
# AB 1020

# CHARITY CARE AND DISCOUNT PAYMENT AND POLICIES

**Effective Date: June 17, 2025**

**Submitted by: Gateways Hospital and Mental Health Center**
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GATEWAYS HOSPITAL & MENTAL HEALTH CENTERS

# TABLE OF CONTENTS

## LIST OF ATTACHMENTS

**PAGE**

GATEWAYS HOSPITAL & MENTAL HEALTH CENTERS

# GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER

## SECTION I

### Background

Gateways Hospital and Mental Health Center is a private non-profit public beneficiary corporation. The Acute Psychiatric Hospital and Mental Health Center receives 100% of its funding from the Los Angeles County Department of Mental Health ("DMH") through a Short Doyle/Short Doyle Medi-Cal contract — a California funding program that supports community mental health services for individuals with Medi-Cal and limited income. These funds ensure the delivery of mental health services to indigent Medi-Cal eligible persons residing in Service Area Four.

Gateways Hospital operates a fifty-five-bed acute psychiatric hospital with two distinct units: one generally designated for adolescents (ages 13 to 17) and one for adults (ages 18 to 64). While the units are currently arranged to provide 27 beds for adolescents and 28 beds for adults, the hospital retains flexibility to reassign unit space based on census needs.

## CHARITY CARE AND DISCOUNT PAYMENT POLICY

### I. POLICY.

As a Short Doyle/Short Doyle Medi-Cal provider, Gateways Hospital and Mental Health Center ("Gateways") follows the screening protocols established by the Los Angeles County Department of Mental Health (DMH) and the California Department of Health Care Services for patients who are indigent or eligible for Medi-Cal.

This policy is intended to ensure that individuals with medical and psychiatric needs — who are uninsured, underinsured, or ineligible for public benefits — can still receive medically necessary treatment. Financial assistance is based on each person's financial situation.

In line with our mission to provide effective and accessible care to all referred individuals, Gateways is committed to ensuring that someone's financial situation does not prevent

them from receiving needed mental health services.

While we offer payment assistance, it is not meant to replace personal responsibility. Patients are expected to participate in the process of applying for assistance and contribute to their care based on what they can reasonably afford. Those who are able to purchase health insurance will be encouraged to do so to help ensure long-term access to services and to protect their financial well-being.

To responsibly manage our available resources and reach as many people in need as possible, the Gateways Board of Directors has approved the following guidelines for providing payment assistance.

## II. PROCEDURES.

### A. Eligible Services.

**1.** Charity care and discount payment apply to all emergency and medically necessary psychiatric services provided at Gateways Hospital. This includes both inpatient and outpatient behavioral health services.

Eligible services include:

a. **Crisis and psychiatric emergency services** for patients who are in serious mental distress — such as those thinking about suicide, at risk of harming others, or who have harmed themselves — as well as those experiencing major life disruptions like traumatic loss, violence, or other severe mental health symptoms

b. **Services for patients with "grave disability,"** meaning they are unable to care for themselves due to a psychiatric condition, as determined by clinical assessment.

c. **Other medically necessary services,** based on clinical judgment and reviewed on a case-by-case basis.

### B. Eligibility for Patient Payment Assistance.

**1.** Patients may qualify for financial help if they do not have insurance or if their insurance does not fully cover their care. Eligibility is based on family income. Individuals and families with an income at or below 400% of the Federal Poverty Level (FPL) may be eligible for full or partial assistance. Gateways follows current FPL guidelines published annually by the U.S. Department of Health

and Human Services to determine eligibility.

2. Gateways Hospital does not discriminate based on race, color, national origin, age, disability, sex, gender identity, sexual orientation, religion, immigration status, or any other protected category when determining eligibility for financial assistance. Assistance is offered equitably and confidentially, based solely on financial need

**C. <u>Assessment of Financial Need.</u>**

1. Financial need will be determined through a process that involves an individualized assessment, which includes the following:
   a) The patient or the patient's guarantor must provide personal, financial, and other relevant documentation necessary to evaluate financial need;
   b) Gateways will make reasonable efforts to identify and assist with enrollment in alternative sources of coverage from public and private programs;
   c) The assessment will consider the patient's available assets and other financial resources;
   d) Gateways will review the patient's outstanding account balances and prior payment history.

   This determination is primarily based on payor financial information collected during the initial interview (see Payor Financial Information Form, Attachment One)
2. While it is preferred that the request and determination of payment assistance occur prior to receiving services, this is not required. Payment assistance eligibility will be re-evaluated:
   a. at each subsequent service encounter if more than one year has passed since the last evaluation, and any time new financial information becomes available that may impact eligibility.
3. All requests for payment assistance will be reviewed promptly by Gateways' Billing and Collections Department. Patients will be notified of the outcome within two weeks of submission.

**D. <u>Patient Payment Assistance Guidelines</u>**:

1. Services eligible under this policy are offered on a sliding scale based on family income as compared to the Federal Poverty Level (FPL), consistent with the Uniform Patient Fee Schedule for community mental health services (see Attachment Two). This schedule is used by Short Doyle/Short Doyle Medi-Cal providers as part of contractual requirements with the Los Angeles County Department of Mental Health. The payment assistance guidelines are as follows:

   a. Patients with income at or below 200% of the FPL-**Will receive** 100% charity care, with all eligible services provided free of charge using Short Doyle indigent care funds.
   b. Patients with income between 201% and 400% of the FPL-Are eligible to receive discounted care based on the number of dependents and average reimbursement rates received by Gateways from Medi-Cal, Medicare, or other participating health programs. Discount rates are determined using a standardized scale approved by Los Angeles County DMH.
   c. Patients with high medical costs-Individuals whose medical expenses exceed 10% of their annual household income**,** regardless of income level, may qualify for catastrophic discount assistance under AB 1020.
   d. Patients above 400% of the FPL-May be considered for case-by-case discounts based on financial hardship, medical necessity, and availability of hospital resources. Final eligibility in these cases will be determined at Gateways' discretion.

**E. <u>Notification of Payment Assistance Programs to Patients and to the Public</u>**

1. Gateways provides information about its financial assistance program through multiple channels:
   a. Notices are posted in highly visible locations such as waiting rooms, admitting areas, and registration desks at the hospital and affiliated service sites.
   b. Information is also made available on Gateways' website.
   c. Notices are provided in English and in the top 15 languages spoken by Limited English Proficient (LEP) populations in California, in accordance with state requirements.

d. Materials can be requested in alternative formats such as large print, upon request.
e. Anyone may refer a patient for payment assistance, including Gateways' staff, medical staff, physicians, nurses, case managers, or social workers. Requests for assistance may also come directly from the patient, or from a family member, close friend, or authorized representative, consistent with applicable privacy laws.

