Imperial Valley Healthcare District

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| Title: **Financial Assistance Program (FAP), Charity Care Program** | Policy No. ADM-00312 |
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The electronic version of this policy supersedes any printed copy

## 1.0 Purpose:

To define the criteria used by Pioneers Memorial Hospital (PMH) to evaluate and determine qualification for the Financial Assistance Program (FAP) and Charity Care program. PMH strives to ensure that the financial capacity of people who need health care services shall not prevent them from seeking or receiving care.

## 2.0 Scope:

2.1 Patients who receive medically necessary services from PMH (as defined in California Welfare & Institutions Code §14059.5), including patients, patient families, physicians and hospital staff. This policy does not apply to physician services rendered at PMH.

2.1.1 Emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or

patient with high medical costs who are at or below the 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

2.2 In the event that the hospital determines a particular service is not medically necessary, the referring physician and/or the supervising health care provider must sign an attestation indicating the rationale for determining the hospitals service(s) as not medically necessary. Said attestation must be completed prior to the denial of full or partial financial assistance by PMH.

## 3.0 Policy:

3.1 Under the patient Financial Assistance Program (FAP), all uninsured patients and those who request financial assistance will be required to complete a Financial Assistance Application (FAA). The FAA is a unified patient application for both full charity care and discount payment. This enables PMH to provided the maximum financial assistance available to the patient. PMH shall provide direct assistance to facilitate completion of the FAA.

3.2 All hospital documents including the FAA shall be in at least a 12 point sans serif font, using straightforward language so that patients may easily read and understand these documents. Documents will be maintained available in any

language commonly spoken by five (5%) or more of the service population. All patient notices will be accompanied by a tagline sheet with the following statement provided in English and the top 15 languages spoken by limited English speaking persons in California:

3.3 ATTENTION: If you need help in your language, please call 1-800-874-9426, enter ID number 201448, where patients obtain more information. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

3.4 Patients must be honest and forthcoming when providing all information requested by PMH as part of the financial screening process. The FAA provides patient information necessary for determining patient qualification by the hospital and such information may be used to qualify the patient or family representative for maximum coverage available through government programs. Factors

considered when determining whether an individual is qualified for financial assistance pursuant to this policy include:

3.4.1 Family income based upon federal income tax returns, recent pay stubs, or other relevant information provided by the patient in the absence of said documents; and "Patients family means the following:

For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

3.4.2 PMH FAP relies upon the cooperation of individual patients who may be eligible for full or partial assistance. Patients must make every reasonable effort to provide PMH with documentation and health insurance coverage information such that PMH may make a

determination of the patient's qualification for coverage under the appropriate program. Prior to leaving PMH, patients should verify what additional information or documentation must be submitted to PMH.

3.4.3 Patients should expect and are required to pay any or all amounts due at the time of service, including but not limited to, co-payments, deductibles, deposits and Medi-Cal/Medicaid Share of Cost amounts.

3.5 Eligibility alone is not an entitlement to qualification under the PMH FAP. PMH must complete a process of application evaluation and determine qualification before full charity or discount payment may be granted.

3.6 PMH, in its sole discretion, may determine that it has sufficient patient financial information from which to make a financial assistance qualification decision without a completed FAA.

3.7 Financial assistance determination will be made only by approved PMH personnel according to the following levels of authority:

3.7.1 -Director of Patient Business Office: Accounts less than $10,000

3.7.2 -Chief Financial Officer: Accounts greater than $10,000

## 4.0 Procedure:

4.1 Eligibility for full charity care or discount payment financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay in accordance with Federal Poverty Level (FPL) standards.

4.2 Charity Care & Discount Payment Eligibility - Eligibility under the PMH FAP is provided for any patient whose family income is less than 400% of the current federal poverty level, if not covered by a third-party insurance or, if covered by third party insurance which does not result in full payment of the account.

4.3 All open accounts at the time of application will be reviewed for qualification.

4.4 Self pay patients who are Uninsured - If an uninsured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the patient qualifies for full charity care.

