

HELP PAYING YOUR BILL

Policy

Cottage Health's mission is to provide superior health care for and improve the health of our communities through a commitment to our core values of excellence, integrity, and compassion. As part of this mission, Cottage Health is pleased to offer a Financial Assistance program to patients unable to pay for emergency or medically necessary care.

This Patient Financial Assistance Policy (Policy) establishes eligibility requirements and the application process for patient Financial Assistance, also known as charity or discount care, at Cottage Health hospitals. This Policy is consistent with Cottage Health's values of excellence, integrity, and compassion and is compliant with all State and Federal laws.

Cottage Health provides, without discrimination, care for emergency medical conditions within the meaning of the Emergency Medical Treatment and Labor Act ("EMTALA") to individuals, regardless of their ability to pay for services. This provision applies to care for emergency medical conditions, within the meaning of EMTALA; please refer to ED Policy "EMTALA – Transfer Policy."

Scope

Services Covered

This Policy covers technical facility fees for emergency and other medically necessary care provided at the following Cottage Health hospital and hospital-based facilities:

- Santa Barbara Cottage Hospital;
- Santa Ynez Valley Cottage Hospital;
- Goleta Valley Cottage Hospital; and
- Hospital-Based Clinics
- Cottage Rehabilitation Hospital

Services Not Covered

All Physician Fees Not Covered

This Policy does not cover fees from physicians (also known as "professional fees") for emergency and other medically necessary care provided by physicians and certain other medical providers who treat patients seen at Cottage Health facilities that are not billed by Cottage Health. Additionally, service provided at Cottage Urgent Care is not covered under this policy.

The physicians bill separately from Cottage Health, and this Policy does not apply to their charges. Payment for those professional fees billed by these health care providers is the patient's responsibility and does not qualify for a discount or charity care adjustment under this Policy. This Policy only applies to the technical facility fees for emergency and other medically necessary care provided at a Cottage Health hospital or in a hospital-based facility or clinic.

Although emergency physicians are not covered by this Policy, under California law, an emergency physician who provides emergency medical services in a hospital that provides emergency care is required by law to provide discounts to:

1. Uninsured patients who are at or below 400% of the federal poverty level
2. Patients with High Medical Costs (as defined below) who are at or below 400% of the federal poverty level.
 - a. This requirement does not impose additional obligations upon Cottage Health. Patients can seek additional information about this requirement directly from the emergency physician who provided care.

Additional Services Not Covered

Cosmetic Procedures that are medically necessary are covered under this policy. Cosmetic procedures that are not medically necessary are excluded from this policy.

Services offered at Cottage Residential Center ("CRC") and the Comprehensive Outpatient Program Experience ("COPE") are also excluded from this policy. Please refer to Policy 8560.74, "Financial Assistance for Non-Urgent Services" for details regarding assistance available to patients of the CRC and COPE programs.

Services provided by Pacific Diagnostic Laboratories in freestanding clinics off-campus are also excluded.

Additionally, any services provided in freestanding clinics that are not licensed as a service of the hospital are excluded. Services provided at a Cottage Urgent Care are excluded from this policy.

Definitions

Amounts Generally Billed, or "AGB": An amount calculated using the methodology described in this Policy that sets a limit on the amount Cottage Health may charge for emergency and medically necessary care provided by a Cottage Health hospital facility to a patient eligible for Financial Assistance based on the eligibility criteria outlined in this Policy. Under this Policy, AGB only applies to patients eligible for Financial Assistance discounts, because Cottage Health writes off 100% of the amount patients are personally

responsible for paying when they demonstrate a household income of equal to or less than 500% of the federal poverty level.

Charity Care: Also known as free care or help with hospital bills. Charity care refers to medical services provided to patients who are unable to pay for their care due to financial hardships, regardless of insured status.

Discounted Care: A reduction in the amount billed to a patient for medical services provided but are not free.

Extraordinary Collection Actions (ECAs): Actions that a hospital may take to collect a bill that are defined in IRS Code section 501(r)(6), including actions that require a legal or judicial process.

Patient's Family: Under California law, a Patient's Family means the following:

- (1) For persons 18 years 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.
- (2) For persons under 18 years of age or for a dependent child 18 to 20 years of age (inclusive): parents, 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).

Federal Poverty Level (FPL): A uniform measure of income that is adjusted for inflation, published annually by the United States Department of Health and Human Services, and used by Cottage Health to determine eligibility for Financial Assistance under this Policy.

Financial Assistance: Charity (free) or discounted care provided to individuals who cannot afford to pay all or a portion of their hospital medical bills. Eligibility for Financial Assistance is determined based on the criteria identified in this Policy.

