FRESNO SURGICAL HOSPITAL

January 29, 2026

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Re: No. 2024-0349-3

Dear Ms. Samantha Mateo,

I recently reached out to you for assistance, and I still have not received a response from anyone in the Hospital Fair Billing Program. As explained to you in my email (enclosed) dated January 20, 2026, we received notice No. 2024-0349-3 (enclosed) from your office while I was out of the country for many weeks and a carbon copy was sent to an employee, the secondary contact person, that is no longer employed with Fresno Surgical Hospital as of August 2025. I informed HCAi of this change on September 9, 2025, to update HCAi's contact information for the secondary contact person, however, I do not believe this happened since the notification referred to in this letter was still emailed to the wrong secondary person. If this notice was mailed by US mail, it would have been received by one of our team members and routed to the correct person, unfortunately it was emailed via HDC and sent to someone that no longer works for our hospital.

We are committed to making proper corrections and have requested assistance, and in good faith have reached out to you, but we are still waiting for a response. Moreover, penalizing our hospital at $500 per day is excessive especially when you consider the delivery method error of this notice and no response from your department. I am requesting an extension to and waiver of all penalty fees incurred. This letter along with the enclosures will be emailed to hfbp@hcai.ca.gov, uploaded in HDC for HCAi's review and response, and hard copies mailed to the Sacramento and Los Angeles addresses as stated on your public website with a copy to Ms. Elizabeth A. Landsberg.

Lastly, I am attaching policies (enclosed) from our parent company for your review to see if this would remedy the corrections stated in No. 2024-0349-3. I would like to speak with a Supervisor from the Hospital Fair Billing Program to discuss this notice and remediation at their earliest convenience. I can be reached by the following methods:

Office: (559) 447-7615
Email: Jrodriguez2@fshosp.com

Thank you for helping us resolve this matter.

Sincerely,

Chief Financial Officer
Fresno Surgical Hospital

Cc: Ms. Elizabeth A. Landsberg
Enc: January 20, 2026 email; Parent company policies; Notice No. 2024-0349-3

Jim Rodriguez

From: Jim Rodriguez
Sent: Tuesday, January 20, 2026 1:49 PM
To: 'HDC - Hospital Fair Billing Program'
Cc: Kimberly Passmore
Subject: RE: Report Document Delinquent Notice
Attachments: REV 1 - Fresno Surgical - 2025Dec17.pdf

Importance: High

Good afternoon,

I received your email notification. I was out of the country for several weeks when this notice came in. Also, as previously communicated, Deborah DeBenedetto-Coe is no longer with Fresno Surgical Hospital. Kimberly Passmore, copied on this email replaced Deborah back in August. I informed HCAI of this change via email on Tuesday, September 9, 2025 at 9:01AM. I even spoke with an HCAI analyst to confirm Kimberly's update later that day, yet this notification still went out to Deborah during my absence.

I kindly request an extension on making these corrective actions and a waiver on any penalty fees incurred. I would also welcome a telephone conversation to discuss this and some of the findings stated in the notice attached.

Thanks,

Jim S. Rodríguez, MBA
Chief Financial Officer
Fresno Surgical Hospital

From: HDC - Hospital Fair Billing Program <hfbp@hcai.ca.gov>
Sent: Saturday, January 17, 2026 1:34 AM
To: Jim Rodriguez <JRodriguez2@fshosp.com>
Subject: Report Document Delinquent Notice

Dear Jim Rodriguez:

The Department of Health Care Access and Information (HCAI) has determined that FRESNO SURGICAL HOSPITAL (Hospital) located at 6125 NORTH FRESNO STREET, failed to timely respond to correspondence from HCAI regarding the rejection of Hospital's policy submission number 2024-0349-3.

Pursuant to Title 22, California Code of Regulations section 96051.21(a), Hospital is liable for a penalty assessment of five hundred dollars ($500) per day until the requested documentation is submitted

through the policy submission portal.

Any accrued late penalties will be included in HCAI's final determination once the policy review process is completed. If you believe this is a mistake, please include documented proof of timely filing in your response to HCAI's Initial Compliance Determination or by adding a comment in the policy submission portal.

NOTE: If you were approved for an extension and are still receiving this message, please be advised that an extension must be requested for each document you were asked to resubmit.

IF YOU HAVE AN OPEN APPEAL, the deadline for submitting revised policies is paused until the appeal is resolved. You may ignore these messages or request an extension.

Regards,
Hospital Fair Billing Program

HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

UPDATED COMPLIANCE DETERMINATION

December 17, 2025 **VIA HDC**

Fresno Surgical Hospital
6125 North Fresno St.
Fresno, CA 93710

HCAI ID: 106104047

Dear Fresno Surgical Hospital (Hospital):

The Department of Health Care Access and Information (Department) completed its review of revised policy submission number 2024-0349-3. The Department's updated findings are contained in the enclosed Revision 2 Compliance Review Report, which is incorporated by reference into this notice.

Corrective Action

All identified violation must be corrected for Hospital's documents to be in compliance with the statutory and regulatory requirements, and many of the previously identified violations remain uncorrected.

If Hospital disputes the existence of a violation in the Department's findings, please provide a written response explaining Hospital's position. **Failure to correct the violations in the next revision will be considered intentional unless a written response is provided.**

Further revisions to Hospital's financial assistance policy, financial assistance application, debt collection policy, discharge notice and wall posting must be uploaded through the online policy submission portal in accordance with Title 22, California Code of Regulations section 96051.6(d)(3) by **January 16, 2026**. Please review the submission requirements. Clean and marked-up versions of Hospital's revised policies **must** be submitted to clearly identify corrected violations.

Please ensure corrections to Hospital's website are completed by the due date above. Extension requests may be approved at the Department's discretion. Without an

approved extension, a penalty of $500 per day will accrue until the revised documents are submitted.

Sincerely,

Hospital Fair Billing Program

Department of Health Care Access and Information
hcai.ca.gov

Enclosures

cc: Jim Rodriguez, Primary Hospital Contact (sent via HDC)

Debbie DeBenedetto-Coe, Secondary Hospital Contact (sent via HDC)

Department of Health Care Access and Information

Compliance Review Report Submission No: 2024-0349-3

HOSPITAL: Fresno Surgical Hospital

SUBJECT: Hospital Fair Pricing Act – 2024 Biennial Review

DATE: December 17, 2025

☐ Initial ☒ Revision 1 ☐ Revision 2 ☐ Revision 3

OVERVIEW

On February 4, 2025, the Department of Health Care Access and Information (Department) notified the above hospital (Hospital) of the violations identified during the review of its revised policy submission and requested corrective action. Hospital submitted revised policies on June 12, 2025.

After review, the Department has determined 31 of the previously identified violations remain uncorrected and 3 new violations have been identified. Overall, 34 violations (3 Major, 12 Moderate, and 19 Minor) require correction.

Please note, the Department has made changes to its process and this report will only list violations that require corrective action. Any violations that appeared in previous Compliance Review Reports that have been adequately corrected, have been removed. **In addition to this report, enclosed are copies of Hospital's submitted documents with comments from the Department highlighting issues that need to be addressed.**

Updated findings are below and in the enclosed Hospital documents with HCAI comments incorporated by reference.

VIOLATIONS

SUBMISSION REQUIREMENTS

1) Contact Information

Statutory/Regulatory Reference(s): 22 CCR § 96051.5(b)(3).

Violation Type: Minor

Findings: The policy submission portal user registration request for Hospital's designated secondary contact fails to include the contact's business title.

2) Scanned Document

Statutory/Regulatory Reference(s): 22 CCR § 96051.6(c)(2).

Violation Type: Minor

Findings: Hospital's financial assistance policy is a scanned image of a paper document.

DOCUMENT ACCESSIBILITY

3) Design and Presentation

Statutory/Regulatory Reference(s): 22 CCR § 96051.1(a)(1); HSC § 127405(a)(1)(A).

Violation Type: Minor

Findings: Hospital failed to ensure all documents provided or made available to a patient are designed and presented in a way that is easy to read and understand by a patient.

4) Plain Language

Statutory/Regulatory Reference(s): 22 CCR § 96051.1(a)(3); HSC § 127405(a)(1)(A).

Violation Type: Minor

Findings: Hospital failed to ensure all documents provided or made available to a patient use plain, straightforward language that avoids technical jargon.

DISCOUNT PAYMENT AND CHARITY CARE POLICY

5) Discount Payment Eligibility

Statutory/Regulatory Reference(s): HSC § 127405(a)(1)(A).

Violation Type: Major

Findings: Hospital failed to ensure uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level are eligible to apply for discount payment under its financial assistance policy. Hospital's definition of family, page 8, is inconsistent with HSC § 127400(h). Language on page 9 should also be edited to be consistent with the Act.

Hospital excludes certain services. Page 2 of the policy states, "FSH may exclude services that are covered by an insurance program at another provider location but are not covered at Fresno Surgical Hospital after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency

Medical Treatment and Active Labor Act (EMTALA} obligations are satisfied." And additionally excludes, "Medi-Cal or other public assistance programs' Share of Costs are considered an important part of those Government Programs. Financial Support cannot be applied to Share of Cost balances."

6) Monetary Asset Consideration

Statutory/Regulatory Reference(s): HSC § 127405(b)(1).

Violation Type: Moderate

Findings: Hospital failed to ensure monetary assets are not considered in determining eligibility under its financial assistance policy. Page 3 of the policy states, documentation for establishing income with include information regarding, "monetary assets, including savings and invest accounts…"

7) Other Program Application

Statutory/Regulatory Reference(s): HSC § 127405(b)(2).

Violation Type: Moderate

Findings: Hospital failed to ensure patients are not required to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment. On page 6 of the financial assistance policy, it states, "Determination for financial assistance will be made after all efforts to qualify the patient for governmental assistance or other programs have been exhausted."