4.4.1 If an uninsured patient's family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

4.4.1.1 If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges,

the patient's payment obligation will be a percentage of the Medicare amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be on the sliding scale shown in Attachment C.

4.5 Insured Patients - If an insured patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, PMH will accept the amount paid by the third-party insurer and the patient will have no further payment obligation.

4.5.1 If an insured patient's family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines,

and the patient meets all other Financial Assistance qualification requirements, the following will apply:

4.5.1.1 If a patient has insurance that covers part of their charges, and they only owe a deductible or co-payment, patient will not pay more than the Medicare rate

4.6 Special Charity Care Circumstances - Patient and patient's families are deemed as automatically eligible for full charity care in the following situations:

4.6.1 Patient is determined by PMH Registration staff to be homeless and without third party payer coverage.

4.6.2 Deceased patients who do not have any third-party payer coverage, an identifiable estate or for whom no probate hearing is to occur.

4.6.3 Patients who have been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months. The patient or family representative shall provide a copy of the court order document as part of their application.

4.6.4 Patients seen in the emergency department, for whom PMH is unable to issue a billing statement, may have the account charges written off (i.e., the patient leaves before billing information is obtained). All such

circumstances shall be identified on the patient's account notes as an essential part of the documentation process.

4.6.5 Patients who are eligible for government sponsored low-income assistance programs (e.g., Medi-Cal/Medicaid, California Children's Services, and any other applicable state or local low-income program) are automatically eligible for full charity care when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other government programs serving the needs of low-income patients (e.g., Child Health and Disability Prevention (CHDP) and some California Children's Services (CCS)) where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance coverage. Under PMH's FAP, these types of non-reimbursed patient account balances are eligible for full write-off as Charity Care. Specifically included as Charity Care are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by

qualifying low-income programs, and other denials (e.g., restricted coverage) are to be classified as Charity Care.

4.6.6 Any uninsured patient who is classified as a foreign refugee, with documentation from the US Border Patrol, Customs and Immigration Service, and/or other government entity with jurisdiction, may be deemed as eligible for full charity care.

4.6.7 Any uninsured patient whose income is greater than 400% of the current FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients who have higher incomes do not qualify for routine full charity care or discount payment care. However, consideration of a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the patient's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $150,000.00 may be

considered for eligibility as a catastrophic medical event**. This does not apply to the Rural Health Clinics.**

4.6.8 Any account returned to PMH from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.

4.6.8.1 Criteria for Re-Assignment from Bad Debt to Charity Care - All outside collection agencies contracted with PMH to perform account follow-up and/or bad debt collection will utilize the

following criteria to identify a status change from bad debt to charity care:

4.6.8.2 Patient accounts must have no applicable insurance (including governmental coverage programs or other third-party payers); and

4.6.8.3 The patient or family representative must have a credit and/or behavior score rating within the lowest 25th percentile of credit scores for any credit evaluation method used; and

4.6.8.4 The patient or family representative has not made a payment within 180 days of assignment to the collection agency; and

4.6.8.5 The collection agency has determined that the patient/family representative is unable to pay; and/or

4.6.8.6 The patient or family representative does not have a valid Social Security Number and/or an accurately stated residence address in order to determine a credit score.

4.6.8.7 All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by PMH Billing

Department personnel prior to any re-classification within the hospital accounting system and records.

4.7 Patient Notification - Once a determination of charity care eligibility is made, a letter indicating the determination status will be sent to the patient or family representative. The determination status letter will indicate one of the following:

4.7.1 Approval: The letter will indicate the account has been approved, the level of approval and any outstanding amount owed by the patient. Information and directions for any further patient actions will also be provided.

4.7.2 Denial: The reasons for eligibility denial based on the FAA will be explained to the patient. Any outstanding amount owed by the patient will also be identified. Contact information and instructions for payment, including a reasonable payment plan will also be provided.

