Scripps

Policy: Financial Assistance, Billing and Collections (Including Charity and Discounted Care) (FAP)

Effective: 07/28/26 **Identifier: S-FW-LD-5421**

Acute Care:	**ENC ☒ GR ☒ LJ ☒ MER ☒ Ambulatory ☒ SHAS ☒**

PURPOSE:

To outline a fair, consistent, and non-discriminatory process for patients of Scripps Health ("Scripps") for care delivered at Scripps' Hospitals (defined herein) and Scripps Medical Foundation who require financial assistance with emergency and medically necessary care. To establish options and procedures for financial assistance, including no cost and discounted care, to eligible individuals who are unable to pay for all, or part of the medical services received. Scripps provides financial assistance in compliance with all state and federal laws and regulations.

I. SCOPE & COVERAGE

A. The scope of this policy and the financial assistance programs herein constitutes the official Financial Assistance Policy ("FAP") for each hospital owned by Scripps Health, which include Scripps Memorial Hospital La Jolla, Scripps Memorial Hospital Encinitas, Scripps Green Hospital, and Scripps Mercy Hospital's two locations in Hillcrest and Chula Vista. Each hospital may be referred to as a "Hospital" and, collectively, the "Hospitals."

B. A list of providers at the Hospitals who are covered by Scripps FAP is available on *scripps.org/FAP*.

II. POLICY

A. The Scripps FAP is intended to help patients who are unable to afford the cost of medically necessary care. Financial assistance is not a substitute for health insurance, Medicare, or other third-party coverage. Scripps will seek payment from available insurers and other payors before determining a patient's eligibility for financial assistance.

B. Emergency Medical Conditions

1. Scripps provides emergency medical care without discrimination and regardless of a patient's ability to pay, eligibility for financial assistance under this policy, or eligibility for government assistance programs
2. Scripps will make reasonable efforts to help patients meet their financial obligations for emergency and medically necessary services. Medically necessary services include care for conditions that, if left untreated, could adversely affect an individual's health, as well as non-elective services provided in response to life-threatening circumstances in a non-emergency department setting.

C. Eligibility for charity care or discounted care will be determined based on financial need in accordance with this policy. Financial assistance may be available to uninsured or underinsured patients who are unable to pay for all or part of their care, including:

1. Patients without health insurance.
2. Patients who are ineligible for third-party coverage or assistance programs.
3. Patients whose third-party coverage does not fully cover their medical expenses.

4. Patients with high medical expenses and family income at or below 400 percent of the Federal Poverty Level ("FPL").

D. All medically necessary services provided by the hospital are eligible for consideration under the Discount Payment Program. Services provided within any of the Hospitals are presumed medically necessary unless the treating Hospital obtains a valid attestation from the referring or supervising provider that the services were not medically necessary. Such an attestation must be obtained before eligibility may be denied on that basis.

Patients may apply for financial assistance for services that are not medically necessary. Requests for assistance for non-medically necessary services may be approved on a case-by-case basis under the discretionary financial assistance policy.

E. **Non-Discrimination.** Financial assistance determinations are based solely on financial need. Scripps does not consider age, sex, gender identity or expression, marital status, race, color, ethnicity, national origin, religion, disability, sexual orientation, immigration status, veteran or military status, or any other characteristic protected by federal, state, or local law.

F. Scripps will maintain an audit trail of its commitment and efforts to provide financial assistance.

G. Definitions of terms used in this policy are provided in **Attachment A**: Patient Financial Services Glossary of Terms.

III. PROCEDURES

A. Physician Services

1. Physicians bill their services separately as independent contractors.
2. Emergency physicians are required by law to provide discounts to uninsured patients or patients with high medical expenses who earn at or below 400 percent of the federal poverty level.

B. Patient Communication and Community Outreach

1. <u>Making Patients Aware of Financial Assistance</u>
   a. Scripps will make reasonable efforts to inform patients about the availability of financial assistance and to identify patients who may qualify for assistance.
   b. Posters with information about financial assistance and care are displayed in registration areas in each Hospital; their emergency departments (Scripps Green Hospital does not have an emergency department), outpatient settings, and main admission areas.
2. <u>Financial Assistance Documents</u>

   The following documents are available to all patients:

   a. Financial Assistance, Billing and Collections (Including Charity and Discounted Care) (FAP)
   b. Patient Account Management, Billing and Collections policy.
   c. Scripps Financial Assistance Notice and Plain Language Summary ("PLS"). A copy of the PLS is offered to patients at registration. The PLS is incorporated

into the patient's discharge summary and a copy is included with all billing statements. Upon request, a copy will be mailed to the patient within 72 hours.

d. Financial Assistance Application and instructions.