8) Discount Payment Eligibility Criteria

Statutory/Regulatory Reference(s): HSC § 127405(b).

Violation Type: Moderate

Findings: Hospital failed to ensure its financial assistance policy for discounted payment limits eligibility criteria to income consistent with the application of the federal poverty level. Page 4 states supporting documentation such as P&L statements and bank statements will be requested to support information reported.

9) Eligibility Disputes

Statutory/Regulatory Reference(s): HSC § 127405(a)(1)(A).

Violation Type: Moderate

Findings: Hospital failed to ensure its financial assistance policy designates the business manager, chief financial officer, or other appropriate manager for review of eligibility disputes. There is no mention of reviewer for eligibility disputes.

10) Application Deadline

Statutory/Regulatory Reference(s): HSC § 127405(e)(4).

Violation Type: Major

Findings: Hospital failed to ensure eligibility for discounted payment or charity care may be determined at any time it is in receipt of documentation identified in Health and Safety Code section 127405(e)(1) or (2). Page 3 of Hospital's financial assistance policy references information about the application deadline that must be provided in the notice provided to patients before initiating ECAs. Page 4 states, "FSH must process the FAP application if the patient provides the missing information/ or documentation during the 240-day application period (or, if later, within the 30-day resubmission period.)" Page 5 also references the application deadline, and "Application Period" is defined on page 8

11) Medically Necessary Services

Statutory/Regulatory Reference(s): 22 CCR § 96051.7(a).

Violation Type: Moderate

Findings: Hospital failed to ensure all medically necessary services are eligible for discounted payment. Page 2 of Hospital's financial assistance policy has a blanket exclusion of "cosmetic services, infertility treatments and other elective procedures." Page 2 also states: "FSH may exclude services that are covered by an insurance program at another provider location but are not covered at Fresno Surgical Hospital."

12) Emergency Physician Statement

Statutory/Regulatory Reference(s): HSC § 127405(a)(1)(B).

Violation Type: Minor

Findings: Hospital failed to ensure its financial assistance policy includes the emergency physician statement required by Health and Safety Code section 127405(a)(1)(B).

13) Reimbursement

Statutory/Regulatory Reference(s): HSC § 127440.

Violation Type: Minor

Findings: Hospital failed to ensure it reimburses any amount over $5.00 actually paid in excess of the amount due under the Hospital Fair Pricing Act including interest. Page 6 of Hospital's financial assistance policy will not refund "such other amount set by notice or other guidance published in the Internal Revenue Bulletin."

14) Credit Reporting

Statutory/Regulatory Reference(s): HCS § 127425(f)(1).

Violation Type: Minor

Findings: Hospital failed to ensure adverse information is not reported to a consumer credit reporting agency. Page 8 of the policy lists, "Reporting outstanding debts to credit bureaus" as a potential extraordinary collection activity. Language in the debt collection policy must also be corrected.

15) Real Property

Statutory/Regulatory Reference(s): HSC § 127425(h)(1).

Violation Type: Minor

Findings: Hospital failed to ensure liens on any real property are not used as a means of collection unpaid hospital bills. Page 8 of the policy lists, "Placing liens on property of individuals." as a potential extraordinary collection activity. Language in the debt collection policy must also be corrected.

APPLICATIONS FOR DISCOUNT PAYMENT OR CHARITY CARE

16) Documentation Limitations

Statutory/Regulatory Reference(s): HCS § 127405(e)(1)

Violation Type: Major

Findings: Hospital's application failed to ensure its application makes clear only recent paystubs *or* income tax returns are required for documentation of income for patients

applying only for discount payment. Hospitals application states patients must provide pay vouchers *and* tax statements.

DEBT COLLECTION POLICY

17) Standards and Practices Defined

Statutory/Regulatory Reference(s): HSC § 127425(c); 22 CCR § 96051.6(a)(3).

Violation Type: Minor

Findings: Hospital failed to ensure its debt collection policy defines standards and practices for the collection of debt for patients who qualify for financial assistance. The debt collection states fails to address the specific issues of patients who have previously qualified for financial assistance. Issues include but are not limited to the length of the payment plan, the specific issues related to termination of the payment plan and the requirement that no interest or fees be charged.

18) Documentation Limitation

Statutory/Regulatory Reference(s): HSC § 127405(e)(3); 22 CCR § 96051.6(a)(3).

Violation Type: Minor

Findings: Hospital failed to ensure its debt collection policy includes language that information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the discount payment or charity care eligibility determinations cannot be used for collection activities.

DISCHARGE NOTICE

19) Help Paying Your Bill

Statutory/Regulatory Reference(s): HSC § 127410(a); 22 CCR § 96051.9(a)(3)(G).

Violation Type: Minor

Findings: Hospital failed to ensure its discharge notice includes the “Help Paying Your Bill” statement.

20) Covered California

Statutory/Regulatory Reference(s): HSC § 127410(a).

Violation Type: Minor

Findings: Hospital failed to ensure its discharge notice includes information about Covered California.

21) Shoppable Services

Statutory/Regulatory Reference(s): HSC § 127410(a); 22 CCR § 96051.9(a)(3)(E).

Violation Type: Minor

Findings: Hospital failed to ensure its discharge notice includes the direct internet address for the hospital's list of shoppable services. The URL provided (https://fresnosurgicalhospital.com/patients-visitors) goes to a 404 error page.

22) Hospital Bill Complaint Program

Statutory/Regulatory Reference(s): 22 CCR § 96051.9(a)(3)(F).

Violation Type: Minor

Findings: Hospital failed to ensure its discharge notice includes the statement on the Hospital Bill Complaint Program.

23) Tagline Sheet

Statutory/Regulatory Reference(s): 22 CCR § 96051.1(b).

Violation Type: Moderate

Findings: Hospital failed to ensure its discharge notice includes a tagline sheet with the statement in 22 CCR § 96051.1(b) in English and the top 15 languages spoken by limited-English-proficient individuals in California.

HOSPITAL POSTINGS

24) Font Requirement

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(a)(1).

Violation Type: Minor

Findings: Hospital failed to ensure its postings use a sans serif font.

25) Posting Title

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(b)(1).

Violation Type: Moderate

Findings: Hospital failed to ensure its posting is titled “Help Paying Your Bill.”

26) Hospital Bill Complaint Program

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(b)(3).

Violation Type: Minor

Findings: Hospital failed to ensure its posting includes “Hospital Bill Complaint Program” as a titled section heading, followed by the required statement.

27) More Help

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(b)(4).

Violation Type: Minor

Findings: Hospital failed to ensure its posting includes “More Help” as a titled section heading, followed by information about organizations to help patients understand the billing and payment process, as well as the internet webpage for Health Consumer Alliance.

28) Accessible Format Information

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(b)(5).

Violation Type: Moderate

Findings: Hospital failed to ensure its posting includes information on how a patient with a disability may access the notice in an accessible alternative format.

29) Other Language

Statutory/Regulatory Reference(s): 22 CCR § 96051.10(b)(6).

Violation Type: Moderate

Findings: Hospital failed to ensure its posting includes information on how a patient may access the notice in another language.

WEBSITE POSTING

30) "Help Paying Your Bill" Link

Statutory/Regulatory Reference(s): HSC § 127410(c)(5); 22 CCR § 96051.11(a)(2)(A-C).

Violation Type: Moderate

Findings: Hospital failed to ensure a link called "Help Paying Your Bill" is prominently displayed on its website in all required locations. The "Help Paying Your Bill" link is not located on the hospital website's footer, on any webpage where the patient may find information about paying a bill, or in the hospital's website header or within one click on the hospital's drop-down menu from the hospital's website header.

31) Webpage Title

Statutory/Regulatory Reference(s): 22 CCR § 96051.11(a)(1).

Violation Type: Minor

Findings: Hospital failed to ensure it has a webpage titled "Help Paying Your Bill." Hospital's webpage about its financial assistance programs located at https://fresnosurgicalhospital.com/Financial-Information, is titled "Financial Information."

32) Eligibility Information

Statutory/Regulatory Reference(s): 22 CCR § 96051.11(a)(1)(A).

Violation Type: Moderate

Findings: Hospital failed to ensure its webpage includes information on eligibility requirements for discount payment**.**

33) Policy Links

Statutory/Regulatory Reference(s): HSC § 127410(c)(5); 22 CCR § 96051.11(a)(1)(C).

Violation Type: Moderate

Findings: Hospital failed to ensure its webpage includes links to the financial assistance policy.

34) Hospital Bill Complaint Program

Statutory/Regulatory Reference(s): 22 CCR § 96051.11(a)(5).

Violation Type: Minor

Findings: Hospital failed to ensure its webpage includes the Hospital Bill Complaint Program statement.

Status **Active** PolicyStat ID **15839998**

Origination	1/18/2021	Policy Area	FN: Finance
Last Approved	5/24/2024	Policy #S	FN 13.074
Last Revised	3/24/2022		

Financial Assistance to Patients

PURPOSE:

Fresno Surgical Hospital (FSH) is committed to providing high quality, comprehensive health care service to our patient community. This includes those who are unable to pay as well as those whose limited means make it extremely difficult to meet the health care expenses incurred. Fresno Surgical Hospital is committed to:

- Provide access to quality health care services with compassion, dignity and respect for those we service;
- Provide caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

Fresno Surgical Hospital honors the dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability, or sex. Free aids and services to people with disabilities are available as well as free language services to people whose primary language is not English.

PROCEDURE:

This Financial Assistance to Patients (FAP) procedure is designed to address the patients' need for financial assistance as they seek services through Fresno Surgical Hospital (FSH). It applies to all eligible services as provided under applicable state or federal law. Eligibility for financial assistance and support will be determined on an individual basis using specific criteria and evaluated on an assessment of the patient's and/or family's health care needs, financial resources and obligations.