4.7.3 Pending: The applicant will be informed as to why the FAA is incomplete. All outstanding information will be identified, and the

notice will request that the information be supplied to PMH by the patient or family representative.

4.8 All financial assistance letters will also contain information on the Hospital Bill Complaint Program, including the following statement:

4.8.1 Hospital Bill Complaint Program

4.8.1.1 The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to

HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

4.8.1.2 All financial assistance letters will also include the following statement:

4.8.2 Help Paying Your Bill

There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

4.9 Qualified Payment Plans - When a determination of discount payment has been made by PMH, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term Qualified Payment Plan.

4.9.1 PMH shall discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to

effectively meet the payment terms. As a general guideline, payment plans will be structured to last no longer than 12 months.

4.9.2 PMH shall negotiate in good faith with the patient; however, there is no obligation to accept the payment terms offered by the patient. In the event that PMH and an individual patient or guarantor cannot reach an agreement to establish a Qualified Payment Plan, the hospital will use the “Reasonable payment plan” formula as defined in Health & Safety Code Section 127400 (i) as the basis for a payment plan. A “Reasonable payment plan” means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for essential living expenses. In order to apply the “Reasonable payment plan” formula, PMH shall collect patient family information on income and “Essential living expenses” in accordance with the statute. PMH shall use a standardized form to collect such information. Each patient or guarantor seeking to establish a payment plan by applying the “Reasonable payment plan” formula shall submit the family income

and expense information as requested, unless the information request is waived by representatives of PMH.

4.9.3 No interest will be charged to qualified patient accounts for the duration of any payment plan arranged under the provisions of the FAP.

4.9.4 Once a payment plan has been approved by PMH, any failure to pay all consecutive payments due during a 90-day period will constitute a payment plan default. It is the patient or guarantor's responsibility to contact the PMH Patient Business Office if circumstances change, and payment plan terms cannot be met. However, in the event of a payment plan default, PMH will make a reasonable attempt to contact the patient or their family representative by telephone and give notice of the default in writing. Notices of plan default will be sent the patient at least sixty (60) days after the first missed bill and provide the patient at least thirty (30) days to make a payment before the extended payment plan becomes inoperative. The patient shall have an opportunity to renegotiate the extended payment plan and may do so by contacting a Patient Business Office representative. The patient's

financial responsibility shall not exceed the discounted amount previously determined. The patient will receive credit for any payments made before the extended plan became inoperative and the account will become subject to collection.

4.9.5 Dispute Resolution In the event that a dispute arises regarding Financial Assistance Program qualification, the patient may file a written appeal for reconsideration with PMH. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

4.9.6 Any or all appeals will be reviewed by the Director of the Patient Business Office. The Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Director shall provide the patient with a written explanation of findings and the determination. If the party making the appeal disagrees with the findings, they make an additional

written appeal to the Chief Financial Officer. The decision of the Chief Financial Officer is final. There are no further appeals.

4.10 Public Notice

4.10.1 PMH shall post notices informing the public of the FAP, the FAA, and the Billing and Collection Policy. Such notices shall be posted in high volume inpatient and outpatient service areas of PMH, including but not limited to, the emergency department, billing office, inpatient admission and outpatient registration areas, outpatient observation units, or other common patient waiting areas of PMH. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.

4.10.1.1 These notices shall be posted in English and Spanish and are available in other languages as required by Health & Safety Code §127410 (a).

4.10.1.2 All posted notices shall be in a sans serif font, using black text on a white background. Posted notices shall be no smaller than an

11”x17’ sheet and written in an easy to read and understand format. Posted notices will be in English and Spanish and any other language commonly used by five (5%) percent or more of the service population.

4.10.1.3 Hospital postings will have the following subject headings:

4.10.1.3.1 “Help Paying Your Bill” with information about the hospital full and partial financial assistance program.

4.10.1.3.2 “How to Apply” with contact information for the hospital employee and office where information about financial assistance and an application may be obtained.

