



SENECA HEALTHCARE DISTRICT POLICY & PROCEDURE

DEPARTMENT: FINANCE
POLICY TITLE: FINANCIAL ASSISTANCE
POLICY/REFERENCE #: FIN-006

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COMPLIANCE REQUIREMENT: CA Health and Safety Code
§127400 through §127446

EFFECTIVE DATE:
8/5/2026

POLICY

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

PROCEDURE

1. PURPOSE

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

2. RESPONSIBILITIES

SHD Patient Access and Finance Departments are responsible for offering financial assistance to all eligible SHD patients. SHD Finance staff are responsible for obtaining the necessary information for determining patient eligibility and applying any corresponding discount to the patient's financial obligation to SHD.

3. POLICY FOR FINANCIAL ASSISTANCE

a. POLICY

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

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

b. DEFINITIONS

- i. Medically Necessary: Health care services or products that a prudent physician would provide to a patient to prevent, diagnose, or treat an illness, injury, or disease, or any symptoms thereof, that are necessary and are:
 - 1. Provided in accordance with generally accepted standards of medical practice
 - 2. Clinically appropriate with regard to type, frequency, extent, location and duration,
 - 3. Not primarily provided for the convenience of the patient, physician or other provider of the health care,
 - 4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
 - 5. The most clinically appropriate level of health care that may be safely provided to the insured.
- ii. Emergency Care: Immediate Care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
- iii. Uninsured: Patients with no insurance or third-party assistance to help resolve their financial responsibility to healthcare providers.
- iv. Under-insured: Patients having some insurance coverage but not enough, or when a patient is insured yet unable to afford the out-of-pocket responsibilities not covered by patient insurer.
- v. Presumptive Eligibility: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.
- vi. Financial Assistance Committee: A multi-disciplinary team formed internally to review all financial assistance applications for approval and denial determinations in accordance with this policy.
- vii. Catastrophic Financial Assistance: Financial assistance available to patients with a federal poverty level, greater than 400% and whose annual out-of-pocket costs are greater than 10% of the patients current family income or family income in the prior 12

months. Eligible patients will be considered for a catastrophic discount that will cap their out-of-pocket expense at a 25% threshold of annual gross income. Should the patient default on payment arrangements for the discounted balance, the catastrophic discount shall be added back to the account with the adjusted balance referred to a collection service.

c. ELIGIBLE SERVICES

- i. Emergency medical services, general acute care hospital services and rural health clinic services.

d. FINANCIAL ASSISTANCE CRITERIA

- i. All homeless and/or uninsured patients are referred to SHD's Revenue Cycle Coordinator contracted Billing Office for assistance with acquiring third party coverage or applying for Financial Assistance.
- ii. Eligibility
 - 1. Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination.
 - 2. Gross income should fall within established standard for determination of the FPL, considering family size, geographic area and other pertinent factors.
 - 3. 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.
 - 4. If a dependent child is over the age of 18 and does not appear on a parent or caretaker's most recent tax return, the dependent child must provide a copy of their own most recent tax return.
 - 5. Patients whose family income is at or below 150% of the FPL are eligible to receive 100% discount (charity care).
 - 6. Patients who do not qualify for free care, and whose family income is more than 150% but at or below 400% of the FPL are eligible to receive reduced rates.. Not to exceed Medicare or Medi-Cal reimbursement rates, whichever is greater.
 - 7. Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
 - 8. Financial Assistance status will be determined by the Chief Financial Officer (CFO) and Revenue Cycle Coordinator, after the time of discharge and

after all required documentation is submitted by the patient or responsible party.

9. Once the account is settled, the information used for determination will be kept on file by SHD for at least seven (7) years.
10. Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to SHD may request a payment plan from SHD's Revenue Cycle Coordinator or contracted Billing Office.
11. Patients who are a victim of a crime could be eligible for State of California funding from the Victim of Crime (VOC) program. Patients can apply at the District Attorney's office at the courthouse in Quincy. The patient will not qualify if:
 - a. There is insurance involved;
 - b. He/she initiated the crime;
 - c. He/she expires.

iii. Patients with Insurance

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

iv. Hospital Presumptive Eligibility (HPE)

1. An admissions representative will assist uninsured patients to apply for Hospital Presumptive Eligibility.

e. SPECIFIC PROCEDURE:

i. Identification

1. Candidates for Financial Assistance can be identified at any point along the patient revenue cycle process. Every effort shall be made to identify eligibility during the service period.
2. Initial referrals may be directed to the Revenue Cycle Coordinator, the Finance Department, or the contracted Billing Office.
3. The patient/guarantor is instructed regarding the application process and is provided with SHD's Financial Assistance Application to complete.
4. Notes related to patient conversations/encounters and application information is documented in the appropriate system by SHD staff.

ii. Pending Applications

1. The application for Financial Assistance and all supporting documentation completed by the patient are thoroughly researched and reviewed.
 2. A review of insurance, lack thereof, and identification of any other potential payer source is conducted.
 3. The Financial Assessment Worksheet will be completed by a SHD representative in the Finance Department.
 4. The Revenue Cycle Coordinator will follow up to obtain any additional information needed by phone or by sending letters requesting documentation. If, after three (3) documented contacts have been attempted and the 150th day from application is exceeded without receipt of the requested information, the application is documented as denied in the Electronic Health Record system, closed, and the account released from hold status to resume processing as a Self-Pay receivable per protocol.
 5. Financial Assistance applications are reviewed by the Revenue Cycle Coordinator or appropriate SHD personnel per the approved Expected Payment Limit (Attachment A).
 6. Authorized employees must sign their approval or denial and reason for determination on the application. Authorized employees must assure that reasonable efforts have been made to assure that alternative resources are not available to cover the cost of services.
 7. The file will then be returned to the Revenue Cycle Coordinator to process any authorized write-offs and send the Eligibility Determination Notice to the patient.
 8. The patient financial record with eligibility determination will be archived for no less than 7 years.
- iii. Denied Applications
1. An Eligibility Determination Notice is mailed to the address submitted on the application.
 2. A request for appeal of a final determination must be made in writing to the SHD Chief Financial Officer within 30 days of the final determination. An independent review of the patient or guarantor's financial information will be performed and the patient/guarantor will be notified of the review outcome within 30 days.
 3. The patient's financial class reverts to Self-Pay and the account is processed as a Self-Pay receivable per protocol. Patients may request a payment plan from the Revenue Cycle Coordinator or contracted Billing Office.

4. ENFORCEMENT

Violation of this policy may result in disciplinary action, up to and including termination as outlined in SHD's Compliance Policy CMPL-005.

REFERENCE

Title 22 of the California Code of Regulations sections 96051 to 96051.37

AB 1020, AB 2297

Health & Safety Code § 127400 et seq.

Attachment A: Expected Payment Limit (*1 page*)

Related to this policy

<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

Financial Assistance Application

Financial Assessment Worksheet

Eligibility Determination Notice

Attachment A: Expected Payment Limit

Financial Assistance Program Discount based on Federal Poverty Guidelines

FPL	Discount %	Discount Type
0-150%	100%	Charity Care
151-250%	75%	Sliding Fee
251-350%	50%	Sliding Fee
351-400%	25%	Sliding Fee

	Estimated or Actual Amount
Revenue Cycle Coordinator	Up to and including \$500
Chief Financial Officer	Above \$500