I. Qualifying Criteria for Financial Assistance

a. Services eligible for Financial Assistance:

i. All services needed for the prevention, evaluation, diagnosis or treatment of a medical

condition and not mainly for the convenience of the patient or medical care provider.

ii. Emergency medical care services will be provided to all patients who present to the hospital, regardless of the patient's ability to pay.

b. Services not eligible for Financial Assistance:

i. Cosmetic services, infertility treatments and other elective procedures and services that are not medically necessary.

ii. Services not provided and billed by FSH (e.g. independent physician services, private duty nursing, ambulance transport, retail medical supplies, surrogacy services, pathology, laboratory, etc.)

iii. FSH may exclude services that are covered by an insurance program at another provider location but are not covered at Fresno Surgical Hospital after efforts are made to educate the patients on insurance program coverage limitations and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

iv. Medi-cal or other public assistance programs' Share of Costs are considered an important part of those Government Programs. Financial Support cannot be applied to Share of Cost balances.

c. Applying for Financial Assistance:

- Fresno Surgical Hospital will make FAP applications available as part of the intake or discharge process as well as in the patient registration lobby areas and billing office. Documents will also be made available in the primary language of the local population that constitutes more than 5 percent of the residents of the community, or over 1,000 persons served by FSH.
- Applications can also be downloaded from the FSH website or sent by mail by contacting the billing office listed on the website.
- Patient Accounting Representatives are available to assist with the completion of the application. Language support is available as needed by patients.
- FSH will take measures to notify members of the community served by FSH about the FAP. Such measures may include: the distribution of information sheets summarizing the FAP to local public agencies and nonprofit organizations that address the health needs of the community's low income populations.
- FSH will provide patients with a written notice that indicates financial assistance is available for eligible patients, identifies the Extraordinary Collection Actions (ECA) that FSH (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECA may be initiated that is no earlier than 30 days after the date that the written notice is provided. FSH will include a plain language summary of the FAP with the written notice and make a reasonable effort to orally notify the patient about the Fresno Surgical Hospital FAP and about how the patient may obtain assistance with the FAP application process.
- In the case of deferring or denying, or requiring a payment for providing medically necessary

care due to an individual's nonpayment of one or more bills for previously provided care covered under the Fresno Surgical Hospital FAP, FSH may notify the individual about its FAP less than 30 days before initiating the ECA. However, to avail itself of this exception, FSH must satisfy the following conditions:

Provide the patient with a FAP application form (to ensure the patient may apply immediately, if necessary). The patient is to be notified in writing about the availability of financial assistance for eligible individuals and the deadline, if any, after which the hospital will no longer accept and process a FAP application submitted by the patient for the previously provided care at issue. This deadline must be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously provided care was provided. Thus, although the ECA involving deferral or denial of care may occur immediately after the requisite written notice is provided, the patient must be afforded at least 30 days after the notice to submit a FAP application for the previously provided care.

Notify the patient about the FAP by providing a plain-language summary of the FAP and by orally notifying the patient about the hospitals FAP and about how the patient may obtain assistance with the FAP application process.

Process the application on an expedited basis, to ensure that medically necessary care is not unnecessarily delayed if an application is submitted.

The modified reasonable efforts discussed above are not needed in the following cases:

- If 150 days have passed since the first post-discharge bill for the previously provided care and FSH has already notified the patient about intended ECA.
- If FSH has already determined whether the patient was FAP-eligible for the previously provided care at issue based on a complete FAP application or had presumptively determined the patient was FAP-eligible for the previously provided care.

Completed applications, along with supporting documentation to determine household size and family income, are to be returned to FSH and/or mailed to the address on the application within the prescribed time.

Once the completed application is received, processing and determination of financial application may take up to 30 days.

d. Documentation for Establishing Income:

i. Information provided to FSH by the patient and/or family should include earned income, including monthly gross wages, salary and self-employment income; unearned income including alimony, retirement benefits, dividends, interest and income from any other source (e.g., food stamps); monetary assets, including savings and invest accounts excluding retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans for all dependents in the household; the number of dependents in the household and other information requested on the FAP application.

The first $10,000 of monetary assets shall not be counted in determining eligibility, nor shall 50% of monetary assets over the first $10,000 be counted in determining eligibility.

ii. Supporting documents such as payroll stubs, tax returns, P&L statements and bank statements will be requested to support information reported and shall be maintained with the completed application and assessment. FSH may not deny financial assistance based on the omission of information or documentation that is not specifically required by the FAP or FAP application form.

iii. FSH will provide patients that submit an incomplete FAP application a written notice that describes the additional information and/or documentation that must be submitted within 30 days from the date of the written notice to complete the FAP application. The notice will provide contact information for questions regarding the missing information. FSH may initiate ECA if the patient does not submit the missing information and/or documentation within the 30 day resubmission period and it is at least 150 days from the date FSH provided the first post-discharge billing statement for the care. FSH must process the FAP application if the patient provides the missing information/or documentation during the 240-day application period (or, if later, within the 30-day resubmission period.)

e. Presumptive Assistance:

FSH recognizes that not all patients are able to provide complete financial information. Therefore, Fresno Surgical Hospital may also engage outside resources to aid in the identification of those patients who are without the resources to pay for healthcare services. When such approval is granted it is classified as "Presumptive Assistance."

i. The predictive model is one of the reasonable efforts that will be utilized by FSH to identify patients who may qualify for financial assistance prior to initiating collection actions, i.e. write-off of a patient account to bad debt and referral to collection agency. This predictive model enables Fresno Surgical Hospital to systematically identify financially needy patients.

ii. Examples of presumptive cases include the following:

- Deceased patients with no known estate
- Homeless patients
- Non-covered medically necessary services provided to patients qualifying for public assistance programs (e.g., non-emergent services for patients with emergent only coverage)
- Patients currently receiving public assistance (e.g., food stamps)
- Patient bankruptcies
- Members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.

iii. For patients who are non-responsive to the FAP application process, other sources of information, if available, should be used to make an individual assessment of financial need. This information will enable FSH to make an informed decision on the

financial need of non-responsive patients.

iv. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need prior to referral to collection or write-off to bad debt. This review utilizes a health care industry recognized, predictive model that is based on public record databases. These public records enable FSH to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

v. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information within the established timelines and be considered under the traditional financial assistance application process.

vi. Patient will be notified of their approval for assistance. Patient who receive less than the most generous assistance levels may appeal within 30 days of the notice. The determination of a patient being eligible for less than the most generous assistance is based on presumptive support status or a prior FAP eligibility determination. Additionally, FSH may initiate or resume ECA if the patient does not apply for more generous assistance within 30 days of notification if it is at least 150 days from the date FSH provided the first post-discharge billing statement for the care. FSH will process any new FAP application that the patient submits by the end of the 240-day application period or, if later, by the end of the 30-day period given to apply for more generous assistance.

f. Timeline for Establishing Financial Eligibility-Application Period:

i. Every effort should be made to determine a patient's eligibility for financial assistance prior to or at the time of admission or service. The application period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement to the patient or one of the following:

- The end of the period of time that a patient is eligible for less than the most generous assistance available, based upon presumptive support status or a prior FAP eligibility determination, and who has applied for more generous financial assistance; or
- The deadline provided in a written notice after which ECA may be initiated. FAP applications will be accepted any time during the application period. The award of financial assistance based on submission of a *completed application* will be in effect for the accounts identified on the FAP application that are within the application period and six months forward from the date of the signed FAP application. The award of financial assistance based on *presumptive support* status is limited to the accounts that are within the application period and only for the date(s) of service for the account(s) reviewed if no application is received. The hospital may require pre-approval for planned surgeries and/or re-verify qualifications at any time. FSH may accept and process an individual's FAP application submitted outside of the application period

on a case-by-case basis as authorized by the established approval levels. Accounts may be referred to a collection agency for initial processing prior to the completion of the application period.

ii. FSH (or other authorized party) will refund any amount the patient has paid for care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible patient, unless such excess amount is less than $5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin). The refund of payments is only required for the episodes of care to which the FAP application applies.

iii. Determination for financial assistance will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted. Compliance with the process to attempt to gain assistance with a government program may be requested to be considered eligible for financial assistance eligibility. A patient will not be denied eligibility if they are making a reasonable effort to obtain private or public health insurance.

iv. FSH will make every effort to make a financial assistance determination in a timely fashion. If other avenues of assistance are being pursued, FSH will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

v. Once qualification for financial assistance has been determined, reviews for continued eligibility for subsequent services should be made after a reasonable time period as determined by FSH.

g. Level of Financial Assistance:

i. FSH will follow the income guidelines established below in evaluating a patient's eligibility for assistance. A percentage of the Federal Poverty Guidelines (FPL), which is updated on an annual basis, is used for determining a patient's qualifications. However, other factors may also be considered such as the patient's financial status and/ or ability to pay as determined through the assessment process.

ii. Family Income at or below 200% of the Federal Poverty Level Guideline:

- A 100% discount for all patient balances will be provided for patients whose family income is at or below 200% of the most recent FPL.

iii. Family Income between 201% and 400% of the Federal Poverty Level Guideline:

- A discount off of total charges equal to the then-current Medicare reimbursement for the same/similar procedure.
- Patients whose income is at or below 400% of the FPL and have annual out of pocket costs at the hospital in excess of 10% of their current family income or family income in the prior 12 months, will be granted additional assistance.
- Patients whose account(s) are partial charity, the balance on the account must be offered interest-free payment arrangements. Patients with whom satisfactory payment agreements cannot be reached during the negotiation process, a payment plan will be established

consisting of monthly payments that do not exceed 10% of the patient's familial monthly income excluding deductions for "essential living expenses". Essential living expenses are defined as rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, child and spousal support, transportation and automobile expenses (including insurance, fuel and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses.

iv. Medically Indigent Support / Catastrophic: Financial Assistance is also available for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their family or household income (for example, due to catastrophic costs or conditions), regardless of whether they have income that otherwise exceed the financial eligibility requirements for free or discounted care under the FSH FAP. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence / catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient's income and expenses. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of income will qualify the insured patient's co-pays, deductibles, and co-insurance payments to qualify as catastrophic charity care. Discounts for medically indigent care for the uninsured will not be less than FSH then-current Medicare payment for the same/similar services provided or an amount to bring the patient's catastrophic medical expense to income ratio back to 20%.

v. While financial assistance should be made in accordance with FSH's established written criteria, it is recognized that occasionally there will be a need for granting additional assistance to patients based upon individual considerations. Such individual considerations will be approved by the Chief Financial Officer and/or Chief Executive Officer.

