SENECA HEALTHCARE DISTRICT
POLICY & PROCEDURE

DEPARTMENT: FINANCE **POLICY TITLE: CHARITY CARE** **POLICY/REFERENCE #: FIN-006.004**	**PAGE 1 OF 15**
COMPLIANCE REQUIREMENT: CA Health and Safety Code §127400 through §127446; Assembly Bill 1020	**EFFECTIVE DATE: 12/30/2021**

POLICY

Seneca Healthcare District (SHD) shall offer all patients charity care as applicable state and federal regulations dictate. Charity care is a *resource of last resort.*

PROCEDURE

1. **Purpose**

   The purpose of the Charity Care policy is to provide discount guidelines for the consistent determination of uncompensated or partial pay care to patients who may not qualify for state, federal, county or other assistance and or have no reasonable means to pay for services received.

2. **Responsibilities**

   The SHD Finance department is responsible for offering charity care to all eligible SHD patients. SHD Finance staff is responsible for obtaining the necessary information for determining patient eligibility and any corresponding discount to the patient's financial obligation to SHD.

3. **Policy for Charity Care**

   a. ***Policy***

   i. Seneca Healthcare District is committed to treating all patients equitably, with dignity, respect and compassion regardless of their financial status or ability to pay. In support of this commitment SHD has established a Financial Assistance Program which offers both free and discounted care, depending on individuals' family size and income.

   ii. Patients seeking assistance may fist be asked to apply for other external programs as appropriate before eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the

financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being. Financial assistance is provided only when care has been provided and is deemed medically necessary and after the patient has been found to meet all financial criteria.

b. ***Definitions***

1. Medically Necessary: Health care services or products that a prudent physician would provide to a patient to prevent, diagnose, or treat an illness, injury, or disease, or any symptoms thereof, that are necessary and are:
2. Provided in accordance with generally accepted standards of medical practice
3. Clinically appropriate with regard to type, frequency, extent, location and duration,
4. Not primarily provided for the convenience of the patient, physician or other provider of the health care,
5. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
6. The most clinically appropriate level of health care that may be safely provided to the insured.

ii. Emergency Care: Immediate Care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.

iii. Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.

iv. Underinsured: Patients having some insurance coverage but not enough, or when a patient is insured yet unable to afford the out-of-pocket responsibilities not covered by patient insurer.

v. Presumptive Eligibility: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

vi. Financial Assistance Committee: A multi-disciplinary team formed internally to review all financial assistance applications for approval and denial determinations in accordance with this policy.

vii. Catastrophic Financial Assistance: Financial assistance available to patients with a federal poverty level, greater than 400% and whose annual out-of-pocket costs are greater than 10% of the patients current family income or family income in the prior 12 months. Eligible patients will be considered for a catastrophic discount that will cap their out-of-pocket expense at a 25% threshold of annual gross income. Should the patient default on payment arrangements for the discounted balance, the catastrophic discount shall be added back to the account with the adjusted balance referred to a collection service.

c. ***Eligible Services***

i. **Covered:** Emergency medical services, general acute care hospital services and rural health clinic services.

ii. **Not Covered:** Elective procedures/surgeries/services, cosmetic services, and skilled nursing services.

d. ***Charity Care Criteria***

i. All homeless and/or uninsured patients are referred to SHD's patient financial counselor/or outside billing company (HRG) for assistance with acquiring third party coverage or applying for charity care.

ii. Eligibility

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination (Attachment A).
2. Gross income should fall within established standard for determination of the FPL, considering family size, geographic area and other pertinent factors.
3. Family size will be considered. For this purpose, "Family" is defined, for an adult patient as spouse, domestic partner, and dependent children under the age of 21, whether living at home or not. For patients under the age of 18, "Family" is defined as the patient's parent(s) and/or caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
4. If a dependent child is over the age of 18 and does not appear on a parent or caretaker's most recent tax return, the dependent child must provide a copy of their own most recent tax return.
5. Patients whose family income is at or below 150% of the FPL are eligible to receive 100% charity care.
6. Patients whose family income is above 150% but not more than 400% of the FPL are eligible to receive reduced rates, based on a sliding fee scale.
7. Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
8. Patients whose out-of-pocket medical expenses exceed 10% of their prior 12 months of income may be eligible for financial assistance at the discretion of SHD.
9. Charity status will be determined by the Chief Financial Officer (CFO) and Patient Financial Counselor, after the time of discharge and after all required documentation is submitted by the patient or responsible party.
10. Once the account is settled, the information used for determination will be kept on file by SHD for at least seven (7) years.
11. Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to SHD may request a payment plan from SHD's patient financial counselor.
12. Patients who are a victim of a crime could be eligible for State of California funding from the Victim of Crime (VOC) program. Patients can apply at the District Attorney's office at the courthouse in Quincy. The patient will not qualify if:
    a. There is insurance involved;

b. He/she initiated the crime;
c. He/she expires.