**F. Budgeting and Reporting**.

1. Funds received through contributions and fundraising activities will be reflected in Gateways' Fundraising Budget. When appropriate, these funds may be used to supplement the indigent care funds provided by the Los Angeles County Department of Mental Health.
2. Gateways may voluntarily report patient assistance costs as deemed appropriate. Statistics related to charity care and discounted payment assistance will be included in Gateways' annual financial statements. These figures will not include amounts written off as bad debt or contractual adjustment

**G. Collection Policies**.

1. Gateways' Business Office has established procedures for both internal and external collection practices that consider a patient's eligibility for payment assistance, their efforts to apply for County or State programs, and their willingness to comply with payment plans.
2. For patients who qualify for financial assistance and actively cooperate in resolving their bills, Gateways will:
   a. Offer interest-free extended payment plans;
   b. Not place liens on primary residences;
   c. Not pursue wage garnishments;
   d. Not refer accounts to collection agencies unless the patient has been determined ineligible for assistance and fails to respond after being notified.

3. These practices align with the patient protections required by Assembly Bill 1020, which prohibits aggressive collection efforts before a financial assistance determination is made and extends the timeframe for such actions to 180 days after initial billing.

## H. Regulatory Requirements.

1. In carrying out this policy, Gateways Hospital will comply with all applicable federal, state, and local laws and regulations, including but not limited to:
    a. Assembly Bill 1020 (AB 1020) – Hospital Fair Billing Policies
    b. California Health and Safety Code §127410(a) – Patient billing and language access
    c. Title 22, California Code of Regulations §96051.1(a)(4) – Language translation requirements for financial assistance notices
2. Gateways will ensure that all required documents and notices are accessible, understandable, and made available in the required formats and languages.

**ELIGIBILITY & APPLICATION POLICY AND PROCEDURE FOR PAYMENT ASSISTANCE FOR PSYCHIATRIC IN-PATIENT & OUT-PATIENT SERVICES**

## SECTION II

## I. POLICY:

To help provide financial support to as many individuals in need as possible, Gateways Hospital and Mental Health Center ("Gateways") has established the following eligibility and application guidelines for its Patient Payment Assistance Program. These guidelines are designed to comply with current California requirements, including Assembly Bill 1020**,** and reflect Gateways' commitment to equitable access to medically necessary mental health services, regardless of a patient's ability to pay.

## II. PURPOSE:

The purpose of this section is to outline the financial criteria and procedures Gateways uses to evaluate whether a patient qualifies for financial assistance. This ensures consistency, fairness, and transparency in how support is offered through the Patient Payment Assistance Program.

## III. DEFINITIONS:

1. **Eligible Psychiatric Services**: Psychiatric services eligible for Payment Assistance Discounts include the following:
   a) Crisis intervention services provided in the psychiatric outpatient departments at Gateways.
   b) Psychiatric emergency services (i.e., patients considered to be dangerous to self and/or others and/or gravely disabled) requiring inpatient treatment.
   c) Any other medically necessary psychiatric services not covered by (a) and (b) above.
2. **Federal Poverty Level (FPL)**: The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human

Services, under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

3. **Financially Qualified Patient:** A patient who is uninsured, underinsured, or experiencing high medical costs, and whose family income is at or below 400% of the Federal Poverty Level (FPL), consistent with the eligibility criteria defined in California Health and Safety Code §127400(g) as amended by Assembly Bill 1020.
4. **Income:**
    a. The Payment Assistance application requires applicants to provide information on their gross income (i.e., annualized income before taxes). Sources of gross income include, but are not limited to:
        i. Wages and salaries
        ii. Social Security payments
        iii. Public assistance
        iv. Unemployment and workers' compensation
        v. Veterans benefits
        vi. Child support and alimony
        vii. Pensions
        viii. Regular insurance and annuity payments
        ix. Income from estates and trusts
        x. Asset withdrawals (e.g., bank accounts)
        xi. Proceeds from the sale of property or liquid assets
        xii. One-time insurance or compensation payments
    b. **Additional considerations:**
        i. The ability to borrow against assets (e.g., life insurance) should be considered a source of income. However, the ability to borrow against a primary residence shall not be included.
        ii. Food or rent received in lieu of wages may be considered income if appropriate documentation is provided.
    c. **Qualified Monetary Assets:**
        i. A portion of a patient's monetary assets will be included in the gross income calculation, except for those who qualify as a **Person with**

**High Medical Costs** (as defined elsewhere in this policy). The inclusion will follow this formula:

- The first $10,000 of a patient's monetary assets will not be counted.
- 50% of the amount exceeding $10,000 will be included in the income calculation.

5. **Payment Assistance Rank Ordering ("PARO") Score**: PARO is a scoring tool that uses a patient's demographic data to estimate their financial status by accessing publicly available databases. It provides an estimate of the patient's household income and size, which helps Gateways determine an approximate Federal Poverty Level (FPL) percentage. While the PARO score offers a helpful estimate, it is not used as the sole source in determining eligibility for payment assistance. Additional supporting documentation or circumstances are required. PARO may also be used to validate financial and demographic information submitted by the patient during the payment assistance eligibility review.

6. **Patient With High Medical Costs**: An underinsured individual whose household income does not exceed 350% of the Federal Poverty Level (FPL), who does not already receive a discounted rate through third-party coverage, and meets one of the following criteria:
   a. The patient's out-of-pocket costs incurred at the hospital in the past 12 months exceed 10% of their household income;
   b. The patient's total out-of-pocket medical expenses (regardless of provider) in the past 12 months exceed 10% of household income, with supporting documentation provided;
   c. The patient meets a lower financial threshold determined by Gateways in accordance with this Payment Assistance Policy.
7. **People in Household/Patient's Household:** The Payment Assistance application form (see Attachment Three) requests specific information about people in the guarantor's household, including name, date of birth, income, employer, and employer phone number. In accordance with Medicaid and California State guidelines, the applicant may only include individuals who meet

the following criteria as part of their household:

a. **For persons 18 years of age and older:**
    i. Spouse or registered domestic partner
    ii. Dependent children under 21 years of age, whether living at home or not
    iii. The separate children of either unmarried parent or of the parent or stepparent
    iv. If there are no children, the household consists of a single person or a married couple
b. **For persons under 18 years of age:**
    i. The parents, married or unmarried, of sibling children
    ii. The stepparents of the sibling children
    iii. A caretaker relative or child under 21 years of age of the parent or caretaker relative

Gateways Hospital continues to use the Uniform Patient Fee Schedule for Community Mental Health Services (1989)**,** as required by the Los Angeles County Department of Mental Health (LACDMH), to determine UMDAP liability for DMH-funded services. While this Payment Assistance Policy has been updated to comply with AB 1020 and Title 22 CCR §96051.1(a)(4)**,** the DMH sliding scale remains applicable and is provided as Attachment Three.