II. Assisting Patients Who May Qualify for Coverage

a. FSH will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services. Patients will be referred to local consumer assistance centers housed at legal offices for assistance with the application process.

b. FSH will have understandable, written procedures to help patients determine if they qualify for public assistance programs or the FAP.

III. Implementation of Accurate and Consistent Policies

a. Representatives from the Patient Accounting department will educate staff members who work closely with patients (billing and collections; patient registration; etc.) about billing, financial assistance, collection policies and practices, and treatment of all patients with compassion, dignity and respect regardless of their insurance status or their ability to pay for services.

b. FSH will honor financial assistance commitments that were approved under previous

guidelines. At the end of that eligibility period, the patient may be re-evaluated for financial assistance using the guidelines established in this procedure.

IV. Other Discounts

a. Self-Pay Discounts: FSH will apply a standard uninsured discount off of charges for all registered self-pay patients that do not qualify for financial assistance, based on a percentage of the then-current Medicare reimbursement rate for the same/similar procedure.

b. Additional Discounts: Adjustments in excess of the percentage discounts described in this procedure may be made on a case-by-case basis upon an evaluation of the age and collectability of the account and authorized by FSH's established approval levels.

Definitions:

Application Period - The period of time beginning the day that care is provided and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either of the following:

i. The end of the 30-day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.

ii. The deadline provided in a written notice after which ECA may be initiated.

Discounted Care - A partial discount off the amount owed for patients that qualify under the FAP.

Eligible Patient - An individual who meets the eligibility criteria described in this Policy, whether he or she is (1) uninsured; (2) receives coverage through a public program (e.g., Medicare, Medi-Cal or subsidized health care coverage purchased through a health information exchange), or (3) an insured patient with co-pay, deductible, and co-insurance amounts.

Emergent - Medical services are those needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by the Emergency Medical Treatment and Active Labor Act (EMTALA).

Extraordinary Collection Actions ("ECA") - Collection actions taken by FSH (or a collection agency on their behalf) include the following actions:

- Deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP.
- Reporting outstanding debts to credit bureaus.
- Pursuing legal action to collect a judgment (i.e., garnishment of wages, debtor's exam).
- Placing liens on property of individuals.

Family (as defined by the U.S. Census Bureau) - A group of two or more people who reside together and who are related by birth, marriage or adoption. If a patient claims someone as a

dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility under the FAP.

Family Income - A person's Family Income includes the income of all adult family members (related by birth, marriage or adoption in the household. For patients under 18 years of age, family income includes that of the parents and/or step-parents or caretaker relatives' annual income from the prior 12-month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate or using previous year's tax returns.

Federal Poverty Guidelines ("FPG") - Guidelines which establish the levels of annual income for poverty as determined by the United States Department of Health and Human Services. These guidelines are updated annually in the Federal Register.

Financial Assistance - Support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by Fresno Surgical Hospital who meet the eligibility criteria for such assistance and who have exhausted public and private payor sources.

Financial Assistance Policy ("FAP") - A written Policy and Procedure that meets the requirements described in Section 1.501(r)-4(b).

Financial Assistance Policy ("FAP") Application - The form and accompanying documentation a patient submits to apply for financial assistance under Fresno Surgical Hospital's FAP. FSH may obtain information from an individual in writing or orally (or combination of both).

Homeless - Describes the status of a person who resides in one of the places or is in a situation described below:

- in places not meant for human habitation, such as cars, parks, sidewalks; or
- in an emergency shelter; or
- in transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters; or
- in any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.

Income - Wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran's benefits, alimony, survivor's benefits, pensions, retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

Medical Necessity - Treatment, procedures and services as defined and documented in the State of California Medi-Cal provider manual.

Policy - A statement of the high-level direction on matters of strategic importance to Fresno Surgical Hospital or a statement that further interprets Fresno Surgical Hospital's governing

documents.

Plain Language Summary of the FAP - A written statement that notifies a patient that the hospital facility offers financial assistance under a FAP and provides the following additional information in language that is clear, concise, and easy to understand:

- A brief description of the eligibility requirements and assistance offered under the FAP.
- A brief summary of how to apply for assistance under the FAP.
- The location where the patient can obtain copies of the FAP and FAP application form.
- Instructions on how the patient can obtain a free copy of the FAP and FAP application form by mail.
- The contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and provide assistance with the FAP application process.
- A statement of the availability of translations of the FAP, FAP application form, and plain language summary of the FAP in other languages, if applicable.

Procedure - A document designed to implement a Policy or a description of specific required actions or processes.

Service Area - The list of zip codes comprising Fresno Surgical Hospital's surrounding market area that constitutes a "community of need" for primary health care services.

Underinsured - An individual who, despite having health care coverage, finds that the obligation to pay insurance premiums, copayments, coinsurance, and deductibles is such a significant financial burden that he or she delays or does not receive necessary health care service due to the out-of-pocket costs.

Uninsured Patient - An individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medi-Cal, SCHIP and CHAMPUS), Worker's Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which Fresno Surgical Hospital is subrogated, but only if payment is actually made by such insurance company.

Vulnerable - Those persons whose health and well-being are considered to be more at-risk than the general population due to socioeconomic status, illness, ethnicity, age or other disabling factors.

References:

- Patient Protection and Affordable Care Act: Statutory section 501(r), Public Law
- Internal Revenue Service, Instructions for Schedule H (Form 990)
- Department of Treasury, Internal Revenue Service, Additional Requirements for Charitable Hospitals; Final Rule: Volume 79, No. 250, Part II, 26 CFR, Part 1
- State of California AB774 (Chapter 755, Statutes of 2006; also called the Hospital Fair Pricing

Policies Law)

- Federal Register and the Annual Federal Poverty Guidelines
- IRS Code, 26 CFR Parts 1 and 53 and 1545-BL58 Additional Requirements for Charitable Hospitals
- Catholic Health Association of the United States - A Guide for Planning & Reporting Community Benefit

Attachments

Federal Poverty Level (FPL) and Charity Adjustment Guidelines

Financial Assistance to Patients Application

Nondiscrimination and Accessibility Requirements

Approval Signatures

Step Description	Approver	Date
BOM FINAL	Managers Board of: Executive Assistant	5/24/2024
MEC	Committee Medical Executive [AF]	5/24/2024
DMC	Document Management Committee [CG]	5/24/2024
Policy Owner	Jim Rodriguez: Chief Financial Officer	5/16/2024

FRESNO SURGICAL HOSPITAL

AN AWARD-WINNING PHYSICIAN OWNED HOSPITAL

Thank you for your interest in our Financial Assistance Program. If you and/or a family member have applied for financial assistance at Fresno Surgical Hospital within the last six (6) months, please contact our office at (559) 447-7735 before completing this application.

Please return the completed application and all applicable documents listed below within thirty (30) days:

- **Three (3) months complete, itemized bank statements for all checking, savings, and/or investment accounts showing deposits and withdrawals. Please provide explanation for all deposits. (Required)**

- **Proof of earned and/or unearned income as documented below. (Required)**

1. Three (3) recent pay stubs for yourself, spouse and all dependents showing pay rate and hours worked OR
2. Current, or most recently filed, federal tax return for yourself and spouse OR
3. Contribution statement from family/friends stating how living expenses are being met AND
4. Any of the following documents, as applicable for yourself, spouse and all dependents:
    - Most recent tax return including Profit/Loss statement if self-employed
    - Most recent tax return for verification of dependents
    - Unemployment benefits statement
    - Student financial aid award letter
    - Determination letter for public assistance (e.g., CalFresh, Medi-Cal, etc.)
    - Social Security and/or Social Security Disability award letter or check
    - Dividend, interest and income from any other source (e.g., rental income, alimony income, retirement benefits, etc.).

If you are unable to provide any of these documents, please provide a letter of explanation as to why the documents were not returned.

Please return the financial assistance application and supporting documents to:

Fresno Surgical Hospital
Business office
6121 N Thesta Suite #101
Fresno, Ca 93710

Please allow approximately 30 days for processing once we have received a completed application. If you have any questions or require information in another language, please contact our office at the number listed below.

Sincerely,

Fresno Surgical Hospital
Customer Service
(559) 447-7735

FRESNO SURGICAL HOSPITAL

AN AWARD-WINNING PHYSICIAN OWNED HOSPITAL

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

Fresno Surgical Hospital, honor the sacredness and dignity of every person, complies with applicable Federal Civil Rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Fresno Surgical Hospital: Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language and interpreters services through video and audio interpreter system network.
- Written information in other formats such as large print, audio, accessible electronic and other formats.