4.10.1.3.3 “Hospital Bill Complaint Program” followed by the language: If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

4.10.1.3.4 “More Help” followed by: There are free consumer advocacy organizations that will help you understand the

billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

4.10.1.3.5 Information on how a patient with a disability may access the notice in an alternative format, including but not limited to, large print, braille, audio, or other accessible electronic formats.

4.10.1.3.6 Information on how to access the notice in another language.

4.10.2 Additionally, the Financial Assistance Policy, the Financial Assistance Application, Public Notice, and the Billing and Collection Policy shall be easily found online at: www.pmhd.org. The webpage is titled “Help Paying Your Bill,” and a link is found on both a footer and header dropdown menu no more than one click away. –The website shall also

include the standard language reference to the Hospital Bill Complaint Program.

4.10.3 Paper copies of the above referenced documents shall be made available to the public upon reasonable request at no additional cost. PMH shall respond to such requests in a timely manner.

4.11 Full Charity Care and discount payment Care Reporting

4.11.1 PMH shall report actual Charity Care provided in accordance with this regulatory requirement of the Department of Health Care Access and Information (HCAI) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, PMH will maintain written documentation regarding its Charity Care criteria, and for individual patients, PMH will maintain written documentation regarding all Charity Care determinations. As required by HCAI, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.

4.11.2 PMH will appoint an authorized primary and secondary contact to receive compliance and informational communications from HCAI. Each of these two designated PMH personnel will register with HCAI and any

changes to the primary or secondary contacts will be communicated to HCAI within ten (10) working days.

4.11.3 PMH will appoint an authorized primary and secondary contact to review and respond to patient complaints. Each of these two designated PMH personnel will register with HCAI and any changes to the primary or secondary contacts will be communicated to HCAI within ten (10) working days

4.11.4 PMH shall provide HCAI with a copy of this FAP which includes the full charity care and discount payment policies within a single document. The FAP also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for full charity care and discount payment-partial charity care; and 3) the review process for both full charity care and discount payment-partial charity care. The Billing & Collection policy will also be submitted as it contains elements required under Health & Safety Code Sections 1274000 et. seq. These documents

shall be supplied to HCAI every two years or whenever a significant change is made.

## 5.0 References:

5.1 California Welfare & Institutions Code §14059.5 - definition of medically necessary Services (referenced in section 2.0)

5.2 Health & Safety Code §127410 (c) – regulation for notices posted.

## 6.0 Attachment List:

6.1 Attachment A - Financial Assistance Program Summary, Public Notice

6.2 Attachment B - Financial Assistance Application

6.3 Attachment C – Financial Assistance Sliding Scale Discount payment Schedule

6.4 Attachment BB - Financial Assistance Application – Spanish

6.5 Attachment AA - Financial Assistance Program Summary, Public Notice -Spanish

## 7.0 Summary of Revisions:

7.1 Revised Healthcare District to Hospital as well as PMHD to PMH.

7.2 Revised partial charity to discount payment.

7.3 3.4.1 Revised Family meaning.

7.4 4.6 Rephrase section in plain language.

7.5 4.9.4 Remove verbiage on plan default notices timeframes.

# Public Notice

# Financial Assistance Program Summary

## Financial Assistance

Please inform us if you have any type of health insurance coverage from a health insurer, health care service plan, Medicare, Medi-Cal/Medicaid, CCS, or other state funded programs designed to provide health coverage. If you do not have health insurance coverage, PMH will provide you with an application for Medi-Cal, or other government coverage program for which you may be eligible. Because it may benefit you, please contact our financial counseling staff who are may reached by phone at: (760) 351-3322 and (760) 351-3323, from 8:30 a.m. to 4:30 p.m.

## PMH Patient Financial Assistance Policy (FAP) Eligibility

We are dedicated to ensuring that high quality care is extended to all, regardless of their ability to pay. PMH's FAP helps to make emergency and other medically necessary services available to the whole community. No one will be denied access to services due to inability to pay. There is a discounted/sliding fee schedule available based on family size and income.