8. **Qualified Monetary Assets**: The Payment Assistance application form requests specific information regarding Qualified Monetary Assets. For purposes of the application, these include

    **a. Savings:** Cash equivalents held by any member of the household, excluding funds in tax-exempt accounts or retirement/deferred-compensation plans qualified under the Internal Revenue Code. This includes accounts such as 401(k), 403(b), or IRA savings accounts, which are not considered qualified savings for this purpose

    **b. Other Monetary Assets:** The estimated fair market value of any other real assets that are readily convertible to cash and held by any member of the household.

## 9. DISCOUNT CALCULATION PROCES:

**a.** The Uniform Patient Fee Schedule is used to determine a patient's payment assistance allowance. All discounts below are based on total charges and are calculated independently of the Uninsured Patient Discount**.**

**i.** Patients with income ≤ 200% of the FPL are eligible for free care (100% discount)

**ii.** Patients with income between 201% and 350% of the FPL are eligible to receive services at the highest average rate reimbursed by any government-sponsored health program in which Gateways participate

**iii.** Patients with income between 351% and 500% of the FPL are eligible for services at 135% of the highest average government rate.

**iv.** Patients with income above 500% of the FPL may qualify for discounted rates on a case-by-case basis based on hardship or medical indigence.

The 2024 poverty guidelines are in effect as of January 17, 2024
The Federal Register notice for the 2024 Poverty Guidelines published January 17, 2024

| Family Size | 100% | 200% | 350% | 400% | 500% |
|---|---|---|---|---|---|
| 1 | $15,060 | $30,120 | $52,710 | $60,240 | $75,300 |
| 2 | $20,440 | $40,880 | $71,540 | $81,760 | $102,200 |
| 3 | $25,820 | $51,640 | $90,740 | $103,280 | $129,100 |
| 4 | $31,200 | $62,400 | $109,200 | $124,800 | $156,000 |
| 5 | $36,580 | $73,160 | $127,990 | $146,320 | $182,900 |
| 6 | $41,960 | $83,920 | $146,860 | $167,840 | $209,800 |
| 7 | $47,340 | $94,680 | $165,790 | $189,360 | $236,700 |
| 8 | $52,720 | $105,440 | $184,760 | $210,880 | $263,600 |

*Note: For households with more than eight (8) members ad $5,380 per member.*

**b.** Additional discounts:

i. **Hardship Criteria:** If the remaining liability after discount exceeds 15% of annual income (including excess qualified assets), the amount above that threshold is also discounted.

ii. **High Medical Costs:** For patients meeting this definition

- If insurance paid more than the highest government rate, the balance is written off as charity care.
- If insurance paid less**,** the amount above that rate is adjusted as charity care; the rest may be collected.

**c.** Payment Plans: Up to 30 months of interest-free monthly payments are available for those approved for assistance. Discretionary plans may be offered to others.

**d.** Discretionary Adjustments: Gateways may increase discounts beyond calculated levels and must document the justification.

**e.** Documentation: All payment assistance determinations and calculations will be maintained by Gateways.

## IV. GUIDELINES / PROCEDURES

### A. FINANCIAL SCREENING

1. **Definition & Purpose**: Financial screening is the process of evaluating a client's (or their guarantor's) ability to pay for services. This includes their ability to contribute personally, access third-party benefits, and qualify for social welfare programs.
2. **UMDAP Liability**: The Uniform Method of Determining Ability to Pay (UMDAP) assigns a sliding scale liability applicable to services received by the client and their dependent family members. This liability is valid for a period of one year. It may be adjusted during that year if the client's financial situation improves. Clients will never be billed more than the actual cost of services received.
3. **Single Liability Period:** There is only one UMDAP liability period per year, regardless of the number of providers or counties in California where the client receives services. Any subsequent provider must honor the liability scale set by the original provider for the remainder of the twelve-month period.
4. **Screening Objective:** The primary goal of the financial screening interview is to collect complete and accurate billing and payor information. All third-party payor sources are identified, and clients are referred to any social programs for which they may qualify.
5. **Third-Party Payor Inquiry:** Clients are routinely asked about their eligibility for Medi-Cal or other third-party benefits. Gateways ensures that all available benefits are explored and used to the fullest extent possible.

6. **Right to Refuse / Consequences:** Clients may decline to provide financial information. However, if a client or guarantor refuses to cooperate with billing or fails to provide required information, they will be responsible for paying the actual cost of services received.
7. **PFI Form Requirement:** The financial screening interview is guided by the Patient Financial Information (PFI) Form (see Attachment One). All necessary data must be collected to complete this form accurately.
8. **Timing of the Interview / Default Billing:** Gateways aims to complete the financial interview at the client's first visit. In emergencies, basic information (e.g., name, address, phone number, and Social Security Number) is collected and a full interview is conducted at the next available opportunity or before the client's inpatient discharge. If adequate financial data is not available at the time of service, the client will be temporarily billed the full cost of care. This charge may be adjusted later once financial documentation is submitted.

## B. UNIFORM METHOD OF DETERMINING ABILITY TO PAY (UMDAP)

1. The State of California Department of Mental Health requires that all Short/Doyle providers employ the UMDAP System when assessing the ability of a client/payor to personally pay for services rendered. The UMDAP System was developed to establish a reasonable, equitable, and uniform methodology for that assessment.
2. Third-party benefits are separate and applied first to the actual cost of care, then to the annual UMDAP liability. Third-party payments do not reduce the established UMDAP liability, except when the combined amount of the third-party payment and UMDAP liability exceeds the actual cost of care.
3. See the following examples:

The actual cost of care is $1,000 and the UMDAP liability amount is $100. If the client has insurance that

paid $500, nothing is applied against the UMDAP liability amount because the amount paid by the insurance did not reach or go below the UMDAP liability of $100.

| | |
|---|---|
| Actual Cost of Care | $1,000 |
| Minus Insurance Payment | - 500 |
| Balance = | $ 500 |

(The balance amount will be funded by the UMDAP liability amount of $100 and county general funds of $100. The UMDAP liability amount is used before county general funds.)

The actual cost of care is $1,000 and the UMDAP liability amount is $100. If the client has insurance that paid $950, then $50 would be applied o the UMDAP liability. The client would be liable for the remaining $50 balance.

| | |
|---|---|
| Actual Cost of Care | $1,000 |
| Minus Insurance Payment | - 950 |
| Balance = | $ 50 |

(The balance amount will be funded by the UMDAP liability amount of $50 without using county general funds.)

If additional services were received during the annual liability Period, the same formula would apply.

| | |
|---|---|
| Additional Services Actual Cost of Care | $1,200 |
| Minus Insurance Payment | - 1,100 |
| Balance = | $ 100 |

(The balance amount will be funded by the UMDAP liability amount of $50 *[the remaining UMDAP balance from the original $100]* and $50 county general funds. The UMDAP liability is used before the county general funds.)