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters services
- Information written in other languages

If you need these services, please contact us at (559) 447-7735

If you believe that Fresno Surgical Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, fax or email to:

Fresno Surgical Hospital, Attn:
Risk Management
6125 N Fresno Street
Fresno, Ca 93710
559-436-3406
Email: cqo@fshosp.com

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to:

Department of Health & Human Services 200
Independence Avenue, SW, Room a509F,
HHH Building, Washington, DC 20201
Web https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone 1-800-368-1019 TTY 1-800-537-7697

FRESNO SURGICAL HOSPITAL

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Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-559-447-7735

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-559-447-7735

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-559-447-7735

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-559-447-7735.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.)번으로 전화해 주십시오. 1-559-447-7735.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-559-447-7735.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните . 1-559-447-7735.

Hindi

ध्यान द�: य�द आप �हद� बोलते ह �तो आपके ि◌लए मुफ्त म� भाषा सहायता सेवाएं उपलब्ध ह।) पर कॉल कर�।1-559-447-7735.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます）まで、お電話にてご連絡ください。1-559-447-7735.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-559-447-7735.

Panjabi

ਿ◌ਧਆਨ ਿ◌ਦਓ: ਜੇ ਤੁਸ਼ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ਼ ਭਾਸ਼ਾ ਿ◌ਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।) ਤੇ ਕਾਲ ਕਰੋ। 1-559-447-7735.

FRESNO SURGICAL HOSPITAL

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Portugese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para . 1-559-447-7735

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-559-447-7735

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با تماس بگیرید1-559-447-7735

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយ
ផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-559-447-7735

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-559-447-7735

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-559-447-7735.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 -)
1-559-447-7735: رقم هاتف الصم والبكم -.

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-559-447-7735.

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-559-447-7735.

Hawaiian

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā : 1-559-447-7735.

FRESNO SURGICAL HOSPITAL

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CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

Professional services provided by affiliated physicians or other providers may be billed separately. Application of Financial Assistance is at the discretion of those providers in accordance with their policies, procedures, and applicable regulations. The information provided in this application may be provided to affiliated providers to assist the patient. Fresno Surgical Hospital honors the sacredness and dignity of every person, complies with applicable federal and state laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability or sex.

Patient Name			Date of Birth
Street Address		Telephone	Message Phone
City/State/Zip			Social Security Number
Mailing Address (if different) or email if preferred			

Please provide the following information for yourself (if not the patient), spouse and dependents:

Name	SSN	Date of Birth	Relationship to Patient

Please list all account numbers and/or dates of service to be considered for financial assistance:

Patient Name	Account #	Date of Service	Medical Balance

FRESNO SURGICAL HOSPITAL
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Healthcare Marketplace Status

Have you applied for Insurance?	□ No	□ Yes	If Yes, Name/ID
If Yes, did you apply through:			□ Medicaid - State □ Health Exchange/ Healthcare.gov □ Other _____
Were you approved for an insurance plan?	□ No	□ Yes	
Have you enrolled and paid the premium for an insurance plan?	□ No	□ Yes	

Monetary Assets

Checking Account Balance	Bank:	$
Savings Account Balance	Bank:	$

Employment

Person Employed	Employer	Gross Pay Period	# of Pay Periods	Annual Gross
		$		$
		$		$
		$		$
		$		$

Other income Source	**Monthly**	**Annually**
Alimony	$	$
Public Assistance Program Type_____(e.g., Cash, Food Stamps, etc.)	$	$
Payment from Retirement Plan	$	$
Social Security / Social Security Disability	$	$
Unemployment or Worker's Comp No. of Weeks:_____ Start Date:_____End Date:_____ Per Week $:_____	$	$
Other Income (Stocks/Bonds/Annuities/Interest/Rental Property)	$	$
Other Income (from family, friends, church, etc...)	$	$

FRESNO SURGICAL HOSPITAL

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VERIFICATION OF INCOME AND IDENTIFICATION

If we need additional information, you will be notified by telephone, US Mail or e-mail.

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I authorize the release of any and all information from the California Department of Health Care Services. **I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements if applicable.** I also understand that I will be liable for payment of any services rendered at Fresno Surgical Hospital if the above information is given under false pretenses. I know that I am asking for financial assistance from Fresno Surgical Hospital only and not from other health care providers or physicians.

SIGNATURE: **DATE:**

_____ _____

SPOUSE SIGNATURE (if applicable) **DATE:**

_____ _____

Status Active PolicyStat ID 15840011

Origination	11/23/2004	Policy Area	FN: Finance
Last Approved	5/24/2024	Policy #S	FN 13.019
Last Revised	5/24/2024		

Bad Debt Collections

PURPOSE:

To provide guidelines for the conversion and write-off of patient account balances exceeding normal time lines for collection.

POLICY:

Fresno Surgical Hospital (FSH) encourages payment of all accounts in a timely manner while promoting ethical business practices in the collection of delinquent accounts. FSH accepts insurance assignment and other payment arrangements, however, the patient is ultimately responsible for payment of all services rendered.

Patient accounts will be considered Bad Debt and referred to an outside collection agency upon meeting the following guidelines:

- Patient fails to bring their account into good standing by reaching agreeable payment arrangements and/or paying their outstanding balance in full.
- Patient fails to fulfill the terms of a patient payment agreement by missing two (2) consecutive payments.
- Patient refuses further contact with the Patient Accounting Department by either telephone or mail.
- Patient mail is returned with no forwarding address and Patient Accounting Department is unable to locate additional contact information.

Accounts will be written off as bad debt if they meet the following criteria:

- Account is greater than 120 days old
- Account is in Bad Debt Status

PROCEDURE:

1. Patient co-pays, deductibles, and secondary portions will be collected at the time of service whenever possible. Patients who fail to make payment will receive a patient statement requesting payment in full.
2. At patient's request, payment arrangements may be extended. A minimum payment of $25.00 per month is expected with payment terms not to exceed nine months via recurring payments debited either by credit card or bank account, or six months via patient physical remittance. Patients requesting payment terms in excess of this time frame may be considered under the following approval guidelines:
    - Patient Accounting Manager up to 18 months
    - Chief Financial Officer 19 months or greater
3. Fresno Surgical Hospital has partnered with Mnet Financial to offer extended payment arrangements with a minimum payment of $25.00 and payment terms up to 120 months. These payment plans are offered to the patient at an interest rate of 14% per annum, which will be collected by Mnet Financial. Accounts assumed by Mnet Financial, which are subsequently returned to Fresno Surgical Hospital for non-payment will be automatically transferred to an outside collection agency for processing to include any penalties and interest incurred by the patient while the account was managed by Mnet Financial.
4. Accounts in good standing will receive a monthly statement every thirty-calendar days. Delinquent accounts will receive a Contract Past Due Letter requesting that the account be brought current, immediately. Accounts that remain delinquent will be mailed a second Contract Past Due Letter thirty days subsequent to the first letter. Accounts remaining 91+ days delinquent will be transferred to a bad debt status for consideration of transfer to an outside collection agency. Bad debt accounts may be identified through the "Print Collection Agency Accounts" report within the Meditech system.
5. Partial account payments of one-third of the outstanding balance or greater will be accepted without prior payment arrangements being established. Patients who make partial payments of less than one-third of the outstanding balance will receive a "Thank You" letter which requests payment in full on the remaining balance due. Accounts 61+ days delinquent will receive a Final Past Due notification. Accounts 91+ days delinquent will be transferred to a bad debt status for consideration of transfer to an outside collection agency. Bad debt accounts may be identified through the "Print Collection Agency Accounts" report within the Meditech system.
6. Patients who fail to make prior payment arrangements, and do not make payment on their account will follow the collection cycle below:
    a. Patient Statement (1st collection attempt)
    b. Day 31 – Past Due Notification (2nd collection attempt)
    c. Day 61 – Final Past Due Notification (3rd collection attempt)
    d. Day 91 – Bad Debt, transfer to an outside collection
7. Bad Debt accounts will be reviewed by the Patient Accounting Manager prior to referral to an

outside collection agency. Upon assignment, the Patient Accounting Manager will reconcile all assigned accounts with the collection agency to ensure that the accounts have been appropriately recorded. Upon verification, Bad Debt write off will then be completed within the Meditech system.

8. The collection agency shall not report any adverse information to a consumer credit reporting agency or commence civil action against any patient for non-payment any time prior to thirty (30) days from date assigned to Agency. Account must be a minimum of one hundred and fifty (150) calendar days outstanding prior to such action being taken. All collection actions will be in accordance with State and Federal debt collection rules and regulations.
9. Accounts collected after a bad debt write-off will be reversed and the payment applied to the patient account.
10. Agency requests for lien and/or legal action will be reviewed and approved by the Chief Financial Officer. These requests should include: patient name, balance due, guarantor information, collection activity (internal and external), and any additional information available.
11. Upon receipt of Chapter 7 bankruptcy notification, the Patient Accounting Manager will identify applicable accounts and place correspondence on hold. The patient account will be noted and written off as Bad Debt.
    Notification will be forwarded for accounts previously transferred to an Agency. Agency will validate the bankruptcy discharge and cancel account.
12. Upon receipt of Chapter 13 bankruptcy notification, the Patient Accounting Manager will identify applicable accounts and place correspondence on hold. The patient account will be noted, forwarded to Agency for creditor representation, and written off as Bad Debt.
    Notification will be forwarded for accounts previously transferred to an Agency. Agency will validate the filing and act as creditor representative.

Associated Policies:

FN 13.062 Payment Arrangements

Approval Signatures

Step Description	Approver	Date
BOM FINAL	Managers Board of: Executive Assistant	5/24/2024
MEC	Committee Medical Executive [AF]	5/24/2024
DMC	Document Management Committee [CG]	5/24/2024
Policy Owner	Jim Rodriguez: Chief Financial Officer	5/16/2024

Financial Information

Fresno Surgical Hospital will make every possible effort to accept all PPO insurance, even if we are not contracted and considered a preferred provider. In most cases, we will accept the patient's in-network benefits with no penalty to the patient for coming to a non-network facility.