Gross Charges: Cottage Health's full, established price for medical care that it consistently and uniformly charged to patients before applying any contractual allowances, discounts, or deductions.

Guarantor: Patient or other individual responsible for payment of the patient's care.

High Medical Costs: Under California law, a patient with High Medical Costs is an individual whose family income does not exceed 400% FPL who has (a) annual out-of-pocket costs incurred by the individual at Cottage Health that exceed the lesser of 10% of the patient's family income in the prior 12 months or 10% of the patient's current family income; or (b) annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

Household Income: The patient/responsible party's gross income, as well as the gross income of other adults listed as members of the patient/responsible party's household on the relevant tax return. Acceptable income source documents are listed under "Financial Assistance Application Process," below.

Medically Indigent: Guarantors whom Cottage Health has determined are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income (for example, due to catastrophic costs or conditions), even though they have income. Medical bills and liabilities considered in this determination include those from organizations outside of Cottage Health.

Medically Necessary Care: A medical service or treatment that is absolutely necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

Primary Language: A language used by the lesser of 1,000 people or 5% of the community served by a Cottage Health hospital facility based upon the most recent Community Health Needs Assessment performed by the hospital facility.

Recent Pay Stubs: Paystubs from within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

Recent Tax Returns: Tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed.

Financial Assistance Available

Eligibility Requirements

Eligibility for Financial Assistance is based on the following criteria:

Charity Care

- For 100% Financial Assistance, often referred to as "charity care," Cottage Health will consider household income and family size. Uninsured Patients and patients with High Medical Costs with a Household Income equal to or less than 500% of FPL are eligible for 100% Financial Assistance.
- This satisfies the requirement under California law that patients whose family income does not exceed 400% FPL and who (a) are uninsured, or (b) have High Medical Costs, shall be eligible for financial assistance and shall not pay more than what the hospital would expect to receive from providing services to a government payor; Cottage Health's provision of charity care to these patients satisfied this requirement because qualifying patients are eligible for a 100% write-off of the balance due.

- 100% financial assistance or discounted care is available for guarantors who demonstrate they are Medically Indigent. Cottage Health has sole discretion when determining a guarantor's status as being Medically Indigent.

Discounted Care

- Discounted care is available for patients with a Household Income up to 700% of the FPL, taking into consideration Number of Family Members (and not considering Monetary Assets). Discount percentages based on Household Income and Number of Family Members are consistent with annual FPL sliding scale guidelines and are attached and incorporated into this Policy as Attachment A, Patient Financial Assistance Calculation Form. Discounts are taken off of the patient's out-of-pocket financial responsibility. If the application of the AGB percentage leads to a lower patient financial responsibility than the discounts achieved through Attachment A, the AGB discount will apply.

Non-Reimbursed Charges

- Patients who are eligible for FPL-qualified programs such as Medi-Cal, Medicaid, and other government-sponsored low-income assistance programs, are deemed to be eligible for financial assistance. Therefore, such patients are eligible for financial assistance under this policy when the programs deny payment and then deem the charges billable to the patient. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Specifically included as eligible are charges related to the following:
 - o Denied services
 - o Non-covered services
 - o Treatment Authorization Request (TAR) denials
 - o Denials due to restricted coverage
 - o Medicaid claims (including out of state Medicaid claims) with "no payment"
 - o Any service provided to a Medicaid eligible patient with no coverage and no payment
 - o Share of cost for Medicaid members are eligible for financial assistance
 - o Patient has an active Medicaid plan or is eligible for Medicaid

Patients seeking out-of-network services

- Patients with out-of-network (non-contracted) third-party coverage who wish to obtain non-emergent hospital-based services at Cottage Health will not be eligible for financial assistance unless a Single Case Agreement is negotiated with the out-of-network provider in advance of service.

- o This provision does not apply to care for emergency medical conditions, within the meaning of EMTALA; please refer to ED policy “EMTALA – Transfer Policy.”
- o This provision does not apply to patients who have insurance through a payor that is out-of-network due to ongoing contractual negotiations.

Discovery of Patient Financial Assistance Eligibility During Collections

While Cottage Health strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. If a Financial Assistance determination creates a credit balance in favor of a patient, Cottage Health will reimburse payments to qualifying patients if it has been less than five years since the patient's last payment to the hospital, hospital assignee, or debt buyer. Any refund of a credit balance shall include interest on the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health and Safety Code section 127440, provided that hospitals are not required to refund a credit balance that, together with interest, is less than five dollars (\$5). Cottage Health collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Cottage Health will reverse the account out of bad debt and document the respective discount in charges as charity care.