Patients who do not have health insurance coverage and whose family income is 400% or less of the federal poverty guidelines may be eligible for assistance through PMH. Free care is available for an uninsured or underinsured patient whose family income is 200% or less of federal poverty guidelines. Discounted payment is available for insured, uninsured, and patients between 201% and 400% of the federal poverty guidelines. An FAP-eligible individual will not be charged more than Medicare/Medi-Cal rates whichever is higher for emergency or other medically necessary care.

## What Does PMH Financial Assistance Cover?

The FAP covers emergency and medically necessary service provided at PMH. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. The PMH FAP does not apply to physician services provided at PMH.

However, emergency physicians at PMH have adopted a separate policy that provides discounts to uninsured patients or patients with high medical costs whose income is at or below 400% of the Federal Poverty Level. Information is available at 1-800-498-7157.

## How To Apply For PMH Financial Assistance

Financial Assistance Program applications are available to all patients without charge. For paper copies, please ask at any Admitting and Registration desk.

They are available online at: www.pmhd.org/charge-estimates.

Electronic copies of program information are available by email upon request. Call (760) 351-3322 and/or (760) 351-3323 to request electronic copies. Please be prepared to provide an email address that the information can be sent to when calling.

A patient may request information by mail at:

Pioneers Memorial Hospital

207 West Legion Road

Brawley, CA 92227

## Applications Available in Other Languages

Copies of the Financial Assistance Policy, FAP application form, and FAP Summary are available in English and Spanish. Other languages may also be available. For more information, call (760) 351-3322 or speak to a financial counseling staff member for assistance.

## Consumer Assistance- More Help

Non-profit credit counseling services may be available in the area. Please contact the PMH Financial Counseling Office at (760) 351-3322, from Monday to Friday 8:30 a.m. to 4:30 p.m. if you need more information or assistance in contacting a credit counseling service.

The Health Consumer Alliance is an independent organization that may help patients and/or guarantors understand the billing and payment process. The organization also provides information on Covered California and assistance with Medi-Cal. Please find them at: https://healthconsumer.org

## Price Transparency

Information on standard hospital costs for commonly provided services, including the PMH list of shoppable services is available at: www.pmhd.org/charge-estimates

## Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. For more information or to file a complaint, visit the Hospital Bill Complaint Program at:

**HospitalBillComplaintProgram.hcai.ca.gov**

# ATTACHMENT AA

## Ayuda para Pagar
## Resumen del Programa de Asistencia Financiera

### Asistencia financiera

Por favor infórmenos si tiene algún tipo de cobertura de seguro médico de alguna aseguradora médica, plan de servicios de atención médica, Medicare, Medi-Cal/ Medicaid, CCS u otros programas financiados por el estado diseñados para brindar cobertura médica. Si no tiene cobertura de seguro médico, Pioneers Memorial Hospital (PMH) le proporcionará una solicitud para Medi-Cal u otro programa de cobertura del gobierno para el que pueda ser elegible. Debido a que puede beneficiarlo, contacte a nuestro personal de asesoramiento financiero al que puede comunicarse por teléfono al: (760) 351-3322 y (760) 351-3323, de lunes a viernes 8:30 a.m. a 4:30 p.m.

### Elegibilidad para la Política de Asistencia Financiera (FAP) para pacientes con PMH

Estamos dedicados a garantizar que la atención de alta calidad se extienda a todos, independientemente de su capacidad de pago. La FAP de PMH ayuda a que los servicios de emergencia y otros médicamente necesarios estén disponibles para toda la comunidad.

Los pacientes que no tienen cobertura de seguro médico y cuyo ingreso familiar es 400% o menos de las pautas federales de pobreza pueden ser elegibles para recibir asistencia a través de PMH. Ningún paciente va hacer negado servicio, por no poder pagar. La atención gratuita está disponible para un paciente sin seguro cuyo ingreso familiar es 200% o menos de las pautas federales de pobreza. La atención con descuento está disponible para pacientes asegurados y no asegurados entre el 201% y el 400% de las pautas federales de pobreza. A una persona elegible para FAP no se le cobrará más que las tarifas de Medicare/Medi-cal lo que sea mayor, para casos de emergencia u otra atención médicamente necesaria.

