CHARITY CARE/FINANCIAL ASSISTANCE

POLICY

Children's Recovery Center (CRC) strives to improve the health and well-being of the children in the community we serve regardless of their ability to pay. All patients/guarantors regardless of their insurance or level of income will be treated fairly and with respect during and after their stay at Children's Recovery Center.

This policy addresses Children's Recovery Center's commitment to assist all patients without regard to ability to pay. All uninsured patients and patients with high medical costs who are at or below 350% of the federal poverty level ("FPL") may apply for participation under the charity care policy or the discount payment policy.

PURPOSE

The purpose of this policy is to address the criteria and application process for charity care or financial assistance for patients who are uninsured or underinsured and are cared for at the Children's Recovery Center.

NOTIFICATION

Charity Care and Discount Payment information will be provided by public notice as follows:

Patient Bills: Bills mailed directly to the patient will include a notice explaining the availability of financial assistance to patients who are uninsured or have high medical costs based on a determination of eligibility in accordance with this policy. A contact and phone number for patients/guarantors to call to obtain more information about financial assistance will be included.

Posted Notices: Notices will be posted in the Administration and admitting areas indicating how to obtain information about financial assistance.

Distributed Notices at time of registration: Notices will also be distributed in the Administration and admitting areas indicating how to obtain information about financial assistance. All such notification shall be provided in English and Spanish and will be translated for patients/guarantors who speak other languages.

EXCLUSIONS

Children's Recovery Center's charity care and discount policy does not apply to physician or professional charges that are not billed by the hospital.

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PROCEDURE

CRC limits eligible patients' obligation to not more than the applicable Medi-Cal rates in effect at date of service. All patient information is kept confidential, and the handling of personal health information is protected in accordance with federal and state privacy laws.

Our collection policy prohibits pursuing legal action for non-payment of bills against any patient/guarantor who is unemployed and/or without other significant income. Nor do we charge interest in installment payment plans.

Patients/guarantors are expected to cooperate with CRC's financial assistance procedures and to contribute to the cost of their care based on their ability to pay.

CHARITY CARE ELIGIBILITY

A patient is eligible for charity care at no charge to the patient or their family if they meet the following eligibility requirements.

Uninsured:

A patient who is uninsured and who is at or below 200% of the federal poverty level (FPL) is eligible to apply for charity care.

Insured:

A patient who is insured but has "high medical costs" and who is at or below 200% of the federal poverty level (FPL) is eligible to apply for charity care. High medical costs are defined as annual out-of-pocket medical expenses incurred by the patient at CRC that exceed 10% of the patient/guarantor's income in the prior 12 months.

DISCOUNT PAYMENT ELIGIBILITY

A patient is eligible for discounted payments based upon the following eligibility criteria.

Uninsured:

A patient who is uninsured and who does not qualify for charity care may be eligible for a partial discount as long as their income is at or below 350% of the federal poverty level.

Insured:

A patient who does not qualify for charity care and is insured but has "high medical costs" and who is at or below 350% of the federal poverty level (FPL) is eligible to apply for a partial discount.

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In order to qualify for either Charity Care or Discount Payments, the patient must apply for Medi-cal coverage, as requested. If denied, then the patient must provide CRC with the written denial. In addition, the patient must complete a Financial Assistance Application Form and return it to the Administration office within two weeks.

The review process begins once the application has been received by Administration. The applicants will be screened to identify any connection with Medicare, Medi-Cal, Health Family Program, California Children's' Services or any other payers source. Administration will review the application to determine its completeness and that the required information is attached. Administration will review the documents within three business days to confirm that the information provided by the patient is substantiated. Administration will validate proof of income through pay stubs or income tax returns. The review process includes:

1) Determination of whether the patient is eligible as a self-pay patient or insured patient.

2) If the patient is applying as a self-pay: Calculate FPL percentage, Obtain Medi-Cal Denial and determine discounted percentage based on FPL percentage

3) If patient is applying as an insured patient: Determine whether the patient liability is based on a discounted rate from the hospital's charges as negotiated between the hospital and the insurer; calculate FPL percentage; if applicant is below 350% FPL then determine whether the patient has high medical costs; if high medical cost is greater than 10%of annual family income then determine discount if any.

4) The Director, Patient Care or CEO must approve the application determination as follows:

   Charity Care: Patient is eligible for 100% charity care or free care.

   Discount Payment: Patient is eligible for, at a minimum, the greater of Medi-Cal or CCS payment rate. The discount level increases based on a sliding scale as follows:

Self Pay patients:	FPL at 201-250%	75% Discount
	FPL at 251-300%	50% Discount
	FPL at 301-350%	25% Discount

   Insured patients: Patient liability reduced to difference between Medi-Cal Rate and Insurance payment.

   Denied: No financial assistance is granted

5) After Approval:

The Billing Department will adjust the approved discounted amount, leaving the patient with a zero or discounted amount due.

The Billing Department will send the patient a letter of acceptance.

6) After Denial:

The Billing Department will send the patient a denial letter, stating the reason for the denial.

7) Appeals to Denied Applications

The application being appealed will be reviewed by the DON or the CEO.

If the denial is reversed then the reviewer will send the patient an appeal acceptance letter stating the reason for the acceptance.

8) Debt Collections for Eligible Patients

If a payment has not been received in full by agreed upon timeline, the Billing Department will enforce its debt collection policy.

The hospital shall not allow an account to have adverse information reported to a credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 180 days after billing.