Policy Updates for Access to Healthcare Crisis Situations

During a public emergency, Cottage Health may declare an Access to Healthcare Crisis and adjust its financial assistance policy to meet the needs of the community in crisis. These situations may include, but are not limited to, public health emergencies and natural disasters. If an Access to Healthcare Crisis is applicable, Cottage Health will attach an addendum to the policy. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy.

Non-Covered/Denied Charges for All Coverages

Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, and Santa Ynez Valley Cottage Hospital. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.

Presumptive Charity Care

Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates a financial hardship. The reason for presumptive eligibility will be reflected in the transaction code used to adjudicate the patient's claim. Additional patient notes may be

included. Examples of these exceptions where documentation requirements are waived include, but are not limited to:

- o An independent credit-based financial assessment tool indicates indigence
- o Is actively receiving benefits from government assistance programs, i.e.: CALFRESH, School Meals Program, SNAP, WIC, TANF
- o Determination of patient financial assistance eligibility by Vice President, Revenue Cycle

Financial Assistance is available to all patients who satisfy the eligibility requirements outlined in this Policy, after all private health insurance payments have been applied. Patients eligible for Financial Assistance may include patients who are eligible for Medi-Cal but whose eligibility dates do not cover the entirety of the care they receive. Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services who are eligible.

If a student applying for assistance is claimed as a dependent on the family tax return, then the entire family income must be considered in determining eligibility for Financial Assistance.

For deceased guarantors, refer to policy “8545.08 Deceased Patients” to determine any changes to the guarantor based upon legal transfer of assets and whether they are subject to Probate. If Cottage is not able to identify a surviving spouse or identifiable assets for deceased guarantors, or identify a new guarantor based upon a legal transfer of liabilities such as in the case of a patient who is a minor child, presumptive charity will be awarded, and the outstanding balance will be written-off as such. If a deceased patient has a surviving spouse, and the surviving spouse has elected to forgo formal Probate, the surviving spouse may apply for Financial Assistance, in which case the eligibility requirements outlined in this Policy are applicable.

Patients who are eligible for Financial Assistance under this Policy will not be charged more than the amount of payment the hospital would expect, in good faith, from either Medicare or Medi-Cal, whichever is greater.

Basis for Calculating Amounts Generally Billed (AGB)

Patients determined to be eligible for Financial Assistance will not be charged – meaning, such patients will not be personally responsible for paying – more than Amounts Generally Billed (AGB) to individuals who have insurance for emergency or other medically necessary care, after all deductions, discounts, and insurance reimbursements have been applied.

In accordance with applicable law, Cottage Health utilizes the “look-back method” for calculating AGB. Specifically, Cottage Health divides the sum of the amounts of all

Cottage Health claims for all medical care that has been allowed by Medicare fee-for-service and all private health insurers during a prior 12-month period by the sum of the Gross Charges for those claims. Claims used in the calculation depend on whether the claim was allowed by a health insurer during the 12-month period, not whether the care resulting in the claim was provided during that 12-month period.

When including allowed claims in calculating its AGB percentage(s), Cottage Health includes the full amount that has been allowed by the health insurer, including both the amount the insurer will pay or reimburse and the amount (if any) the patient (or the patient's guarantor) is personally responsible for paying in the form of co-payments, co-insurance, and deductibles, regardless of whether or when the full amount allowed is actually paid and disregarding any discounts applied to the patient's portion.

Cottage Health hospital facilities each utilize a different Medicare provider agreement, and each calculate their own AGB percentage for their facility based on claims and Gross Charges for all such hospital facilities. Such AGB percentage is available, in writing and free of charge, on Cottage Health's website at www.cottagehealth.org/FAP. Patients may also request a paper copy of Cottage Health's AGB, to be mailed without charge, by submitting a request by email to CottageBilling@sbch.org, by calling 805-687-6510, or by submitting a request in writing to one of the following:

- Cottage Health Business Office, 6550 Hollister Avenue, Goleta, CA 93117
- Santa Barbara Cottage Hospital, 400 W. Pueblo St. Santa Barbara, CA 93105
- Goleta Valley Cottage Hospital, 351 S. Patterson Ave., Goleta, CA 93111
- Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd., Solvang, CA 93463 7

Financial Assistance Application Process

Process

To be considered for Financial Assistance eligibility, an individual must submit a complete Financial Assistance Policy Application (FAP Application) and all required documentation that aligns with the date of service and not the application date.