## C. COMPLETING THE PATIENT FINANCIAL INFORMATION (PFI) FORM- (SEE ATTACHMENT ONE)

1. The Patient Financial Information (PFI) form is used to capture client/payor financial information in order to determine a client's ability to pay for services. It is also used to identify and document third-party payor sources for billing purposes. All information recorded on the PFI is confidential, in accordance with Welfare and Institutions Code §5328
2. Each provider must provide a photocopy of the completed PFI upon request.
3. If a photocopy of the current PFI is not available, the provider may complete a new PFI using information obtained from the Integrated System **(IS)**. In such cases, the provider should retain the existing UMDAP liability period and clearly indicate on the PFI that the information was pulled from the IS.
4. If a PFI has already been completed by another provider, subsequent providers must honor the previously established UMDAP liability sliding scale for the remainder of the liability period. However, the provider must still confirm with the client that all financial information remains accurate and up to date.

## D. SHARE OF COST MEDI-CAL (SOC)

1. Gateways' Medi-Cal Program provides health care coverage not only to individuals receiving government cash assistance but also to individuals and families with incomes too high to qualify for welfare, yet too low to afford private health care.
2. Some Medi-Cal recipients are required to contribute to their health care expenses. This contribution is known as Share of Cost (SOC)the monthly amount a recipient must spend on health care services before

Medi-Cal coverage begins.

3. Clients with Share of Cost are not eligible for Medi-Cal benefits until their SOC amount has been met and certified through the State's MEDS (Medi-Cal Eligibility Data System) online system.
4. Services rendered to SOC clients cannot be billed to Medi-Cal unless the SOC has been cleared. The SOC can only be cleared after services are provided, not in advance.
5. Once the SOC is cleared and certified in the MEDS system, the provider may bill Medi-Cal for the remaining balance above the SOC and for all additional services provided during that same month.

**6. <u>Clearing of SOC</u>**

a. Service providers shall clear or certify the SOC as soon as services are provided
b. All services rendered by a provider must be properly documented and meet the medical necessity requirement.
c. Providers shall not render services solely to meet or clear the SOC in order to qualify clients for Medi-Cal benefits; nor shall providers bill a third party payor or the Medi-Cal program for such services.
d. The cost of services reimbursed by a third party (e.g., Medicare or private insurance) may not be used to clear the SOC. The amount paid by the third party must be deducted from the total cost, and only the remaining balance may be applied to clear the SOC.
e. Crossover or Third Party Billing: Providers are required to bill Medicare and/or other third-party payors (such as private insurance) for the actual cost of care. However, only the remaining balance after third-party reimbursement can be applied toward clearing the SOC.

**7. <u>Client Billing</u>**

a. **UMDAP Liability Determination**: Clients must be billed

either their monthly SOC or their annual UMDAP liability (whichever is less, and not to exceed actual cost of care). Therefore, providers must determine the client's UMDAP liability amount during financial screening.

b. **Financial Obligation Agreement**: Providers must collect the client's portion of the cost of care at the time services are rendered, or through a later payment or installment plan. These agreements must be in writing (see Attachment 4), signed by both the provider and the client. Gateways allows clients up to 24 months to pay for services.

c. **Medi/Medi SOC Clients**: For clients with both Medicare and Medi-Cal (SOC), providers should wait for the Medicare remittance before collecting payment. Providers should then collect either the SOC, UMDAP liability, or the Medicare deductible plus co-payment, whichever is lowest.

d. **SOC Re-Evaluation**: Clients who state they cannot pay their SOC should be referred to DPSS (Department of Public Social Services) for re-evaluation.

e. **Collection and Recording of Fees:**

    i. The client fee card must be used to record all financial transactions for the client, including charges, payments, and adjustments

    ii. When photocopied, the card serves as the monthly billing invoice.

    iii. A separate client fee card is required for each billing source (e.g., client fee, Medicare, insurance).

    iv. Until the client reaches their full UMDAP liability, all payments from any source must be recorded on the fee card to avoid overpayments.

## E. SUMMARY OF ELIGIBILITY CRITERIA

Gateways is committed to providing payment assistance for psychiatric services to those deemed eligible. Gateways will assess patients prior to services being rendered, when possible, and after services are rendered, if not already done so, to determine eligibility for financial assistance. It is an expectation that the patient/guarantor will cooperate and supply all necessary information required to make a determination for financial assistance eligibility. Applicants are required to fully cooperate by applying for any public or private assistance program for which they may be eligible prior to their evaluation for payment assistance.

Eligibility for payment assistance will be considered for those individuals who are uninsured or underinsured, ineligible for any government program, have high medical costs as defined above, and are unable to pay for their care.

Gateways will not delay or deny medically necessary services based on a patient's inability to pay or during the time eligibility for financial assistance is being determined, consistent with California Health & Safety Code §127410(a).

1. For all persons presenting to the hospital for emergency services, payment assistance will be considered after the rendering of service if there is a documented need. Future consideration will be given if, after billing, patients are unable to pay.
2. The hospital will make all reasonable efforts to explain the benefits of Medicaid and other public and private programs to all uninsured patients at the time of registration. Potentially eligible patients will be asked to apply for such programs, and the hospital will provide the necessary applications.
3. If a patient is unable to provide all required documentation for clear reasons (e.g., homelessness), the facility may classify the associated

write-offs as charity care, consistent with internal procedures, and must document the rationale for doing so.

4. In cases where the patient is non-responsive and/or other sources of information (such as PARO score or known eligibility for Medi-Cal) are available to perform a financial assessment, those sources may be used to support or validate the determination for full or partial Payment Assistance eligibility.
5. Eligibility for Payment Assistance for non-residents of the hospital's service area shall be evaluated on a case-by-case basis, based on the hospital services needed and the patient's financial need.

## V PAYMENT ASSISTANCE PROGRAM APPLICATION PROCESS

### 1. Government Program Eligibility Screening Process

**a.** Gateways shall make all reasonable efforts to obtain from the patient or their representative information about whether private or public health insurance or sponsorship may fully or partially cover the cost of services rendered, including but not limited to:

i. Private health insurance
ii. Medicare
iii. Medi-Cal, Healthy Families Program, California Children's Services, or other state-funded programs

b. If the uninsured patient does not indicate coverage or requests a discounted rate or charity care, Gateways shall:

i. Provide an application for Medi-Cal, Healthy Families, or other government programs
ii. Explain the benefits of these programs
iii. Offer the application prior to discharge (for admitted patients) or within a reasonable time for emergency/outpatient care

**2. Payment Assistance Application Process**

**a.** At registration, if appropriate, Gateways staff shall explain eligibility requirements for the Payment Assistance Program and encourage potentially eligible patients/guarantors to apply.

**b.** Gateways shall provide a Payment Assistance Application to any interested or potentially eligible patient at the point of service or during the collection process.