# ATTACHMENT AA

## ¿Qué cubre la asistencia financiera de PMH?

La FAP cubre los servicios de emergencia y médicamente necesarios proporcionados en PMH. Un servicio es médicamente necesario cuando es razonable y necesario para proteger la vida, prevenir una enfermedad grave o una discapacidad importante, o aliviar un dolor intenso. La FAP de PMH no se aplica a los servicios médicos proporcionados en PMH.

Sin embargo, los médicos de urgencias del PMH han adoptado una política separada que brinda descuentos a pacientes sin seguro o pacientes con altos costos médicos cuyos ingresos son iguales o inferiores al 400% del nivel federal de pobreza. La información está disponible llamando al 1-800-498-7157.

## ¿Cómo solicitar asistencia financiera de PMH?

Las solicitudes del Programa de Asistencia Financiera están disponibles para todos los pacientes sin cargo. Para copias en papel, pregunte en cualquier mostrador de admisión y registro.

Están disponibles en línea en: www.pmhd.org/charge-estimates

Las copias electrónicas de la información del programa están disponibles por correo electrónico sobre pedido. Llame al (760) 351-3322 y/o (760) 351-3323 para solicitar copias electrónicas. Esté preparado para proporcionar una dirección de correo electrónico a la que se pueda enviar la información cuando llame

Un paciente puede solicitar información por correo a:

Pioneers Memorial Hospital

207 West Legion Road

Brawley, CA 92227

# ATTACHMENT AA

## Aplicaciones disponibles en otros idiomas

Las copias de la Política de Asistencia Financiera, el formulario de solicitud de FAP y el Resumen de FAP están disponibles en inglés y español. Otros idiomas también pueden estar disponibles. Para obtener mayor información, llame al (760) 351-3322 o hable con un miembro del personal de asesoramiento financiero para obtener ayuda.

## Asistencia al consumidor

Los servicios de asesoría de crédito sin fines de lucro pueden estar disponibles en el área. Comuníquese con la Oficina de Asesoramiento Financiero de PMH al (760) 351-3322, de 8:30 a. m. a 4:30 p. m. si necesita más información o ayuda para ponerse en contacto con un servicio de asesoramiento crediticio.

Health Consumer Alliance es una organización independiente que puede ayudar a los pacientes y/o garantes a comprender el proceso de facturación y pago. La organización también proporciona información sobre Covered California y asistencia con Medi-Cal. Encuéntrelos en: https://healthconsumer.org

## Transparencia de Precios

La información sobre los costos hospitalarios estándar para los servicios comúnmente proporcionados, incluida la lista de PMH de servicios que se pueden comprar, está disponible en: www.pmhd.org/charge-estimates

## Programa de Quejas de Facturas Hospitalarias

El programa de quejas de facturas hospitalarias es un programa estatal que revisa las decisiones del hospital sobre si usted califica para recibir ayuda para pagar sus factura hospitalaria. Si cree que se le negó asistencia financiera por error, puede presentar una queja ante el programa de quejas de facturas hospitalarias. Para obtener mas información o presentar una queja, ingrese a: **HospitalBillComplaintProgram.hcai.ca.gov**

# Pioneers Memorial Hospital

## Financial Assistance Application

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### INSTRUCTIONS

1. Please complete *all* areas on the attached application form. If any area does not apply to you, write N/A in the space provided.
2. Please note that based on eligibility, discount payment offers less financial assistance than charity care.

3. Attach an additional page if you need more space to answer any question.

4. You *must* provide proof of income documents when you submit this application. The following documents are accepted as proof of income:

   **If you filed a federal income tax return you must submit a copy of:**

   a. Federal income tax return (Form 1040) from the recent year. You must include all schedules and attachments as submitted to the Internal Revenue Service;

   **If you did not file a federal income tax return, please provide the following:**

   a. Three (3) recent paycheck stubs; and

If you have no income, or proof of income documents, you may provide a letter explaining how you support yourself/family.