An individual who submits for only discounted payments or charity care is required to submit copies of the following documentation:

- Recent pay stubs **or**
- Recent income tax returns or unemployment statement

Cottage will require updated documentation each January thereafter in order to continue to receive charity care, financial assistance, or discounted payments.

Patients may be denied Financial Assistance if they do not produce a complete FAP Application.

When a patient applies or has a pending application for another health care program at the same time the patient applies for Financial Assistance, neither application precludes eligibility from the other program. Patients are eligible to apply for Financial Assistance under this Policy at any point in time.

Information About Financial Assistance and Help with the Financial Assistance Application

The patient or any person involved in the care of the patient, including a family member or provider, can express financial concerns at any point during the patient's care. Inquiries regarding financial assistance should be directed to the Cottage Health Business Office.

Representatives are available to provide information about the FAP and to assist patients with completing the FAP Application, in person or by telephone, as follows:

Cottage Health Business Office
In Person: 6550 Hollister Avenue,
Goleta, CA 93117 Telephone: 805-879-8963
Hours: 8:00 a.m.–4:00 p.m., Monday–Friday

Disputing a Financial Assistance Determination

In the event of a dispute regarding a determination of Financial Assistance or review of an FAP Application, the affected individual may request a review by Cottage Health's Vice President of Revenue Cycle. This request for review may be emailed to CottageBilling@sbch.org or submitted by telephone at 805-879-8926.

Actions Taken in Event of Nonpayment

Notification Period

Cottage Health shall notify patients of the availability of Financial Assistance under this Policy and the process for patients to apply to receive such assistance by including notice on all patient billing statements. Cottage Health shall not engage in ECAs before making a reasonable effort, as required by state and federal law, to determine whether a patient is eligible for Financial Assistance under this Policy. For a period of at least 180 days following the date of the first post-discharge billing statement, which is referred to as the "Notification Period," Cottage Health will not engage in ECAs to collect amounts due.

At least 30 days before initiating ECAs, Cottage Health will:

1. Furnish written notice to the patient that provides information on the availability of Financial Assistance under this Policy, a copy of our Financial Assistance Application, the specific ECAs Cottage Health intends to take in the event of nonpayment including the name of the agency, and a deadline for the initiation of such ECAs, as well as the statement required pursuant to California law

regarding fair debt collection practices and Federal Trade Commission enforcement;

2. Provide a written plain language summary (Plain Language Summary) of this Policy; and
3. Make reasonable efforts to orally notify the patient about this Policy and how the patient can obtain assistance with the FAP Application before ECAs are initiated.

After conclusion of the Notification Period and satisfaction of the notice provisions outlined in this section, Cottage Health may initiate ECAs to collect amounts due.

If Cottage Health receives a complete FAP Application after any ECAs have been initiated, Cottage Health will suspend the ECAs and make a determination of the individual's eligibility for Financial Assistance.

If Cottage Health receives an incomplete FAP Application after any ECAs have been initiated, Cottage Health will suspend the ECAs and provide a reasonable opportunity for the patient to submit a complete FAP Application by notifying the patient of the requirements for completing the FAP Application and providing contact information for the Cottage Health Business Office.

Cottage Health's Vice President of Revenue Cycle or designee shall determine, on a case-by-case basis, whether Cottage Health has made reasonable efforts to determine whether a patient is eligible for Financial Assistance under this Policy and whether Cottage Health may initiate ECAs.

Charity Care Adjustments

Patients who do not submit a complete FAP Application, but who are projected, based on an initial financial screening, to have a Household Income of 500% FPL or less, may qualify for a charity care adjustment under this Policy. Such initial financial screening shall use information generally available to Cottage Health and shall be in Cottage Health's sole discretion. Cottage Health may use information obtained from sources other than the patient, including estimates of an individual's ability to pay based on public and proprietary information, information included in publicly available databases and information provided by third-party vendors who use information included in publicly available databases. Throughout the Notification Period, Cottage Health will provide all required notices regarding the availability of Financial Assistance and the opportunity to obtain assistance in completing the FAP Application, as well as a Plain Language Summary and compliant billing statements for any balance due to such individual. Prior to or at the conclusion of the Notification Period, even if the individual has not applied for Financial Assistance, Cottage Health may apply a 100% charity care adjustment to any balance due for patients with a financial screening of 500% FPL or lower.