**c.** If the patient does not return a completed application within 30 days, Gateways shall:

i. Send a follow-up letter with a copy of the application
ii. Make one follow-up phone call within one month
iii. Notify the patient that failure to return the application may result in denial of payment assistance and possible collection activity

**d.** Gateways may request supporting documentation with the application. In cases where the patient cannot provide documentation, a designated hospital representative may waive some or all requirements and document the rationale.

**e.** Patients are asked to return the completed form within thirty (30) days of receipt.

**f.** At minimum, Gateways shall re-evaluate eligibility if the last assessment was completed more than 12 months ago. A new application may be requested at any time if additional relevant information is obtained.

**g.** Documentation obtained during the application process may not be used for debt collection.

**h.** Gateways may require waivers or releases authorizing the facility to obtain information from financial institutions or other care providers for verification.

**i.** Patients will also receive a summary document describing:

i. The Uninsured Patient Discount Policy

ii. The Payment Assistance Policy

iii. Instructions for completing the application, in the patient's primary language

**j.** Timing of delivery depends on when the patient is identified as uninsured:

i. Preferably before services, but per EMTALA, may occur after in emergencies

ii. Referrals for payment assistance may come from staff, friends, or family members

iii. Applications are distributed by Patient Financial Services staff (Admitting, Registration, Counseling, etc.

**3. Payment Assistance Review Process**

a. Patient Financial Services will evaluate completed applications to assess the patient's financial situation.

b. A determination will be made to approve or deny full or partial financial assistance.

c. Patients will be notified in writing within 30 days of the decision.

d. If denied, the patient/guarantor may submit additional documentation for reconsideration. (See sample letters in Attachments 5 & 6.)

## VI. SIGNATURE AND WRITTEN COMMUNICATION

1. Gateways will comply with all signage and written communication requirements related to informing patients about available financial assistance:

a. **Posted Notices**: Gateways shall post, in all patient admitting areas, a summary of its Payment Assistance Policy. This summary will include a clear statement that:

i. Uninsured patients with annual household incomes below $250,000 are eligible for reduced rates.

ii. Such patients may also qualify for free or further reduced-cost care by submitting a Payment Assistance application.

b. **Brochures:** Brochures outlining the Payment Assistance Policy shall be made available in:
    i. Admission and Discharge areas (Inpatient and Outpatient),
    ii. Pharmacy
    iii. Patient Financial Services offices
    iv. Main facility and satellite clinic locations.

c. **Language Accessibility**: All signs and brochures must be printed in languages required by applicable law to ensure accessibility to Limited English Proficiency (LEP) patients.
d. **Collection Agency Contracts:** Gateways will include language in its contracts with all third-party collection agencies requiring that:
    i. Agencies provide a dedicated phone number for patients to request Payment Assistance information.
    ii. Agencies offer customer service with bilingual representatives and voicemail options for call-backs, in compliance with applicable language access laws.

## VII. TRAINING

1. Gateways shall provide training to relevant staff personnel regarding Payment Assistance availability and how to sufficiently communicate that availability to patients. The following are the guidelines for the required training for both new and existing staff.
    a. Gateways will designate appropriate staff and provide them with sufficient training to conduct the following:
        i. Distribute information and assist patient with their obligations for fully completing required applications.
        ii. Provide information on how to apply for Payment Assistance and government assistance programs, including local, state, and federal health care programs such as Medicaid.

iii. Assist patient as they complete eligibility documentation for assistance, including providing all required residency, household income, and qualified assets verification; providing all necessary documentation relating to Medicaid enrollment or the denial of Medicaid enrollment; and informing the hospital of changes in household income and/or insurance status.

iv. Assist eligible patients with settling their accounts through a schedule of regular payments if determined eligible to do so by Gateways' Patient Payment Assistance Policy.

2. All new hire training for admitting and registration staff shall contain information on the availability, eligibility and application process for Payment Assistance.

## VIII. APPEAL/DISPUTE PROCESS

**1.** Communication to all patients who are denied Payment Assistance must be in writing (see Attachment Six for example). The communication must contain the reason for the denial and a contact name and number at Gateways.

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

# PAYER FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

## CLIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| 1 | CLIENT NAME | SS # | | DMH CLIENT ID # | FAMILY REGISTRATION # |
| 2 | MAIDEN NAME | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | SPOUSE/PARTNER/SIGNIFICANT OTHER'S NAME | |
| 3 | FOSTER CARE ☐YES ☐NO | VICTIMS OF CRIME ☐YES ☐NO | VETERAN ☐YES ☐NO | WORKER'S COMP ☐YES ☐NO | HOMELESS ☐YES ☐NO | CALWORKS ☐YES ☐NO | OTHER SPECIAL POPULATION: |
| 4 | PROVIDER OF FINANCIAL INFORMATION Name and Address (Complete only if other than the client or responsible person) | | | | |

## THIRD PARTY INFORMATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 5 | MEDI-CAL ☐YES ☐NO | ECM PLAN NAME | MEDI-CAL COUNTY CODE /AID CODE/ CIN # | HEALTHY FAMILIES ☐YES ☐NO | SHARE OF COST ☐YES ☐NO | SOC AMT $ | MEDI-CAL PENDING ☐YES ☐NO |
| 6 | SSI PENDING ☐YES ☐NO | SSI APPLICATION DATE | REFERRED FOR BENEFITS ASSESSMENT ☐YES ☐NO DATE REFERRED | REASON FOR NOT REFERRING MEDI-CAL/SSI ELIGIBLE TO BENEFITS ASSESSMENT | | | |
| 7 | MEDICARE ☐YES ☐NO | MEDICARE NUMBER (MBI) | LIFETIME EXTENDED SIGNATURE AUTHORIZATION SIGNED ☐YES ☐NO DATE SIGNED | MEDI-GAP ☐YES ☐NO | TRICARE ☐YES ☐NO | CHAMPVA ☐YES ☐NO | |
| 8 | HMO/PPO ☐YES ☐NO | MEDICARE ADVANTAGE ☐YES ☐NO | NAME OF CARRIER | SUBSCRIBER POLICY ID # | SUBSCRIBER NAME | | |
| 9 | CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS | | | INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED ☐YES ☐NO | | | |
| 10 | ADD'L HMO/PPO ☐YES ☐NO | MEDICARE ADVANTAGE ☐YES ☐NO | NAME OF CARRIER | SUBSCRIBER POLICY ID # | SUBSCRIBER NAME | | |
| 11 | CARRIER ADDRESS FOR MENTAL HEALTH CLAIMS | | | INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS SIGNATURES OBTAINED ☐YES ☐NO | | | |