5. Your application cannot be processed until *all* required information is provided.

6. It is important that you complete and submit the financial assistance application along with all required attachments.

7. You *must* sign and date the application. If the patient/guarantor and spouse provide information, both *must* sign the application.

8. If you have questions, please call your financial counselors at (760) 351-3322 and (760) 351-3323.

9. Send your completed application to:
   Pioneers Memorial Hospital
   Patient Financial Services Department
   207 West Legion Road
   Brawley, CA 92227

## Pioneers Memorial Hospital
## Financial Assistance Application

| | | | |
|---|---|---|---|
| **PATIENT/ GUARANTOR NAME** | | **SPOUSE NAME** | |
| | | | |
| **ADDRESS** | | **PHONE** | |
| | | Home | |
| | | Work | |
| | | | |
| **SOCIAL SECURITY NUMBER (optional)** | | | |
| **Patient/ Guarantor** | | **Spouse** | |

| **FAMILY STATUS**<br>**List all dependents that you support** | | |
|---|---|---|
| | | |
| **Name** | **Age** | **Relationship** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **EMPLOYMENT STATUS (optional)** | |
|---|---|
| | |
| **Patient/Guarantor Employer** | **Position** |
| | |
| **Contact Person** | **Telephone** |
| | |
| **Spouse Employer** | **Position** |
| | |
| **Contact Person** | **Telephone** |
| | |

| **INCOME** | | |
|---|---|---|
| | | |
| | **Patient/Guarantor** | **Spouse** |
| **1. Gross Wages & Salary/Year (before deductions)** | | |
| | | |
| **2. Self-Employment Income/Year** | | |
| | | |
| **3. Other Income:** | | |
| **3. Interest & Dividends** | | |
| **4. Real Estate Rentals & Leases** | | |
| **5. Social Security** | | |
| **6. Alimony** | | |
| **7. Child Support** | | |
| **8. Unemployment/Disability** | | |
| **9. Public Assistance** | | |

| | | |
|---|---|---|
| **10. All Other Sources (attach list)** | | |
| **Total Income (add lines 1 - 10 above)** | | |

| **UNUSUAL EXPENSES (optional)** | |
|---|---|
| | |
| **Please provide information on any unusual expenses such as medical bills, bankruptcy, court judgments or settlement payments (attach list as needed).** | |
| **Description** | **Amount** |
| | |
| | |
| | |

By signing below, I/we declare that all information provided is true and correct to the best of my/our knowledge. I/we authorize Pioneers Memorial Healthcare District to verify any information listed in this application. We expressly grant permission to contact my/our employer.

_____ _____

Signature of Patient/Guarantor Signature of Spouse

_____ _____

Date

# ATTACHMENT BB

## Pioneers Memorial Hospital

## Solicitud de Asistencia Financiera

## INSTRUCCIONES

1. Por favor complete todas las áreas en el formulario de solicitud adjunto. Si ninguna área aplica para usted, escriba N/A en el espacio proporcionado.
2. Tenga en cuanta que, según la elegibilidad, el pago con descuento ofrece menos asistencia financiera que la atención caritativa.
3. Adjunte una página adicional si necesita más espacio para responder alguna pregunta.
4. Deberá proporcionar comprobantes de ingresos cuando presente esta solicitud. Los siguientes documentos son aceptados como comprobante de ingresos:

   **Si presentó una declaración de impuestos federales (Income Tax), debe presentar una copia de:**

   a. Declaración de impuestos federales (Formulario 1040) del año más reciente. Debe incluir todos los anexos y archivos adjuntos tal como se enviaron al Servicio de Impuestos Internos (IRS);

   **Si no presentó una declaración de impuestos federales, proporcione lo siguiente:**

   a. Tres (3) talones de cheque de pago más recientes.