Cottage Health does not intend to use a determination of eligibility for Financial Assistance utilizing this process as a mechanism to meet Cottage Health's reasonable efforts requirements. Rather, Cottage Health will determine eligibility for Financial Assistance under this Policy only by notifying patients of the Policy and processing FAP Applications. Cottage Health's use of any third-party information for purposes of informing Cottage Health's charity care adjustments does not constitute a presumptive determination of eligibility for Financial Assistance under this Policy.

Payment Plans

Patients may be eligible for an interest-free, extended payment plan, including payments of the discounted charge. Payment plans shall be offered and negotiated and take into consideration the patient's family income and essential living expenses. If the guarantor and Cottage Health cannot agree to the terms, the monthly payment will not exceed 10% of the guarantor's family income for a month, excluding deductions for essential living expenses.

Billing and Collections

Separate from initiating ECAs, as described in this Policy, Cottage Health may employ reasonable collection efforts to obtain payment from patients. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by Cottage Health or by any collection agency engaged by Cottage Health. General collection activities may include issuing patient statements, phone calls, text messages, emails, and ensuring that statements have been sent to the patient or guarantor.

Availability of Financial Assistance Information

Preadmission or Registration: During the preadmission or registration process (or as soon thereafter as practicable) Cottage Health will provide all patients with a paper copy of the Plain Language Summary of this Policy.

Billing Statements: Cottage Health's billing statements include a Plain Language Summary, including a telephone number for patients to call with questions about Financial Assistance and the website address where patients can obtain additional information. A summary of legal rights is also included in the billing statement.

Public Posting: All Cottage Health hospital facilities conspicuously post signs to notify and inform patients of the Policy in public locations, including, but not limited to, admission areas, waiting rooms, billing offices, emergency rooms, and hospital outpatient service settings. These public notices include information about the patient's right to request an estimate of financial responsibility for services.

Paper Copies: Paper copies of this Policy, the Plain Language Summary, and the FAP Application are available upon request and without charge in the admission areas and emergency rooms at the Cottage Health hospital facilities listed below.

Patients may also request paper copies of these materials to be mailed, without charge, by submitting a request by email to CottageBilling@sbch.org, by calling 805-879-8963, or by submitting a request in writing at one of the following:

- Cottage Health Business Office, 6550 Hollister Avenue, Goleta, CA 93117
- Santa Barbara Cottage Hospital, 400 W. Pueblo St. Santa Barbara, CA 93105
- Goleta Valley Cottage Hospital, 351 S. Patterson Ave., Goleta, CA 93111
- Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd., Solvang, CA 93463

Website: Copies of this Policy, the Plain Language Summary, and the FAP Application are available on the Cottage Health website at www.cottagehealth.org/FAP.

MyChart: Patients who have activated a Cottage Health MyChart account can complete a financial assistance through their MyChart account.

Community Awareness: Cottage Health will work with affiliated organizations, physicians, community clinics, and other health care providers to notify members of the community about the availability of Financial Assistance under this Policy.

This Policy, Plain Language Summaries, and FAP Application forms are available on Cottage Health's website at www.cottagehealth.org/FAP and in hard copy form, upon request and without charge, in the primary language(s) of each Cottage Health Hospital Facility's Service Area. In addition, all notices and communications provided pursuant to this Policy will be available in the primary language(s) of each Cottage Health Hospital Facility's Service Area and in a manner consistent with all applicable Federal and State law. For the purposes of this Policy, a Primary Language of Hospital's Service Area is a language used by the lesser of 1,000 people or 5% of the community served by the hospital facility based upon the most recent Community Health Needs Assessment performed by the hospital.

Review of Policy

This Policy will be reviewed periodically by the Cottage Health Finance Committee of the Board of Directors and formal approval of any changes will be approved by the Cottage Health Board of Directors.

Policy Revision Date

September 28, 2018. September 27, 2019. June 19, 2020. November 4, 2020. April 2022,
May 2023, December 2024, June 2026