FSH is a preferred provider for the following plans:

- Aetna
- BCE Emergis / Admar / Up & Up
- Beech Street / CAPP Care
- Blue Cross
- Blue Shield
- Cigna PPO
- Foundation Health (also FHCA)
- Fresno County Self-Insurance Group
- GEHA (Multiplan)
- Health Comp
- Health Net PPO
- Humana
- Interplan Corporation
- Medi-cal (Traditional and Managed Care)
- Medicare
- MetraComp
- Multiplan
- National Choice Care
- Networks By Design
- One Health Plan
- Pegasus/Status Medical Mgt.
- PHCS
- Principal Financial (Multiplan)

- Reviewco/EOS
- Sante Plans:
  - AARP Medicare Complete by Secure Horizons
  - Aetna HMO
  - Blue Cross HMO
  - Blue Shield HMO
  - Cigna HMO
  - Health Net HMO
  - United HealthCare Signature Value HMO
- Stellar Net
- Tricare
- United Agri Benefit Trust
- United Healthcare
- Veterans' Administration (only if authorized)
- Workers Compensation Payors

Financing Option(s)

6125 N. Fresno Street Fresno, California 93710

Menu

FRESNO SURGICAL HOSPITAL

Call

Pay Bill Online

- CareCredit offers promotional financing on purchases of $200 or more.*
- To apply for or pay with the CareCredit credit card, visit our Pay Bill Online page for a facility specific link.
- Call your surgical facility if you have any questions.

*Subject to credit approval. See provider for details.

Financial Assistance

At Fresno Surgical Hospital, we are committed to providing compassionate, high-quality care to the communities we serve. If you don't have health insurance, our financial counseling staff is here to help you to find and access government or private programs that may help you pay for health care.

The first step is to see if you are eligible for a government-sponsored health program (i.e. Medi-Cal/Medicaid, Medicare, disability). Financial Counselors are available to work with you to complete the

application process. If you qualify, these programs can provide access to health care and other vital social services for you and your family. If you need assistance, please call a Financial Counselor at 559-431-8000.

If you are not eligible for a government program, you may qualify for Fresno Surgical Hospital needs-based Financial Assistance program.

A Financial Assistance Program is available to patients that do not have the means to pay for hospital expenses and do not qualify for any Medical Eligibility Programs. You may qualify if your household income is below 200% of the federal poverty limit. To be considered for the financial assistance, you will be required to provide information on your household finances through a confidential Financial Application. Documentation will be requested to verify your circumstances in order to determine eligibility. Please contact Fresno Surgical Hospital at 559-431-8000 for additional information.

Eligibility and Enrollment Services (EES)

The Eligibility and Enrollment Services Program is a hospital service provided to you at no cost. You may qualify for government programs, which would pay for all or part of your hospital and medical expenses. Our Patient Advocates will provide applications and are available to assist you in the application process. Please contact Fresno Surgical Hospital at 559-431-8000 for additional information.

Outside Assistance Programs For Which You May Qualify:

- Medicaid/Medi-Cal
- Supplemental Security Income
- Temporary Assistance for Needy Families
- County Indigent
- Social Security Disability
- Victims of a Violent Crime Fund
- Medical Low Income Adults

Financial Assistance Applications

Financial Assistance Application

Solicitud de asistencia financiera

Financial Assistance to Patients

FRESNO SURGICAL HOSPITAL

6125 N. Fresno Street Fresno, California 93710

559-431-8000

Fresno Surgical Hospital is a facility in which physicians have an ownership or investment interest. The list of physician owners or investors is available to you upon request. We are accredited by The Joint Commission, fully licensed by the state of California and are Medicare certified.

Tenet Health

PROCEDURE

Procedure: California Addendum: Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**No:** EAC.05.03.PR.01
	Page: 1 of 4
	Effective Date: 12/31/24
	Previous Versions: 06/17/22, 10/01/16
Policy: EAC.05.03 Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**Approved By:** Amy Thomason
	Approval Date: 12/31/24

I. Procedure

This addendum applies to Tenet Facilities licensed in the State of California and is intended to provide direction and processes for these Facilities to comply with the requirements of California Code, Health and Safety Code § 127400 et seq. Describe how we execute our policy, how we ensure we meet our policy, etc.

A. Definitions

Essential Living Expenses: Means expenses for any of the following: rent or house payment or maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry, and cleaning, and other extraordinary expenses.

Patients with High Medical Costs: Means patients, insured or not, whose family Income does not exceed 400% of the federal poverty level and who have either 1) incurred or whose family has incurred annual out-of-pocket costs at the Facility that exceed 10% of the Patient's family Income in the prior 12 months or (2) incurred or whose family has incurred annual out-of-pocket costs with other providers that exceed 10% of the Patient's family Income in the prior 12 months.

Reasonable Payment Plan: Means a payment plan that will be instituted for patients who qualify for Discount Care or Charity Care when agreement on a negotiated payment plan cannot be reached. This payment plan will allow for monthly payments that do not exceed more than 10% of a Patient's household Income for a month, excluding deductions for Essential Living Expenses.

B. Requirements

1. Uninsured Patients, Patients with High Medical Costs, and those who are at or below 400% of the federal poverty level, shall be eligible for either full or partial discounts under Tenet's Charity Care program, Reduction or Waiver of Copayments or Deductibles, and Cash Pay Rate policies.

PROCEDURE

Procedure: California Addendum: Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**No:** EAC.05.03.PR.01
	Page: 2 of 4
	Effective Date: 12/31/24
	Previous Versions: 06/17/22, 10/01/16
Policy: EAC.05.03 Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**Approved By:** Amy Thomason
	Approval Date: 12/31/24

2. An emergency physician who provides emergency medical services in a Facility that provides emergency care is also required by law to provide discounts to Uninsured Patients or patients with high medical costs who are at or below 400% of the federal poverty level.

C. Procedures

1. Patient Notice

   a. Each Facility shall provide patients with a written notice that shall contain information about availability of the Facility's discount payment and Charity Care policies, including information about eligibility, as well as contact information for a Facility employee or office from which the person may obtain further information about these policies.

   b. Notice of the Facility's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following: (1) the emergency department; (2) billing office; (3) admissions office; and (4) other outpatient settings.

   c. Facilities subject to this policy will provide paper copies of the Confidential Application for Financial Assistance upon the request of the Patient and without charge to the Patient. The Confidential Application may also be provided to certain patients who do not specifically request an application if there is a belief that that patient may qualify for Financial Assistance.

2. Eligibility

   a. In determining eligibility for discounts under this policy, a Facility may consider only the Income of the patient and their medical costs. A Facility is prohibited by California law from considering the patient's monetary assets.

   b. For purposes of determining eligibility for discounts under this policy, documentation of Income shall be limited to recent pay stubs or Income tax returns. If a patient does not submit an application or documentation of income, a hospital may presumptively determine that a patient is eligible for charity care or discounted payment based on

PROCEDURE

Procedure: California Addendum: Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**No:** EAC.05.03.PR.01
	Page: 3 of 4
	Effective Date: 12/31/24
	Previous Versions: 06/17/22, 10/01/16
Policy: EAC.05.03 Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**Approved By:** Amy Thomason
	Approval Date: 12/31/24

information other than that provided by the patient or based on a prior eligibility determination.

3. Denials and Disputes

   a. Tenet may deny or pend applications for Charity Care pending insurance or third-party liability claim.

   b. A Patient may appeal a denial of Charity Care by submitting additional documentation to substantiate the application and qualification to:

      Attention: CFAC

      P.O. Box 223849

      Dallas, TX 75222-3849

   c. In the event of a dispute with the determination of eligibility for the Charity Care discount, each Facility to which this policy applies will submit such disputed application for review by the Facility's Chief Financial Officer or the Chief Financial Officer's designee acting under the Chief Financial Officer's direction and supervision.

4. Applying the Discounts

   a. After evaluation of a patient's application, or presumptive determination, patients who qualify as Financially Indigent will be afforded Charity Care Discounts of 100% of the Facility's Gross Charges, less any amount previously paid by the patient or any third-party for that care.

   b. If the Facility determines that a patient does not qualify for Charity Care under this policy, the patient will be billed the Uninsured Rate under Tenet Policy, and the patient also will be considered for a partial discount under the Reduction or Waiver of Copayments or Deductibles or Cash Pay Rates.

D. Payment Plan

   a. The Facility shall permit a patient to enter into an extended payment plan to allow payment of the discounted price over time. The Facility and the patient shall negotiate the

PROCEDURE

Procedure: California Addendum: Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**No:** EAC.05.03.PR.01
	Page: 4 of 4
	Effective Date: 12/31/24
	Previous Versions: 06/17/22, 10/01/16
Policy: EAC.05.03 Financial Assistance for Uninsured Patients [COMP-RCC 4.53]	**Approved By:** Amy Thomason
	Approval Date: 12/31/24

terms of the payment plan and take into consideration the patient's family Income and Essential Living Expenses.

b. If the Facility and the patient cannot agree on the payment plan, the Facility shall create a Reasonable Payment Plan, as defined above.

CORPORATE POLICY

Library: Tenet Healthcare - Revenue Cycle Management	**No**: FIN.08.04
	Page: 1 of 5
Title: Payment of Patient Premiums [COMP-RCC 4.55] (Policy)	**Effective Date**: 12/22/25
	Previous Versions: 02/23/17, 02/0915, 09/27/11, 01/19/11
	Approved By: Executive Leadership Team
	Approval Date: 12/22/25

I. Scope

This policy applies to (1) Tenet Healthcare Corporation and its subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare entity in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II. Purpose

The purpose of this policy is to provide directions regarding the limited circumstances under which Tenet Facilities may make insurance premium payments on behalf of patients.