iii. Patients with Insurance
1. Medi-Cal Share of Cost recipients do not qualify for Charity Care as their financial responsibility has been predetermined through the Medi-Cal assessment process.
2. Inpatient days denied by Medi-Cal as not medically necessary become eligible for Charity Care if the denial is upheld following SHD appeal. The Medi-Cal denied day(s) will be adjusted for purposes of stating the "uncollectible" as the charity care amount in preference to inflating the Medi-Cal allowance.
3. Patients with Medicare and commercial HMO/PPO coverage are eligible for Charity Care. If these patients have large out of pocket expenses they will be considered and approved for charity care if they meet all financial requirements. No discount will be applied to the remaining portion of the patient's claim until after their primary and any secondary insurance payments and contractual adjustments are applied.

iv. Hospital Presumptive Eligibility (HPE)
1. An admissions representative will assist uninsured patients to apply for Hospital Presumptive Eligibility.

e. ***Specific Procedure:***

i. Identification
1. Candidates for Charity Care can be identified at any point along the patient revenue cycle. Every effort shall be made to identify eligibility during the service period.
2. Initial referrals may be directed to the patient financial counselor or the business office.
3. The patient/guarantor is instructed regarding the application process and is provided SHD's Charity Care Application to complete.
4. Notes related to patient conversations/encounters and application information is documented in the appropriate system by SHD staff.

ii. Pending Applications
1. The application for charity care and all supporting documentation completed by the patient are thoroughly researched and reviewed.
2. A review of insurance, lack thereof, and identification of any other potential payer source is conducted.
3. Pages 5 and 6 of the application are completed by a SHD representative in the finance department.
4. The patient financial counselor follows up to obtain any additional information needed by phone or by sending letters requesting documentation. If, after three (3) documented contacts have been attempted and the 150th day from application is exceeded without receipt of the requested information, the application is documented as denied in the Electronic Medical Record system, closed, and the account released from hold status to resume processing as a Self-Pay receivable per protocol.

5. Charity care applications are reviewed by the patient financial counselor or appropriate SHD personnel per the approved Write Off Matrix (Attachment B).
6. Authorized employees must sign their approval or denial and reason for determination on the application. Authorized employees must assure that reasonable efforts have been made to assure that alternative resources are not available to cover the cost of services.
7. The file will then be returned to the patient financial counselor to process any authorized write-offs and send the Eligibility Determination Notice (Attachment D) to the patient, if requested.
8. The patient financial record with eligibility determination will be archived for no less than 7 years.

iii. Denied Applications

1. An Eligibility Determination Notice (Attachment D) is mailed to the address submitted during the application.
2. A request for appeal of a final determination must be made in writing to the SHD Compliance Committee within 30 days of the final determination. An independent review of the patient or guarantor's financial information will be performed and the patient/guarantor will be notified of the review outcome within 30 days.
3. The patient's financial class reverts to Self-Pay and the account is processed as a Self-Pay receivable per protocol. Patients may request a payment plan from the patient financial counselor (Attachment C.)

4. **Enforcement**

Violation of this policy may result in disciplinary action, up to and including termination as outlined in the Sanctions Policy/Procedure, CMPL-005.

REFERENCE

California Hospital Association. (2015.) Hospital Financial Assistance Policies and Community Benefit Laws; Second Ed. California Hospital Association; Sacramento CA

Iacino, J. (December 4, 2014.) SB 1276: Hospital Fair Billing Practices (Charity Care and Discount Payment Plans.) California Department of Public Health.

Rowert, K. (November 19, 2014.) AB 774 Reporting Requirement Changes. Office of the Statewide Health Planning and Development; Accounting and Reporting Systems Section.

Attachment A: Federal Poverty Limit Guidelines
Attachment B: Write-Off Matrix *(1 page)*
Attachment C: FIN-FORM-001.001- Charity Care Application *(6 Pages)*
Attachment D: FIN-FORM-004.001 Eligibility Determination Notice *(1 page)*