Attachment A
Patient Financial Assistance Calculation Form 2026

DISCOUNT TABLES 2026

Family Income Based Upon Number of Family Members

Federal Poverty Level (FPL)%	Discount %*	1 Person Family	2 Person Family	3 Person Family	4 Person Family	5 Person Family	6 Person Family	7 Person Family	8 Person Family
500%	100%	\$79,800	\$108,200	\$36,600	\$165,000	\$193,400	\$221,800	\$250,200	\$278,600
510%	95%	\$81,396	\$110,364	\$139,332	\$168,300	\$197,268	\$226,236	\$255,204	\$284,172
520%	90%	\$82,992	\$112,528	\$42,064	\$171,600	\$201,136	\$230,672	\$260,208	\$289,744
530%	85%	\$84,588	\$114,692	\$144,796	\$174,900	\$205,004	\$235,108	\$265,212	\$295,316
540%	80%	\$86,184	\$116,856	\$147,528	\$178,200	\$208,872	\$239,544	\$270,216	\$300,888
550%	75%	\$87,780	\$119,020	\$150,260	\$181,500	\$212,740	\$243,980	\$275,220	\$306,460
560%	70%	\$89,376	\$121,184	\$152,992	\$184,800	\$216,608	\$248,416	\$280,224	\$312,032
570%	65%	\$90,972	\$123,348	\$155,724	\$188,100	\$220,476	\$252,852	\$285,228	\$317,604
580%	60%	\$92,568	\$125,512	\$158,456	\$191,400	\$224,344	\$257,288	\$290,232	\$323,176
590%	55%	\$94,164	\$127,676	\$161,188	\$194,700	\$228,212	\$261,724	\$295,236	\$328,748
600%	50%	\$95,760	\$129,840	\$163,920	\$198,000	\$232,080	\$266,160	\$300,240	\$334,320
610%	45%	\$97,356	\$132,004	\$166,652	\$201,300	\$235,948	\$270,596	\$305,244	\$339,892
620%	40%	\$98,952	\$134,168	\$169,384	\$204,600	\$239,816	\$275,032	\$310,248	\$345,464
630%	35%	\$100,548	\$136,332	\$172,116	\$207,900	\$243,684	\$279,468	\$315,252	\$351,036
640%	30%	\$102,144	\$138,496	\$74,848	\$211,200	\$247,552	\$283,904	\$320,256	\$356,608
650%	25%	\$103,740	\$140,660	\$77,580	\$214,500	\$251,420	\$288,340	\$325,260	\$362,180
660%	20%	\$105,336	\$142,824	\$180,312	\$217,800	\$255,288	\$292,776	\$330,264	\$367,752
670%	15%	\$106,932	\$144,988	\$183,044	\$221,100	\$259,156	\$297,212	\$335,268	\$373,324
680%	10%	\$108,528	\$147,152	\$185,776	\$224,400	\$263,024	\$301,648	\$340,272	\$378,896
690%	5%	\$110,124	\$149,316	\$188,508	\$227,700	\$266,892	\$306,084	\$345,276	\$384,468
700%	0%	\$111,720	\$151,480	\$191,240	\$231,000	\$270,760	\$310,520	\$350,280	\$390,040

* Discounts are applied towards patient out-of-pocket financial responsibility for Cottage Health bill. Annual family income levels up to the stated dollar value are eligible for the corresponding discount.

Effective 01/01/2026

FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS

As part of its mission, Cottage Health is pleased to offer a financial assistance program to patients unable to pay for emergency or medically necessary care.

Patients are eligible for financial assistance if their family income does not exceed 500 percent of the federal poverty level. Patients whose family income is higher than 500 percent of the federal poverty level may be eligible for a discount.

When a completed financial assistance application is received, the patient/guarantor will receive confirmation via phone or email and all accounts listed will be placed on a temporary hold from the billing cycle, pending a final decision. The application will be reviewed and a final determination letter will be mailed within 14 business days. If additional documentation is needed, the patient/ guarantor will be notified. **Cottage Health will provide the maximum amount of benefit to each patient, whether designated to 'charity care' or 'discount payment'. Those that qualify for discount payments may receive less than what is available under the charity care program.**

Confidentiality:

We are committed to maintaining the confidentiality of requests, information and funding. The information requested below is for the sole purpose of financial assistance. We **do not** share information with any third parties, federal or local government agencies.

Instructions:

To apply for financial assistance, please complete the application and attach copies of the following documentation for the patient, guarantor (if different from the patient):

- Driver's license or photo ID (for adult patients)
- Either of the following: recent Income Tax returns or recent Pay Stubs

For purposes of determining eligibility for financial assistance, recent tax returns are tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed, and recent paystubs are paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

Family is Defined as:

- **For patients 18 years of age and older** - self, 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 patients under 18 years of age or for a dependent child 18 to 20 years of age (inclusive)** - self, parent(s), caretaker relatives, and other children of the parent or caretaker relative 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).