III. Definitions

Affordable Care Act: means The Patient Protection and Affordable Care Act.

COBRA: means the Consolidated Omnibus Budget Reconciliation Act of 1986, under which covered employees and their qualified beneficiaries have the opportunity to continue health insurance coverage under company health and dental plans for specified periods of time when a "qualifying event" would normally result in the loss of eligibility. Continued coverage under the company health plan requires the payment of a premium by the individual.

COBRA Qualifying Events: include the resignation, termination of employment, or death of an employee. Reduction of an employee's hours, divorce or legal separation, or a dependent child who no longer meets eligibility requirements are also potential qualifying events.

Eligible Patients: for purposes of this policy only, mean patients who have no active health insurance coverage, but who are eligible for COBRA benefits, or who are eligible for continuation of health plan benefits, but whose premium payments are at risk of lapsing. Eligible Patients do not include individuals who are currently covered under Medicare or any other federal health care program. Eligible Patients do not include physicians or a physician's immediate family member.

Federal or State Marketplace: means the health insurance exchanges established under the Affordable Care Act, where individuals not covered by employer-based or governmental health insurance can purchase a qualified health plan.

Federal or State Marketplace Patient with past-due exchange premiums: for purposes of this policy, means a patient who has purchased insurance through the Federal or State Marketplace, and who is delinquent in paying insurance premiums, but who is still within the applicable "grace period" to retain full coverage.

Immediate Family Member: means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Physician: means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.

IV. Policy

Tenet Facilities may make premium payments on behalf of Eligible Patients, if such payments are made in accordance with the terms of this policy. Such premium payments shall not be considered a payment or gift to a patient under Tenet's Code of Conduct or policy COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals, nor shall the requirements of policy L-6 Hospital-Provided Post-Discharge Assistance to Federal Health Care Program Beneficiaries apply to the premium payments. Tenet Facilities may not make premium payments on behalf of patients who are not Eligible Patients as defined by this policy.

Tenet Facilities may assist Federal or State Marketplace Patients with past-due exchange premiums who are within the applicable "grace period" provided the patient is currently in-house receiving care. Such premiums may not be paid in order to attract the patient to the Marketplace or to a Tenet Facility.

V. Procedure

A. Tenet Facility Implementation

1. During patient registration or patient bedside screening, if the patient indicates a recent change in health insurance status due to what may constitute a "COBRA qualifying event" or a gap in existing insurance coverage:

   a. A registrar, patient access representative, medical eligibility representative or case manager will perform the appropriate screens to determine if the patient is currently a federal program beneficiary or beneficiary under other commercial coverage benefits.

b. If a patient is found to not be a current federal program beneficiary or beneficiary under other commercial coverage benefits, a registrar, responsible patient access representative, medical eligibility representative or case manager will also assist the patient in obtaining employer health benefit information, and with the patient's permission, will contact the patient's insurance or employer to obtain information, including benefit coverage information, premium amounts, and payment deadlines. (See Department Form: Consent to Determine Benefits.)

c. The patient access representative, medical eligibility representative, registrar, or Director of Revenue Analysis (DRA) will present this information to the Tenet Facility Chief Financial Officer (CFO) to evaluate whether to approve the premium payment.

i. The premium payment may be made by the Tenet Facility on behalf of the Eligible Patient to the extent the Chief Financial Officer (CFO) determines making such payment is financially prudent. (Department Form: CFO Financial Decision Making Tool).

a) The premium payment shall not be furnished directly to the Eligible Patient.

d. Payment information and CFO Approval must be submitted to the Controller for payment processing.

e. The costs of premium payments must not be included, directly or indirectly, in any federal health care program cost report or claim or otherwise shifted to any federal health care program. These costs must be allocated to a non-allowable cost center.

2. During patient registration or patient bedside screening, if the patient indicates that he or she may be a Federal or State Marketplace Patient with past-due exchange premiums, a registrar, patient access representative, medical eligibility representative, or case manager will follow-up with the patient's insurer in order to determine whether the patient is still within a grace period to pay missed premiums and retain insurance coverage, and if so, determine the premium amount due to retain coverage.

a. The registrar, patient access representative, medical eligibility representative, or case manager will present this information to the patient and encourage the patient to pay his or her past-due premiums.

b. If the patients is unable to pay past-due premiums, the patient access representative, medical eligibility representative, registrar, or Director of Revenue Analysis (DRA) will

present this information to the Tenet Facility CFO to evaluate whether to approve the premium payment.

i. The premium payment may be made by the Tenet Facility on behalf of the Eligible Patient to the extent the CFO determines making such payment is financially prudent. (Department From: CFO Financial Decision Making Tool). The premium payment must not be furnished directly to the Eligible Patient.

c. The Tenet Facility may also refer the patient to a Qualifying Private, Not-For-Profit Foundation for evaluation of potential assistance with his or her premiums provided that the Foundation makes the determination of financial assistance in its sole discretion without influence or involvement from the Facility.

B. Tenet Facility Donations to Qualifying Private, Not-For-Profit Foundations

1. Tenet Facilities may not make donations to a Qualifying Private, Not-For-Profit Foundation to which the Tenet facility also refers patients for financial assistance with exchange premiums, unless such donations are specifically restricted for uses other than providing individuals with financial assistance with exchange premiums.

a. A Tenet Facility's proposal to make such a donation requires the prior written approval of the Tenet Facility's Region/Market CEO, who may establish additional guidelines or restrictions on the frequency and/or amount of such contributions.

2. A Tenet Facility is prohibited from internally compiling information in order to correlate the amount or frequency of its donations to a Qualifying Private, Not-For-Profit Foundation with the number of patients who use its services, or the volume of those services as a result of such donations.

VI. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. References

Tenet Health

CORPORATE POLICY

Library: Tenet Healthcare - Revenue Cycle Management	**No**: FIN.08.04
	Page: 5 of 5
Title: Payment of Patient Premiums [COMP-RCC 4.55] (Policy)	**Effective Date**: 12/22/25
	Previous Versions: 02/23/17, 02/0915, 09/27/11, 01/19/11
	Approved By: Executive Leadership Team
	Approval Date: 12/22/25

Departmental Form: Consent to Determine Benefits

Departmental From: CFO Financial Decision Making

COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals

L-6 Hospital-Provided Post-Discharge Assistance to Federal Health Care Program Beneficiaries

Tenet Code of Conduct

CMS Center for Consumer Information and Insurance Oversight FAQ, Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Nov. 4, 2013), available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.

CMS Center for Consumer Information and Insurance Oversight FAQ, Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Feb. 7, 2014), available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf.

Letter from Kathleen Sebelius, Secretary of United States Department of Health and Human Services to Richard Umbdenstock, President of the American Hospital Association (May 21, 2014).

OIG Advisory Opinions No. 13-19; No. 07-11; No. 97-1

U.S. Department of Labor Guidance, Continuation of Health Coverage - COBRA

Tenet Health	Accounting Policies and Procedures Manual	No.	FIN C-b-4
	Title:	Page:	1 of 9
		Effective Date:	11-30-12
	ALLOWANCE FOR BAD DEBT	Retires Policy Dated:	06-30-10
		Previous Versions Dated: 10-01-01; 06-01-88	02-20-07;

I. SCOPE:

This policy applies to Tenet Healthcare Corporation ("Tenet"), its consolidated subsidiaries and all hospital and other healthcare operations owned or operated by Tenet's consolidated subsidiaries (each, a "Tenet Facility").

II. PURPOSE:

This policy provides for consistent reporting across all Tenet facilities.

III. POLICY:

This policy requires the use of the Tenet standard "Bad Debt Matrix" in eReserve. The "Bad Debt Matrix" provides reserve percentages for aging categories based on the following reserve methods:

A. Medicare Co-Insurance & Deductibles – Accounts aged over 180 days are reserved at 30% of "net" AR.[1]

B. Self Pay/Other and Self Pay Balance After – Calculations based upon a percentage of the inverse Performance Analysis (PA)[2] determined by Syndicated Office Systems (SOS) using historical collection data. The reserve is based on "net" AR.

C. Net Insurance – Calculations are based on standard reserve percentages depending on the age of the account (see page 3 of this policy). The reserve is based on "net" AR.

IV. PROCEDURE:

A. Hospital Implementation

1. Allowance for Bad Debt

Entries to these accounts will originate from the standard bad debt matrix as detailed below.

---

[1] "Net" AR contains accounts in PBAR that are both at gross and that have been netted down utilizing adjustment codes. The bad debt matrix goes one step further by netting the "net" accounts by any manual reserves placed on the accounts via eReserve.

[2] The inverse PA is calculated as follows: 100% minus SOS collection percentage (PA) equals reserve percentage (inverse PA). The PA is reviewed periodically during the year and updated for changes in the market environment and collection trends. Where no PA is available, contact the Operational Accounting department at the Tenet Headquarters Office.

Additional entries affecting these allowance accounts are transactions with Central Financial Control (CFC) including those associated with Medicare Bad Debt.

2. Monthly Bad Debt Matrix Calculation

The purpose of the Bad Debt Matrix is to determine the adequacy of the Allowance for Bad Debt reserve. By utilizing this standard Bad Debt Matrix, the facility will determine the estimated amount of uncollectible patient accounts receivable at the end of any given accounting period.

All financial classes should be reviewed for uncollectible accounts due to the potential misclassification or changes of status with certain accounts. In addition, on an ongoing basis, all financial classes must be monitored to ensure that the patient accounts are classified properly. Patient accounts that are determined to be misclassified must immediately be transferred to the proper financial class and the proper bad debt reserve established. If financial class changes occur in eReserve, these changes **will not** be reflected on the Bad Debt Matrix in eReserve and therefore, should be accounted for separately on the Specific Allowances and Defined Adjustments line.