Attachment A: Federal Poverty Limit Guidelines

2021 FEDERAL POVERTY GUIDELINES									
Annual Income Guidelines									
Family Size	100%	138%	150%	200%	200%	250%	300%	350%	400%
1	12,880.00	17,774.40	19,320.00	25,760.00	25,760.00	32,200.00	38,640.00	45,080.00	51,520.00
2	17,420.00	24,039.60	26,130.00	34,840.00	34,840.00	43,550.00	52,260.00	60,970.00	69,680.00
3	21,960.00	30,304.80	32,940.00	43,920.00	43,920.00	54,900.00	65,880.00	76,860.00	87,840.00
4	26,500.00	36,570.00	39,750.00	53,000.00	53,000.00	66,250.00	79,500.00	92,750.00	106,000.00
5	31,040.00	42,835.20	46,560.00	62,080.00	62,080.00	77,600.00	93,120.00	108,640.00	124,160.00
6	35,580.00	49,100.40	53,370.00	71,160.00	71,160.00	88,950.00	106,740.00	124,530.00	142,320.00
7	40,120.00	55,365.60	60,180.00	80,240.00	80,240.00	100,300.00	120,360.00	140,420.00	160,480.00
8	44,660.00	61,630.80	66,990.00	89,320.00	89,320.00	111,650.00	133,980.00	156,310.00	178,640.00
Monthly Income Guidelines									
Family Size	100%	138%	150%	200%	200%	250%	300%	350%	400%
1	12,880.00	1,481.20	1,610.00	2,146.67	2,146.67	2,683.33	3,220.00	3,756.67	4,293.33
2	17,420.00	2,003.30	2,177.50	2,903.33	2,903.33	3,629.17	4,355.00	5,080.83	5,806.67
3	21,960.00	2,525.40	2,745.00	3,660.00	3,660.00	4,575.00	5,490.00	6,405.00	7,320.00
4	26,500.00	3,047.50	3,312.50	4,416.67	4,416.67	5,520.83	6,625.00	7,729.17	8,833.33
5	31,040.00	3,569.60	3,880.00	5,173.33	5,173.33	6,466.67	7,760.00	9,053.33	10,346.67
6	35,580.00	4,091.70	4,447.50	5,930.00	5,930.00	7,412.50	8,895.00	10,377.50	11,860.00
7	40,120.00	4,613.80	5,015.00	6,686.67	6,686.67	8,358.33	10,030.00	11,701.67	13,373.33
8	44,660.00	5,135.90	5,582.50	7,443.33	7,443.33	9,304.17	11,165.00	13,025.83	14,886.67

Attachment B: Write Off Matrix

Financial Assistance Program Disocunt based on Federal Poverty Guidelines	
FPL	Discount
0-150%	100%
151-250%	75%
251-350%	50%
351-400%	25%

	Estimated or Actual Amount
Patient Financial Counselor	Up to and including $500
Chief Financial Officer	Above $500

**Amounts shown are maximum per account or combined account balance.*

SENECA
HEALTHCARE DISTRICT

Seneca Healthcare District Charity Care Application

Instructions:

1. **The following documents are required to be submitted with your completed Charity Care Application (copies only, originals will not be returned):**
   - Patient must apply to Covered California and/or Medi-Cal. Eligibility or denial for insurance coverage must be presented to SHD within 30 days of receipt.
   - Copies of 3 (three) most recent pay stubs from all employers
     - If unemployed, a copy of unemployment benefits award letter or pay stub within the last 30 days
   - Copy of most recent income tax return
   - Copy of most recent bank statement(s)
   - Copy of most recent rent/mortgage receipt
   - Copy of most recent utility bills

2. Return completed application to either:

   Seneca Healthcare District
   P.O. Box 1460
   Chester, CA 96020
   Attn: Finance Department

   Or it may be delivered in person at Seneca Healthcare District, 199 Reynolds Road, Chester, CA 96020

3. SHD will complete the remainder of the application, including a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history, and notify the patient of the determination in writing within 45 days of receipt of a completed application.

4. If you have questions or need assistance in completing this application, please contact our Business Office at **855.896.6853.**

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Seneca Healthcare District Charity Care Application

PATIENT INFORMATION

Patient Name: _____

Telephone Number: _____

Address: _____

_____

If Minor; Guardian Name: _____

Do you have? ❒Medi-Cal ❒Medicare ❒Other Insurance ❒Uninsured

If uninsured, have you applied for Medi-Cal/Covered California? ❒ Yes ❒ No

FAMILY INFORMATION

List all dependents that you support below:

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ASSET INFORMATION

Bank Name: _____ Account Number: _____ Balance: $_____

Bank Name: _____ Account Number: _____ Balance: $_____

Bank Name: _____ Account Number: _____ Balance: $_____

Other Assets: _____

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Seneca Healthcare District Charity Care Application

Application Continued:

INCOME INFORMATION

Earned Income (If patient is a minor list parent(s)/guardian(s) income)