Financial Assistance Program and Self-Payment Note:

California law requires that Cottage Health provide the following information to all patients who receive services at one of the Cottage Health facilities:

1. You must inform us if you have any type of health insurance coverage. This includes coverage from a health insurer, healthcare service plan, Medicare, Medi-Cal/Medicaid, California Children's Services (CCS), county programs, Covered California plan, Healthy Families Program, or other state-funded health insurance coverage program.
2. If you lack or have inadequate insurance, or meet certain low and moderate income requirements, you may qualify for a discount or other financial assistance. Because Federal and State laws require all hospitals to make reasonable efforts to collect payment for services, we will use our standard billing process unless you inform us of your special circumstances. Unpaid bills may go to a collection agency if you do not communicate your need for financial assistance. We want to work with you, but we need you to respond with information about your circumstance in order to help. The Cottage Health Financial Assistance Program provides assistance based on income and/or special circumstances. Please contact our Financial Assistance team at 805-879-8963, between the hours of 8 a.m.– 4 p.m. Pacific Time, Monday–Friday, or by walk-in at 6550 Hollister Avenue, Goleta. You may also email CottageBilling@sbch.org with questions or information.
3. State and Federal law requires debt collectors to treat you fairly and prohibits debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8 a.m. or after 9 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For

more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (877-382-4357) or online at ftc.gov.

FINANCIAL ASSISTANCE APPLICATION [CONFIDENTIAL]

GUARANTOR INFORMATION *(person responsible for payment):*

Guarantor Name <i>(first, middle, last):</i>		Guarantor Phone Number:					
Social Security Number:	Date of Birth <i>(MM/DD/YYYY):</i>	Marital Status:					
Address:		City, State, Zip:					
Phone:		Email:					
Family Size (as defined in instructions):	Account Number(s) for which you are applying for financial assistance:						
Guarantor's Employer:*	Employment Status:						
	El time	Full time	El time	Part time	El employed	Self employed	El Unemployed
Employer Address:		City, State, Zip:					
Supervisor's Name:		Supervisor's Phone:					
* If multiple employers, please attach an additional sheet.							

EMPLOYMENT FOR OTHER FAMILY MEMBERS:

Family Member Name:*	Employment Status:						
	El time	Full time	El time	Part time	El employed	Self employed	El Unemployed
Family Member's Employer:	Employer Address:						
Supervisor's Name:	Supervisor's Phone:						
* If multiple family members and/or employers, please attach an additional sheet.							

DEPENDENTS:*

Full Name:	Relationship to Guarantor:	Date of Birth (MM/DD/YYYY):
Full Name:	Relationship to Guarantor:	Date of Birth (MM/DD/YYYY):
Full Name:	Relationship to Guarantor:	Date of Birth (MM/DD/YYYY):
Full Name:	Relationship to Guarantor:	Date of Birth (MM/DD/YYYY):

Full Name:	Relationship to Guarantor:	Date of Birth (MM/DD/YYYY):
------------	----------------------------	-----------------------------

**If more than four dependents, attach additional sheet.*

OTHER HEALTH COVERAGE ASSISTANCE:

You may be eligible for Medicare, Medi-Cal/Medicaid, CCS, Healthy Families Program, insurance through Covered California, or other state- or county-funded health coverage. We have enrollment counselors available to help assist you with applications for coverage. For more information, please call 805-569-8963.

If you would like to provide more information for determining eligibility, please attach to this application.

CERTIFICATION:

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to determine my ability to pay for services provided by Cottage Health, and I give permission to Cottage Health to share the information as necessary for verification and to consider my financial assistance request. I am aware that federal law provides for fines for any false statements or use of false documents in completing this application.

Signature of Guarantor:

Date:

SUBMISSION INFORMATION:

PLEASE SUBMIT THIS APPLICATION BY UPLOADING TO YOUR MYCHART ACCOUNT ONLINE OR MAIL TO: Cottage Health | Financial Assistance Program | PO Box 689 | Santa Barbara, CA 93102

YOU MAY ALSO SUBMIT THIS APPLICATION IN PERSON AT ANY OF THE FOLLOWING LOCATIONS:

Cottage Health Business Office | 6550 Hollister Ave. | Goleta, CA 93117 | Hours: 8 a.m.–4 p.m., Monday–Friday

Santa Barbara Cottage Hospital | 400 W. Pueblo St. | Santa Barbara, CA 93105

Goleta Valley Cottage Hospital | 351 S. Patterson Ave. | Goleta, CA 93111

Santa Ynez Valley Cottage Hospital | 2050 Viborg Rd. | Solvang, CA 93463

For additional information, please contact the Cottage Health Financial Assistance team at 805-879-8963.