## PAYER REFERENCES (CLIENT OR FINANCIALLY RESPONSIBLE PERSON)

| | | | | | |
|---|---|---|---|---|---|
| 12 | NAME OF PAYER | RELATION TO CLIENT | DOB | MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP | PAYER CDL/CAL ID/OTHER ID |
| 13 | PAYER'S ADDRESS | CITY | STATE | ZIP CODE | TEL # |
| 14 | SOURCE OF INCOME: ☐SALARY ☐SELF EMPLOYED ☐UNEMPLOYMENT INSURANCE ☐DISABILITY INSURANCE ☐SSI ☐GR ☐VA ☐Other Public Assistance ☐IN-KIND ☐UNKNOWN ☐OTHER: _____ | | | | PAYER SS # |
| 15 | EMPLOYER | POSITION | | | IF NOT EMPLOYED, DATE LAST WORKED |
| 16 | EMPLOYER'S ADDRESS (Include City, State & Zip Code) | | | | TEL # |
| 17 | SPOUSE | ADDRESS (Include City, State & Zip Code) | | | SPOUSE'S SS # |
| 18 | SPOUSE'S EMPLOYER | POSITION | | | IF NOT EMPLOYED, DATE LAST WORKED |
| 19 | SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code) | | | | TEL # |
| 20 | NEAREST RELATIVE/RELATIONSHIP | ADDRESS (Include City, State & Zip Code) | | | TEL # |

## UMDAP LIABILITY DETERMINATION

### 21 LIQUID ASSETS

| | |
|---|---|
| Savings | $ |
| Checking Accounts | $ |
| IRA, CD, Market value of stocks, bonds and mutual funds | $ |
| **TOTAL LIQUID ASSETS** | $ 0.00 |
| Less Asset Allowance | $ |
| Net Asset Valuation | $ 0.00 |
| **Monthly Asset Valuation (Divide Net Asset by 12)** | $ 0.00 |

VERIFICATION OBTAINED ☐YES ☐NO

### 22 ALLOWABLE EXPENSES

| | |
|---|---|
| Court ordered obligations paid monthly | $ |
| Monthly childcare payments (necessary for employment) | $ |
| Monthly dependent support payments | $ |
| Monthly medical expense payments | $ |
| Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) | $ |
| **Total Allowable Expenses** | $ 0.00 |

VERIFICATION OBTAINED ☐YES ☐NO

### 23 ADJUSTED MONTHLY INCOME

| | |
|---|---|
| GROSS MONTHLY INCOME Self/Payer | $ |
| Spouse | $ |
| Other | $ |
| TOTAL HOUSEHOLD INCOME | $ 0.00 |
| TOTAL FROM BOX 21 + | $ 0.00 |
| SUBTOTAL + | $ 0.00 |
| LESS TOTAL FROM BOX 22 - | $ 0.00 |
| **Adjusted Monthly Income** | $ 0.00 |

VERIFICATION OBTAINED ☐YES ☐NO

| | | | | |
|---|---|---|---|---|
| 24 | Number Dependent on Adjusted Monthly Income (Client included) | **ANNUAL LIABILITY** | **ANNUAL CHARGE PERIOD** FROM _____ TO _____ | Payment Plan $_____ per month for ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ____ months |

## OTHER

| | | | | |
|---|---|---|---|---|
| 25 | PRIOR MENTAL HEALTH TREATMENT DURING CURRENT ANNUAL CHARGE PERIOD ☐YES ☐NO WHERE: | FROM | TO | CURRENT ANNUAL LIABILITY BALANCE |
| 26 | ANNUAL LIABILITY ADJUSTED BY | DATE | REASON ADJUSTED ☐TFA (enter date client signed below) ☐Other (describe below) | |
| | ANNUAL LIABILITY ADJUSTMENT APPROVED BY | DATE | | |
| 27 | An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER | | PROVIDER NAME AND NUMBER | |
| 28 | I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 24 SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON | | DATE | |

MH 281 Rev. 09/01/2023

Authority See W & I Code Sections 5709 & 5710

# UNIFORM PATIENT FEE SCHEDULE
## COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

| MONTHLY ADJUSTED GROSS INCOME* | PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 or more |
| | MEDI-CAL ELIGIBLE AREA** | | | | |
| 0- 569 | 37 | 33 | 30 | 27 | 24 |
| 570- 599 | 40 | 36 | 32 | 29 | 26 |
| 600- 649 | 45 | 40 | 36 | 32 | 29 |
| 650- 699 | 50 | 45 | 41 | 37 | 33 |
| 700- 749 | 56 | 50 | 45 | 41 | 37 |
| 750- 799 | 63 | 57 | 51 | 46 | 41 |
| 800- 849 | 71 | 64 | 58 | 52 | 47 |
| 850- 899 | 79 | 71 | 64 | 58 | 52 |
| 900- 949 | 89 | 80 | 72 | 65 | 59 |
| 950- 999 | 99 | 90 | 80 | 72 | 65 |
| 1000-1049 | 111 | 100 | 90 | 81 | 73 |
| 1050-1099 | 125 | 112 | 101 | 91 | 82 |
| 1100-1149 | 140 | 126 | 113 | 102 | 92 |
| 1150-1199 | 156 | 140 | 126 | 113 | 102 |
| 1200-1249 | 177 | 159 | 143 | 129 | 116 |
| 1250-1299 | 200 | 180 | 162 | 146 | 131 |
| 1300-1349 | 226 | 203 | 183 | 165 | 149 |
| 1350-1399 | 255 | 230 | 207 | 186 | 167 |
| 1400-1449 | 288 | 259 | 233 | 210 | 189 |
| 1450-1499 | 326 | 293 | 264 | 238 | 214 |
| 1500-1549 | 368 | 331 | 298 | 268 | 241 |
| 1550-1599 | 416 | 374 | 337 | 303 | 273 |
| 1600-1649 | 470 | 423 | 381 | 343 | 309 |
| 1650-1699 | 531 | 478 | 430 | 387 | 348 |
| 1700-1749 | 600 | 540 | 486 | 437 | 393 |
| 1750-1799 | 678 | 610 | 549 | 494 | 445 |
| 1800-1849 | 752 | 677 | 609 | 548 | 493 |
| 1850-1899 | 835 | 752 | 677 | 609 | 548 |
| 1900-1949 | 927 | 834 | 751 | 676 | 608 |