Patient's Gross Income: $_____

Spouse's Gross Income: $_____

Other Income

Unemployment: $_____

Social Security: $_____

Dividends/Annuities: $_____

Rental Property: $_____

Other (explain): $_____

Total Monthly Income: $_____ **Total** $_____

(Total of Gross Income, Spouse Gross Income, and Other Income)

EXPENSES INFORMATION

Auto payment: $_____/mo Year/Make/Model: _____

Auto payment: $_____/mo Year/Make/Model: _____

Credit Card: Balance $_____ Limit $_____ Monthly Payment $_____

Credit Card: Balance $_____ Limit $_____ Monthly Payment $_____

Monthly Utility Bills: $_____

Average Monthly Food Bill: $_____

Monthly Utility Bills: $_____

Monthly Utility Bills: $_____

Monthly Utility Bills:$_____

(Please attach additional sheets if necessary to include additional credit/personal loan/medical obligations)

_____

SENECA
HEALTHCARE DISTRICT

Seneca Healthcare District Charity Care Application

Patient Disclosure Report:

Account Number(s): _____

The purpose of this information request is to determine your ability to pay for services at Seneca Healthcare District or your possible eligibility for our Charity Care Policy. This information is **not** an application for Medi-Cal, Covered California, or any County assistance program. Seneca Healthcare District's patient financial specialist will provide you a copy of these applications upon request. If you have been denied by Medi-Cal, Covered California, or County Medical Financial Assistance, submit a copy of the denial with this form.

I_____(print name) certify the foregoing information to be true and correct. I understand Seneca Healthcare District reserves the right to verify all information supplied, including a credit check. I agree to notify the Business Office of any change in my financial information within 10 (ten) days of the change.

I UNDERSTAND THAT UNTIL CHARITY CARE HAS BEEN GRANTED, I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT SENECA HEALTHCARE DISTRICT.

If you have any questions, please call Seneca Healthcare District's Business Office 855-896-6853.

_____ _____

Signature of Patient/Responsible Party Date

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Seneca Healthcare District Charity Care Application

Financial Assessment Worksheet:
*** For Office Use Only ****

Patient Name: _____

Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____
Account:	_____	D.O.S:	_____	Total Charges:	$_____	Balance:	$_____

Date and initial upon receipt of the following documentation:
_____ Covered California/Medi-Cal eligibility or denial
_____ Copies of 3 (three) most recent pay stubs from all employers
_____ If unemployed, copy of unemployment benefits award letter or pay stub within the last 30 days
_____ Copy of most recent income tax return
_____ Copy of most recent bank statement(s)
_____ Copy of most recent rent/mortgage receipt
_____ Copy of most recent utility bills

If all documentation was not received with the application or additional information was requested, date and initial the 3 attempts to contact the patient:
_____ 1st attempt
_____ 2nd attempt
_____ 3rd attempt

Notes:
_____
_____
_____
_____
_____

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Seneca Healthcare District Charity Care Application

Financial Assessment Worksheet Continued:
*** For Office Use Only ****

Summary

Family Size: _____
Gross Annual Family Income: $_____ (A)
Federal Poverty Guideline: $_____ (B)
Percent of FPL _____% A/B
Percentage Discount Applicable: _____%

Worksheet Prepared By:

_____ _____ _____
Signature *Printed Name* *Date*

APPROVAL/DENIAL

Approved: ❒ Denied: ❒ Reason _____

Charity Care Amount Approved: $_____

Accounts to apply charity care write off to:

Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____
Account: _____ Amount: $_____ Date of write off: _____ Initials _____

If total amount of charity care approved ≤ $500, approval required by Patient Financial Counselor
If total amount of charity care approved > $500, approval required by CFO

_____ _____ _____
Signature *Printed Name* *Date*

Attachment D: FIN-FORM-004.001 Eligibility Determination Notice

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ELIGIBILITY DETERMINATION FOR CHARITY CARE PROGRAM

Seneca Healthcare District has conducted an eligibility determination for Charity Care Program for: _____ (Patient's Name) for the following accounts and dates of service:

Account: _____ DOS: _____
Account: _____ DOS: _____
Account: _____ DOS: _____
Account: _____ DOS: _____
Account: _____ DOS: _____

The request of charity care program assistance was made by the patient or on behalf of the patient on _____. This determination was completed on _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

____ Your request for Charity Care has been approved for services rendered on _____ with a balance on account of $_____. If partial charity care was approved and a remainder balance remains due, our office will need to be informed as to how your account balance will be satisfied. Please contact our billing office at 855-896-6853 to make arrangements.

____ Your request for Charity Care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____

____ Your request for Charity Care has been denied because:

_____
_____
_____

If you have any question on this determination, please contact Steve Boline, Chief Financial Officer at (530) 258-3099.

Thank you,

Seneca Healthcare District
Finance Department