BAD DEBT POLICY

Policy Details:

Applies to: Cottage Health, SBCH, GVCH, and SYVCH

Policy Number: 85450.04

Original Policy Effective Date: 11/1989

Last Review Date: June 2026

Owner Title: Vice President, Revenue Cycle

Owner Approval Date: June 2026

VP Approval: Vice President, Revenue Cycle

VP Approval Date: June 2026

Departments Affected: Revenue Cycle

Goal:

To ensure that bad debt accounts are handled consistently and appropriately. This policy will establish requirements and process for outstanding balances at the three Cottage Health hospitals in a manner that is consistent with the values of excellence, integrity and compassion.

Cottage Health and their designated agencies follow all state and federal regulations and guidelines in the collection of debt and adhere to the standards outlined in the Fair Debt Collection Practices Act (FDCPA), as well as IRS Regulations at 26 C.F.R. 1.501(r) and California's Fair Pricing Policies at Health and Safety Code section 127400. When vendor agencies act as an agent for Cottage Health, such vendor agencies shall act in accordance with Cottage Health policies, procedures and guidelines, as well as all applicable law.

Policy:

Following the adjudication of a claim and receipt of insurance payment, accounts are moved to the "Self-Pay" status and the guarantor of the account is billed. For patients who have no insurance, the billing cycle begins with this step. As part of the routine billing cycle, guarantors are offered the option of a reasonable payment plan based upon family income. Please refer to the following policies:

- 8545.01: Financial Assistance Policy
- 8545.02: Establishing an Acceptable Payment Plan
- 8545.03: Self Pay Guarantors Discount Parameters

Once the guarantor becomes the responsible party for remaining charges, a series of six statements are sent over a 180-day period, with a new statement every 30-days. The statements include escalating warnings to inform the guarantor of their delinquent status,

and provide all notice required by applicable law as to Cottage Health's intended collection activities. A "Good-bye Letter" is sent to the guarantor during the sixth billing cycle to inform them that their unpaid accounts will be sent to collection vendor. After 180-days following the later of either the guarantor's first post-discharge billing statement, or the date on which the guarantor becomes the responsible party for remaining charges, or 30-days after the sixth statement is mailed (if later than the applicable 180-day period), accounts will then automatically transfer to the external collection agency if no payment has been made. Transfers to the collection agency occur daily. Accounts will not be transferred to collection if they fall within one of the below categories:

- Guarantor is on a payment plan
- Approved charity (of any type)
- Claims when undergoing quality review
- Claims marked for bankruptcy
- Disputed balances undergoing review
- Claims undergoing any other revenue cycle review

To the extent any action taken by Cottage Health, or its vendor agencies would be considered an "Extraordinary Collection Action" under 26 C.F.R. 1.501(r)-1, Cottage Health and its vendor agencies will comply with all notice requirements outlined at 26 C.F.R. 1.501(r)-6.

In no event shall a hospital furnish any information related to a medical debt to a consumer credit reporting agency. Further, all written contracts with patients creating a medical debt shall include the following term:

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates this section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

If a guarantor is attempting to qualify for eligibility under the Cottage Health Financial Assistance Policy or discount payment policy (collectively Policy 8545.01) and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, Cottage Health will not send the unpaid bill to any collection agency (refer to Policy 8545.02, Establishing a Payment Plan). In dealing with guarantors eligible under the Cottage Health Financial Assistance Policy (Policy 8545.01), Cottage Health will not use wage garnishments or liens.

In determining the amount of a debt Cottage Health can seek to recover from guarantors who are eligible under the Cottage Health Financial Assistance Policy (Policy 8545.01), Cottage Health will comply with all requirements and procedures outlined in the Financial Assistance Policy.

A collection agency or other assignee that is not a subsidiary or affiliate of Cottage Health will not, in dealing with any guarantor under the Cottage Health Financial Assistance Policy (Policy 8545.01), use as a means of collecting unpaid accounts, any of the following:

- (A) A wage garnishment
- (B) Lien

Collection agencies may seek to recover any payments made directly to the patient/guarantor from third-party liability settlements, tortfeasors, or other legally responsible parties.

Notwithstanding anything contained in this Policy, Cottage Health will comply with the billing and collection procedures and requirements outlined in the Financial Assistance Policy (Policy 8545.01).

Disputing a Financial Assistance Determination

In the event of a dispute, the affected individual may request a review by Cottage Health's Vice President of Revenue Cycle. This request for review may be emailed to CottageBilling@sbch.org or submitted by telephone at (805) 879-8926.

PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.			
Key Words:			
Related Policies:			
Previous Review Dates:	12/90, 12/93, 03/97, 08/00, 03/01, 03/03, 12/08	Previous Revision Dates:	03/99, 08/00, 02/05, 02/06, 01/07, 12/08, 12/11, 11/17, 11/19
Superseded:			