| MONTHLY ADJUSTED GROSS INCOME* | PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 or more |
| 1950-1999 | 1029 | 926 | 833 | 750 | 675 |
| 2000-2049 | 1142 | 1028 | 925 | 833 | 750 |
| 2050-2099 | 1268 | 1141 | 1027 | 924 | 832 |
| 2100-2149 | 1407 | 1266 | 1139 | 1025 | 923 |
| 2150-2199 | 1562 | 1406 | 1265 | 1139 | 1025 |
| 2200-2249 | 1734 | 1561 | 1405 | 1265 | 1139 |
| 2250-2299 | 1925 | 1733 | 1560 | 1404 | 1264 |
| 2300-2349 | 2136 | 1922 | 1730 | 1557 | 1401 |
| 2350-2399 | 2371 | 2134 | 1921 | 1729 | 1556 |
| 2400-2449 | 2632 | 2369 | 2132 | 1919 | 1727 |
| 2450-2499 | 2922 | 2630 | 2367 | 2130 | 1917 |
| 2500-2599 | 3275 | 2948 | 2653 | 2388 | 2149 |
| 2600-2699 | 3482 | 3134 | 2821 | 2359 | 2285 |
| 2700-2799 | 3695 | 3326 | 2993 | 2694 | 2425 |
| 2800-2899 | 3915 | 3524 | 3172 | 2855 | 2570 |
| 2900-2999 | 4139 | 3725 | 3353 | 3018 | 2716 |
| 3000-3099 | 4370 | 3933 | 3540 | 3186 | 2867 |
| 3100-3199 | 4607 | 4146 | 3731 | 3358 | 3022 |
| 3200-3299 | 4850 | 4365 | 3929 | 3536 | 3182 |
| 3300-3399 | 5099 | 4589 | 4130 | 3717 | 3345 |
| 3400-3499 | 5458 | 4912 | 4421 | 3979 | 3581 |
| 3500-3599 | 5830 | 5247 | 4722 | 4250 | 3825 |
| 3600-3699 | 6214 | 5593 | 5036 | 4532 | 4079 |
| 3700-3799 | 6610 | 5949 | 5354 | 4819 | 4337 |
| 3800-3899 | 7018 | 6316 | 5684 | 5116 | 4604 |
| 3900-3999 | 7438 | 6694 | 6025 | 5423 | 4881 |
| 4000-4099 | 7870 | 7083 | 6375 | 5738 | 5164 |
| 4100-4199 | 8314 | 7483 | 6735 | 6062 | 5456 |

Above $4200 Add $400 for each $100 additional income.

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (See back page).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/20/89

Uniform Patient Fee Schedule
Community Mental Health Services
Attachment C to DMH Notice 98-13
Effective October 1, 1989

| Monthly Adjusted Gross Income* | Persons Dependent on Income Annual Deductibles | | | | | Monthly Adjusted Gross Income* | Persons Dependent on Income Annual Deductibles | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 or more | | 1 | 2 | 3 | 4 | 5 or more |
| **Medi-Cal Eligible Area**** | | | | | | 1950 – 1999 | 1029 | 926 | 833 | 750 | 675 |
| 0 – 569 | 37 | 33 | 30 | 27 | 24 | 2000 – 2049 | 1142 | 1028 | 925 | 833 | 750 |
| 570 – 599 | 40 | 36 | 32 | 29 | 26 | 2050 – 2099 | 1268 | 1141 | 1027 | 924 | 932 |
| 600 – 649 | 45 | 40 | 36 | 32 | 29 | 2100 – 2149 | 1407 | 1266 | 1139 | 1025 | 923 |
| 650 – 699 | 50 | 45 | 41 | 37 | 33 | 2150 – 2199 | 1562 | 1406 | 1265 | 1139 | 1025 |
| 700 – 749 | 56 | 50 | 45 | 41 | 37 | 2200 – 2249 | 1734 | 1561 | 1405 | 1265 | 1139 |
| 750 – 799 | 63 | 57 | 51 | 46 | 41 | 2250 – 2299 | 1925 | 1733 | 1560 | 1404 | 1264 |
| 800 – 849 | 71 | 64 | 58 | 52 | 47 | 2300 – 2349 | 2136 | 1922 | 1730 | 1557 | 1401 |
| 850 – 899 | 79 | 71 | 64 | 58 | 52 | 2350 – 2399 | 2371 | 2134 | 1921 | 1729 | 1556 |
| 900 – 949 | 89 | 80 | 72 | 65 | 49 | 2400 – 2449 | 2632 | 2369 | 2132 | 1919 | 1727 |
| 950 – 999 | 99 | 90 | 80 | 72 | 65 | 2450 – 2499 | 2922 | 2630 | 2367 | 2130 | 1917 |
| 1000 - 1049 | 111 | 100 | 90 | 81 | 73 | 2500 – 2599 | 3275 | 2948 | 2653 | 2388 | 2149 |
| 1050 – 1099 | 125 | 112 | 101 | 91 | 82 | 2600 – 2699 | 3482 | 3134 | 2821 | 2359 | 2285 |
| 1100 – 1149 | 140 | 126 | 113 | 102 | 92 | 2700 – 2799 | 3695 | 3326 | 2993 | 2694 | 2425 |
| 1150 – 1199 | 156 | 140 | 126 | 113 | 102 | 2800 – 2899 | 3915 | 3524 | 3172 | 2855 | 2570 |
| 1200 – 1249 | 177 | 159 | 143 | 129 | 116 | 2900 – 2999 | 4139 | 3725 | 3353 | 3018 | 2716 |
| 1250 – 1299 | 200 | 180 | 162 | 146 | 131 | 3000 – 3099 | 4370 | 3933 | 3540 | 2186 | 2867 |
| 1300 – 1349 | 226 | 203 | 183 | 165 | 149 | 3100 – 3199 | 4607 | 4146 | 3731 | 3358 | 3022 |
| 1350 – 1399 | 255 | 230 | 207 | 186 | 167 | 3200 – 3299 | 4850 | 4365 | 3929 | 3536 | 3182 |
| 1400 – 1449 | 288 | 259 | 233 | 210 | 189 | 3300 – 3399 | 5099 | 4589 | 4130 | 3717 | 3345 |
| 1450 – 1499 | 326 | 293 | 264 | 238 | 214 | 3400 – 3499 | 5458 | 4912 | 4421 | 3979 | 3581 |
| 1500 – 1549 | 368 | 331 | 298 | 268 | 241 | 3500 – 3599 | 5830 | 5247 | 4722 | 4250 | 3825 |
| 1550 – 1599 | 416 | 374 | 337 | 303 | 273 | 3600 – 3699 | 6214 | 5593 | 5036 | 4532 | 4079 |
| 1600 – 1649 | 470 | 423 | 281 | 343 | 309 | 3700 – 3799 | 6610 | 5949 | 5354 | 4819 | 4337 |
| 1650 – 1699 | 531 | 478 | 430 | 387 | 348 | 3800 – 3899 | 7018 | 6316 | 5684 | 5116 | 4604 |
| 1700 – 1749 | 600 | 540 | 486 | 437 | 393 | 3900 – 3999 | 7438 | 6694 | 6025 | 5423 | 4881 |
| 1750 – 1799 | 678 | 610 | 549 | 494 | 445 | 4000 – 4099 | 7870 | 7083 | 6375 | 5738 | 5164 |
| 1800 – 1849 | 752 | 677 | 609 | 548 | 493 | 4100 – 4199 | 8314 | 7483 | 6735 | 6062 | 5456 |
| 1850 – 1899 | 835 | 752 | 677 | 609 | 548 | Above $4200 add $400 for each $100 additional income. | | | | | |
| 1900 - 1949 | 927 | 834 | 751 | 676 | 608 | | | | | | |