The Specific Allowances and Defined Adjustments section within the Bad Debt Matrix should only be used for unique situations that have been approved by the Regional VP of Finance. To the extent that this field is used, the Specific Allowance section should be utilized to explain the type of AR, Sub Payer Category, AR Amount, Aging Category, Current Reserve Amount and Reserve Adjustment. Some common uses of this section are described below:

- Financial Class Changes – the bad debt matrix does not account for any financial class changes made during the reserve process done in eReserve. If a facility finds a $4,000 account at an age of 50 with a reserve of $1,000 that is coded to a Medicare Supplemental FC incorrectly and changes this in eReserve to the correct FC of Managed Care, this will impact bad debt. Under the Medicare Supplemental FC, there is no bad debt reserve on the account. Under Managed Care, the account would be reserved at $300 ($4,000 - $1,000 = $3,000 * 10% = $300). This additional reserve should be entered in the Specific Allowance and Defined Adjustments section. There is no requirement to account for all FC changes, especially

those that do not meet a minimum threshold.

- Intercompany Accounts – in the patient accounting system, intercompany accounts route to "Other". Since intercompany accounts are customarily paid at 100%, there should be no reserve or bad debt adjustment posted for these accounts. Since the "Other" category is reserved on the bad debt matrix, the entire bad debt reserve for these accounts should be backed out of the calculation by utilizing the Specific Allowance and Defined Adjustments line. For example, if a facility has $5,000 in intercompany accounts and their bad debt reserve percentage for Self Pay/Other accounts is 92%, a $4,600 credit to bad debt should be taken.

3. **Bad Debt Matrix**

Schedule I:
The following instructions should be followed to complete Schedule I of the Bad Debt Matrix in eReserve:

The Matrix populates automatically via an interface from patient accounting for facilities on eReserve, whereby account balances will automatically populate into the appropriate cells on Schedule I based on Sub Payer groupings. Amounts are entered in thousands and equal the corresponding Aged AR report from the Patient Accounting System utilized by the facility.

The standard percentages, as represented in eReserve, are used to determine the Net Insurance (Managed Care) reserve.

The only required input fields on the automated matrix are the Specific Allowances/Defined Adjustments line and the Allowances per GL. The GL balance lines should reflect the balances in the accounts after all SOS/CFC and PBAR interfaces have occurred for the month. The resulting Over/(Under) Reserves should be posted to the appropriate accounts as noted below.

Schedule II:
The contractual allowances calculated on Schedule II should be recorded to a contractual adjustment account. The contractual allowance accounts to utilize for Schedule II allowances are XXX.0.1058.00.0082, XXX.0.1058.00.0084, XXX.0.1058.00.0085, XXX.0.1058.00.0087, or

XXX.0.1058.00.0088 (refer to APPM, Section FIN C-b-5 for specific account definitions and instructions).

NOTE: For non-Acute care facility accounts receivable on a non-standard Tenet patient accounting system and/or not on eReserve (including Hospice, DIC, etc.), a manual Bad Debt Matrix must be prepared using the Net Insurance (Managed Care) percentages as represented in eReserve for all payer categories. Amounts should be entered in thousands and equal the appropriate Aged AR report from the patient accounting system utilized by the facility. If the applicable aging categories are not available, please contact the Operational Accounting department at the Tenet Headquarters Office for further guidance.

B. Responsible Party

Each Tenet Facility Controller shall be responsible for assuring that all personnel adhere to the requirements of this policy, that these procedures are implemented and followed at the Facility, and that the instances of noncompliance with this policy are reporting to the Facility Chief Financial Officer.

C. Auditing and Monitoring

Tenet Audit Services Department shall audit adherences to this policy.

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. DEFINITIONS:

Definitions begin on page 5.

XXX.0.1041.00.0004.00 - Allowance for Bad Debts – Hospice/Home Health

This account should be used to record the estimated amount of uncollectible Home Health/Hospice patient accounts receivable.

Based on the Bad Debt Matrix calculation, the following entry should be recorded in the Bad Debt Allowance account for the reserve estimate for account XXX.0.1030.00.1718.00 (AR Patient – Hospice/Home Health) when the general ledger account balance is **less** than the bad debt computed allowance amount:

Account #	Description	Debit	Credit
XXX.5900.3907	Prov. For Bad Debt-NHE	$ 100,000	
XXX.1041.0004	Allow. For BD Hospice/HH		$ 100,000

The following entry should be recorded with the general ledger account balance is **more** than the bad debt computed allowance amount:

Account #	Description	Debit	Credit
XXX.1041.0004	Allow. For BD–Hospice/HH	$ 100,000	
XXX.5900.3907	Prov. For Bad Debt-NHE		$ 100,000

XXX.0.1041.00.0005.00 - Allowance for Bad Debt – Self Pay/Uninsured
XXX.0.1041.00.0006.00 – Allowance for Bad Debt – Self Pay Balance After
XXX.0.1041.00.0007.00 – Allowance for Bad Debt – Other
XXX.0.1041.00.0008.00 – Allowance for Bad Debt - Insurance

These accounts should be used to record the estimated amount of uncollectible patient accounts receivable excluding Medicare, Managed Medicare, Medicaid(Cal), Managed Medicaid(Cal), Tricare, Charity, and Capitated receivables. Separate contractual allowances should be computed for the aforementioned receivable balances.

The instructions above should be utilized to complete the Bad Debt Matrix in eReserve. Based on the Bad Debt Matrix calculation, the following entry must be recorded in the Bad Debt Allowance account for the reserve estimate for accounts XXX.0.1030.00.0020.00 – XXX.0.1030.00.0032.00 (AR Patient – Control by 8 payers) where the general ledger account balance is **less** than the bad debt computed allowance amount in eReserve:

Account #	Description	Debit	Credit
XXX.5900.39XX	Prov. for Bad Debt	$ 100,000	
XXX.1041.000X	Allow. For Bad Debt		$ 100,000

The following entry should be recorded when the general ledger account balance is **more** than the bad debt computed allowance amount in eReserve:

Account #	Description	Debit	Credit
XXX.1041.000X	Allow. for Bad Debt	$ 100,000	
XXX.5900.39XX	Prov. For Bad Debt		$ 100,000

XXX.0.1041.00.0399.XX Allowance for Bad Debts - Physician Practice & Clinics

These accounts should be used to record the estimated amount of uncollectible Physician Practice and Clinic patient accounts receivable.

Based on the Bad Debt Matrix calculation, the following entry should be recorded in the Bad Debt Allowance account for the reserve estimate for account XXX.0.1030.00.0016.XX (AR Patient - Non-Tenet Physician Services) when the general ledger account balance is **less** than the bad debt computed allowance:

Account #	Description	Debit	Credit
XXX.5900.3910	Prov. for Bad Debt - Non-Pat	$ 100,000	
XXX.1041.0399	Allow. For Bad Debt – Phy Prac		$ 100,000

The following entry should be recorded when the general ledger account balance is **more** than the bad debt computed allowance:

Account #	Description	Debit	Credit
XXX.1041.0399	Allow. for Bad Debt –Phy Prac	$ 100,000	
XXX.5900.3910	Prov. For Bad Debt – Non-Pat		$ 100,000

XXX.0.1044.00.0005.XX Allowance for Bad Debts - NHE AR

This account should be used to record the estimated amount of uncollectible NHE patient accounts receivable. For larger NHEs that are on PBAR and in eReserve, the Bad Debt Matrix in eReserve should be utilized to record the allowance for bad debt entry. For those not in eReserve, the manual Bad Debt Matrix utilizing the percentages, as represented in eReserve, should be completed.

Based on the Bad Debt Matrix calculation, the following entry should be recorded in the Bad Debt Allowance account for the reserve estimate for account XXX.0.1030.00.1618.XX (AR Patient - NHE) when the general ledger account balance is **less** than the bad debt computed allowance::

Account #	Description	Debit	Credit
XXX.5900.3907	Prov. for Bad Debt – NHEs	$ 100,000	
XXX.1044.0005	Allow. For Bad Debt - NHE		$ 100,000

The following entry should be recorded with the general ledger account balance is **more** than the bad debt computed allowance:

Account #	Description	Debit	Credit
XXX.1044.0005	Allow. for Bad Debt – NHE	$ 100,000	
XXX.5900.3907	Prov. For Bad Debt – NHEs		$ 100,000

VI. REFERENCES

a. Technical
   i. Accounting Standards Codification 954-310 Health Care Entities - Receivables.
   ii. Accounting Standards Codification 310-10-35 Losses from Uncollectible Receivables.
   iii. Healthcare Financial Management Association Statement No. 16, "Classifying, Valuing, and Analyzing Accounts Receivable Related to Patient Services paragraphs 4.1 – 4.7 Valuing Revenue and Receivables at the Expected Payment Amount.

b. SOX
   1. A.04.10 – At month end, facility finance/accounting staff utilizes the bad debt matrix with predetermined rates within eReserve, to calculate the bad debt reserve needed on active A/R (hospital) accounts. Bad debt matrix supporting hospital A/R is reviewed by CFO and Regional VP Finance. The Specific Allowances and Defined Adjustments section within the Bad Debt Matrix should only be used for unique situations that have been approved by the Regional VP of Finance. The review should be performed no later than two business days after the month-end close.

c. Related Policies
   i. eReserve User's Guide
   ii. APPM FIN C-c-5

d. Balance Sheet Reconciliation Templates
   i. 1041.0004/1041.0399/1044.0005 – Bad Debt Excel file is template
   ii. 1041.0005/1041.0006/1041.0007/1041.0008 – Bad Debt eReserve file is template