**Si no tiene ingresos o prueba de documentos de ingresos, usted puede proporcione una carta que explique cómo se mantiene a sí mismo/a su familia.**

5. Su solicitud no puede procesarse hasta que se proporcione toda la información requerida.
6. Es importante que complete y envíe la solicitud de asistencia financiera junto con todos los documentos adjuntos requeridos.
7. Debe firmar y fechar la solicitud. Si el paciente/garante y el cónyuge proporcionan información, ambos deben firmar la solicitud.
8. Si tiene preguntas, llame a sus asesores financieros al (760) 351-3322 y (760) 351-3323.
9. Envíe su solicitud completa a:

   Pioneers Memorial Hospital

   Patient Financial Services Department

   207 West Legion Road

   Brawley, CA 92227

# ATTACHMENT BB

**Pioneers Memorial Hospital**
**Solicitud de Asistencia Financiera**

| | | | |
|---|---|---|---|
| **PACIENTE/ AVAL NOMBRE** | | **CÓNYUGE NOMBRE** | |
| | | | |
| **DOMICILIO** | | **TELÉFONO** | |
| | | Casa | |
| | | Trabajo | |
| | | | |
| **NÚMERO DE SEGURO SOCIAL (opcional)** | | | |
| **Paciente/ Aval** | | **Cónyuge** | |

| **ESTADO FAMILIAR**<br>**Enliste todos los dependientes que usted mantiene** | | |
|---|---|---|
| | | |
| **Nombre** | **Edad** | **Relación** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **ESTADO DE EMPLEO (opcional)** | |
|---|---|
| | |
| **Empleador del Paciente/Aval** | **Puesto** |
| | |

# ATTACHMENT BB

| Persona de Contacto | Teléfono |
|---|---|
| | |
| **Empleador del cónyuge** | **Puesto** |
| | |
| **Persona de Contacto** | **Teléfono** |
| | |

| **INGRESOS** | | |
|---|---|---|
| | | |
| | **Paciente/Garante** | **Cónyuge** |
| **1. Sueldos Brutos y Salario/Año (antes de deducciones)** | | |
| | | |
| **2. Ingresos por trabajo por cuenta propia/Año** | | |
| | | |
| **3. Otros ingresos:** | | |
| **3. Intereses y dividendos** | | |
| **4. Alquileres y Arrendamientos de Bienes Raíces** | | |
| **5. Seguridad Social** | | |
| **6. Pensión alimenticia** | | |
| **7. Manutención de los hijos** | | |
| **8. Desempleo/Discapacidad** | | |
| **9. Asistencia Pública** | | |
| **10. Todas las demás fuentes (lista adjunta)** | | |
| **Ingreso total (sume las líneas 1-10)** | | |

| **GASTOS INUSUALES (opcional)** |
|---|
| |
| **Por favor proporcione información sobre cualquier gasto inusual, como facturas médicas, bancarrota, sentencias judiciales o pagos de liquidación** |

# ATTACHMENT BB

| **(adjunte la lista según sea necesario).** | |
|---|---|
| **Descripción** | **Monto** |
| | |
| | |
| | |

Al firmar la presente, declaro/declaramos que toda la información proporcionada es verdadera y correcta según mi/nuestro conocimiento. Yo/nosotros autorizamos a Pioneers Memorial Hospital a verificar cualquier información incluida en esta solicitud. Otorgamos permiso expreso para contactar a mi/nuestro empleador.

_____ _____

Firma del Paciente/Aval Firma del Cónyuge

_____ _____

Fecha

# ATTACHMENT C

## Sliding Scale Discount Payment Schedule

| Family Percentage of FPL | Discount from Medicare Allowable | Patient Out-of-Pocket Payment Percentage (of M/Care) |
|---|---|---|
| | | |
| 201 – 250% | 75% | 25% |
| 251 – 300% | 50% | 50% |
| 351 – 375% | 25% | 75% |
| 376 – 400% | 15% | 85% |