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (see back page)

The above information was provided by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/20/89

Quick Reference

Medi-Cal Eligibility

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

| MFBU | | | |
|---|---|---|---|
| 1 - $602 | 3 - $934 | 6 - $1,417 | 9 - $1,825 |
| 2 - $750 | 4 - $1,100 | 7 - $1,550 | 10 - $1,959 |
| 2 - $934 (Adults) | 5 - $1,259 | 8 - $1,692 | |

Asset allowances for 1989 are:

| Persons | | |
|---|---|---|
| 1 - 2000 | 4 - 3300 | 7 - 3750 |
| 2 - 3000 | 5 - 3450 | 8 - 3900 |
| 3 - 3150 | 6 - 3600 | 9 - 4050 |

Aid categories commonly found in community mental health are:

| | |
|---|---|
| **Refugee**: First 18 months in the U.S. | **Disabled**: Meeting federal definition of disability |
| **Aged**: 65 years of age and over | **AFDC**: Aid to Family with Dependent Children |

Medi-Cal Share-of-Cost

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-year old man would be eligible for Medi-Cal except that his income is too high. He has a $1000 medical bill. He meets the low asset levels, but his income from retirement is $1000 per month. His income is $1000 minus the standard $20 disregard and the $24.90 payment for the Medicare Part B, leaving a "net" of $955.10. His "share-of-cost" for Medi-Call is $955.10 minus $602 ("need level") or $353.10. Medi-Cal will pay the remainder of the $1000 medical bill for that month and other months when he obligates the share of cost. He has to submit a Medi-Cal form MC-177 each month he obligates a share of cost above $353.10. His eligibility will be predetermined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

10/20/89

# Gateways Hospital and Mental Health Center

## CHARITY / DISCOUNT CARE ELIGIBILITY DETERMINATION

| GENERAL | | | | |
|---|---|---|---|---|
| Guarantor Name: | | | | |
| Address: | | | | |
| City: | State: | Zip: | Country: | |
| Phone ( ) | How Long at this address? | | | |
| Method of Verification: | Power bill | Water bill | Drivers License | Other |
| Previous Address: | | | | |

| Eligibility Requirements for Charity or Discout Care | |
|---|---|
| Social Security Number: | Date of Birth: |
| Place of Employment: | |
| Length of Employment:<br>If not employed, what is your source of income? | |
| Gross income per month: | Number of dependents: |
| Spouse's Name: | |
| Spouse's Place of Employment:<br>How long: | |
| Gross income per month: | Total Gross Income per month: |
| Verified by tax return: (year) | Do you have health insurance? |
| If so what type of insurance_____<br>and with whom? | |
| Effective Date: | Is a copy of card available? |

| MEDICAL ELIGIBILITY | |
|---|---|
| Have you applied for Medi-cal or any other government assistance Y or N If so when? | |
| Were you denied assistance? Y or N If denied why? | |
| Applicants Signature: | Date: |
| Applicants Signature: | Date: |

ATTENTION: If you need help in your language, please call 1-323-644-2000. or visit Gateways Hospital & Mental Health Center. The office is open Monday to Friday 8:30am to 3:30pm and located at 1891 Effie St. Los Angeles, CA 90026. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

# Financial Obligation Agreement

**Client Name:** _____ **DMH Client ID #:** _____

California Welfare and Institutions Code 5709 states that a person receiving mental health services at a Los Angeles County operated or contracted facility may be responsible for the cost of those services in accordance with their ability to pay. As a result of your financial screening, a determination has been made regarding your financial responsibility, as indicated here.

☐ Annual Liability = **$0.00** based on income and/or Medi-Cal without Share of Cost

**- OR -**

☐ Based on the fee schedule issued by the State of California, your annual liability for the period of _____ to _____ will be $ _____ or the actual cost of care, whichever is less.

**Change in Financial Situation:** You are required to notify all service providers as soon as there is a change in your financial situation such as changes in employment status, income, cash assistance (e.g., Social Security Supplemental Income [SSI], Social Security Disability Income [SSDI], General Relief [GR], etc.) or when there is a change your Medi-Cal, Medicare, or other healthcare insurance coverage. In the event of changes in financial situation or insurance coverage, you must be re-evaluated to determine whether your financial obligation for the remainder of this annual liability period has changed. Failure to notify this provider of changes in your financial situation or insurance coverage could lead to you being responsible for the full cost of the services received.

- In the event your annual liability exceeds the actual cost of care, you may discontinue your monthly payments once the actual cost of care has been paid in full.

***I understand that by signing this agreement, it is my responsibility to pay the monthly annual liability payment and report any change to my financial and/or health coverage immediately.***

**Agreement to Pay:** We have agreed to allow you to make monthly payments to pay off this debt. You have agreed to pay $_____ per month for _____ months.

_____ _____

Client/Responsible Party Signature Date

_____ _____

Program Representative's Signature Date

U | OU | M-CARE | M-CAL | M-CALX | FI | CHMP | PHP

**GATEWAYS HOSPITAL AND MHC**
**1891 EFFIE ST., LOS ANGELES, CA 90026**
**(323) 644-2000**

DATE
MIS NUMBER

*Client*

*Responsible Person*

*Address*

*City, State, Zip*

**THIS STATEMENT INCLUDES ALL CHARGES AND CREDITS THROU** _____ **AMOUNT NOW DUE** _____ **Please Enter Amount Paid**

***RETURN TOP PORTION WITH YOUR PAYMENT***

| | ***SERVICES*** | | | | | | ***PAYMENT DUE*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | SERVICES PROVIDED* | | | | | | | | | |
| MONTH | I | G | M | P | TOTAL U/S | COST OF CARE THIS MONTH | AMOUNT DUE LAST MONTH | PAYMENTS AND ADJUSTMENTS | PAYMENT PLAN AMOUNT DUE THIS MONTH *** | TOTAL AMOUNT DUE THIS MONTH |
| | | | | | | | | | | **$0.00** |
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**UMDAP PERIOD**

**2/1/2018** TO **1/31/2019**

ANNUAL LIABILIT **FCC**

***PAYMENT PLAN**

| DATE | AMOUNT | COMMENTS |
|---|---|---|
| 02/06-02/13 | $ 5,005.00 | IP Hospitalization |

**If you have a question or problem about this statement, please call the Business Office at ext: 254 or 252.**

| Service Codes | Pmt & Adj. Codes |
|---|---|
| I - Individual | C - Champus |
| G - Group | E - Error |
| M - Medication | I - Insurance |
| P - Psych-Emergency | M - Medicare |
| | P - Patient |
| | T - Theraputic |
| | U- Umdap |

**Make your Check or Money Order Payable To:**

***GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER***

**Please Do Not Send Cash**

**76CA29S** **MH-002F**

--------Thank You----------