontics and lens ocular implants.
- In addition, non-essential services and services that are not appropriate to a surgical specialty hospital setting may also be excluded from this Policy.

Eligible Patients

- You are uninsured (self-pay) OR have high medical costs, AND
- Your family income is not more than 400 percent of the federal poverty level.

Definitions

- *Uninsured 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 by the Hospital. A patient also will be deemed to be uninsured for the purposes of this Policy to the extent that the patient has exhausted his or her insurance benefits.
- *Family*: for patients 18 years of age and older, a spouse, domestic partner (as defined in Section

297 of the Family Code) and dependent children under 21 years of age, whether living at home or not; (b) for patients under 18 years of age, a parent, caretaker relative and other children under 21 years of age of the parent or caretaker relative.

Family income includes the following:

- Earnings
- Unemployment compensation
- Workers' compensation
- Social Security
- Supplemental Security Income
- Public assistance
- Veterans' payments
- Survivor benefits
- Pension or retirement income
- Interest and dividends
- Rents
- Royalties
- Income from estates, trusts, educational assistance
- Alimony
- Child support
- Assistance from outside the household and other miscellaneous sources

Non-cash benefits (such as food stamps and housing subsidies) are not counted.

Family income is calculated before taxes and excludes capital gains or losses.

Patient Notification

Hospital shall post written notice related to this Policy in a prominent location within the Hospital, including, but not limited to the following:

- Patient waiting area
- Business Office
- Hospital website

Hospital shall provide patients, in a timely manner, a copy of this Policy upon request.

Financial Statement for Financial Assistance

- Hospital shall make all reasonable efforts to obtain from its patients (or their representatives) information about whether private or public health insurance may fully or partially cover the charges for care rendered.

- If hospital bills a patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, Hospital will provide a copy of the Notice of Charges and Financial Statement for Financial Assistance.

- A patient requesting charity care must return a completed Application with supporting documentation to Hospital's Business Office for review and a determination of patient eligibility.

- All Applications shall be maintained on file in Hospital's Business Office.

- A completed Application should include information regarding the patient's health benefits which may fully or partially cover the Hospital's charges for the care rendered, including, but not limited to, any of the following:

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

  If the patient has applied, and been denied coverage, under the above, the denial should be included with the Application.

  If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for full or partial charity care, neither application shall preclude eligibility for the other program.

- Patients who do not provide the requested information necessary for complete and accurate assessment of their financial situation in a timely manner may not be eligible for charity care.

- Patients who have applied for and obtained charity care within the last 12 months shall be deemed ineligible for charity care.

- Applications that do not meet all of the established criteria may be approved based upon extraordinary circumstances with the documented approval of a member of Hospital Administration.

- Charity care eligibility will be determined by and reviewed by the Hospital's Business Office Manager or other designated individual.

- The Hospital's Business Office Manager will notify the patient of Hospital's determination in writing within three (3) business days of receipt of the completed Application.

- Hospital may provide partial charity (discounts) to patients who have demonstrated an inability to pay the entire amount owed to Hospital. The criteria used to determine the amount of partial charity will apply equally to all patients regardless of payer (to extent permitted by payer).

- In the event a patient is found to be eligible for partial charity care (i.e. discounted care), Hospital shall permit the patient to pay their financial obligations to Hospital over time, without interest (Automatic Payment Plan).

Review Process

- A patient submits his or her Application with supporting documentation.

- If the Application is submitted by a patient with insurance coverage, the applicable primary payer contract or pertinent regulatory language is reviewed.

- If the payer contract or regulation language precludes discounting or write-offs of patient obligations, the Application for full or partial charity care will be declined.

- The Application will be reviewed for completeness.
    - Missing items are requested from the patient.
    - If missing items (or an acceptable alternative) are not furnished, the patient's application for full or partial charity care will be declined.

- Income test is applied and if the total family income is above 400 percent of the Federal Poverty Level or the patient's total monetary assets exceeds a ceiling, the Applications for full or partial charity care will be declined.

    Charity Care Sliding Scale

    The amount of charity will be determined using the following Charity Care Sliding Scale, to determine the level of charity and patient responsibility:

Federal Poverty Level	Charity Level	Patient Responsibility
301-400%	50%	50%
251-300%	60%	40%
201-250%	70%	30%
151-200%	80%	20%
101-150%	90%	10%
0-100%	100%	0%

- Patient responsibility, calculated from the table above, is compared to Part 5, Line G of the Application and the greater of the two amounts is to be billed to the patient.

- Full or partial charity care arrangements must be approved by a member of Hospital Administration.

- The patient is notified regarding the level of charity approved and the discounted balance to be paid.

- The patient account is appropriately noted and adjusted.

- If the patient is granted partial charity care (i.e. discounted care), Hospital shall permit the patient the opportunity to enter into an Automatic Payment Plan.

- Hospital shall negotiate in good faith with a patient granted a discounted payment to determine the terms of an Automatic Payment Plan, taking into consideration the patient's family income and essential living expenses.