3. Access to Documents

Documents listed above are available free of charge:

a. Paper copies are available in each emergency department and main registration areas in each Hospital.

b. Patients may request a copy be sent to them electronically.

c. Electronic copies are available on the scripps.org website in English and in the primary languages of the limited English proficiency ("LEP") patient populations served by Scripps.

4. Community Outreach

Scripps works with the California Hospital Association to inform those who are likely to need financial help.

a. Scripps provides the Financial Assistance Plain Language Summary to local consumer assistance organizations and agencies serving individuals who may need financial assistance.

b. Scripps provides the Financial Assistance Policy and related information to the California Department of Health Care Access and Information ("HCAI") as required by law.

C. **Financial Screening and Program Eligibility**

1. All patients are screened for insurance coverage and eligibility for assistance programs, including financial assistance.

2. Scripps will make reasonable efforts to determine whether private or public insurance may cover all or part of a patient's medical expenses.

3. Uninsured patients will receive a good faith estimate of expected charges and information about available financial assistance and application.

4. Scripps will assist patients in determining eligibility for Medi-Cal, County Medical Services ("CMS"), Covered California, and other available third-party coverage programs.

5. Scripps will conduct presumptive screening before establishing payment plans or referring accounts for collection activity to identify patients who may qualify for financial assistance.

D. **Financial Assistance Application Process**

1. Applying for Financial Assistance

a. Patients or their guarantor may apply for charity care or discounted care by completing a Financial Assistance Application.

b. Scripps uses one application for both charity care and discounted care programs. Patients may apply on their own behalf or authorize a

representative, such as a nonprofit organization or legal aid representative, to apply for them. Representatives must provide documentation showing the patient's authorization, such as a signed HIPAA authorization or authorized representative form. If a patient is unable to complete a written application, the patient may provide a signed statement or verbal attestation to that effect. With the patient's permission, Scripps staff may assist with or complete the application.

c. Patients may request assistance with the application process by contacting a Scripps financial counselor at 1-877-727-SCRIPPS or by visiting the admitting or registration department at a Hospital.

2. Patient Responsibilities

a. Patients and their representatives are expected to cooperate in the application process and provide complete and accurate information needed to evaluate eligibility so the hospital may identify other sources that could help pay for healthcare services.

b. Patients may be asked to pay what they can based on ability to pay.

c. Patients applying for charity care may be required to apply for available public or private health coverage and cooperate with eligibility determinations for other coverage programs.

d. Patients applying for discounted care will not be required to apply for Medicare, Medi-Cal, or other coverage before being screened for or receiving a discount.

e. Scripps may require participation in a Medi-Cal eligibility screening and may encourage patients to explore coverage options for future health care needs. Such coverage is not a condition of receiving discounted care.

f. Patients are encouraged to submit qualifying information within 30 days whenever possible.

3. Required Documentation

a. To determine financial need, patients must provide either:

- A recent pay stub; or
- A recent income tax return.

b. Recent income tax returns are returns reflecting family income for the year in which the patient was first billed, or for the twelve months preceding the first bill.

c. Recent pay stubs must be dated within six months before or after the date of first billing. For services not yet provided, pay stubs must be dated within six months of the application date.

d. If a patient cannot provide a pay stub or tax return, Scripps may accept alternative forms of documentation, including:

- Employer statements

- Documentation of approval or denial of government assistance programs
- Written declarations
- Verbal statement

e. Only pay stubs and tax returns may be required as proof of income. Submission of other documentation is voluntary.

4. Review of Eligibility

a. Scripps collects only the information necessary to determine eligibility for financial assistance and available government assistance programs.

b. A financial counselor may review information including:

- Financial Assistance Application
- Credit bureau information, including the absence of credit history
- Bank statements showing payroll deposits
- Pay stubs
- Tax returns
- Written declarations
- Verbal attestations
- Reports from presumptive eligibility or public assistance screening tools
- Other documentation supporting financial need

c. A financial counselor will review applications for completeness and accuracy and will provide patients with an opportunity to submit missing or clarifying information before a determination is made. Scripps may verify information provided by the patient or obtained from other sources when necessary to determine eligibility.

d. Scripps will not deny financial assistance solely because a patient does not provide optional documentation. Financial assistance may be approved based on other available evidence or the patient's attestation. Information collected for financial assistance determinations will not be used for collection activities unless obtained independently outside the financial assistance review process.

e. When determining eligibility for charity care or discounted care:

i. Scripps limits its consideration of assets to health savings accounts held by the patient or the patient's family.

ii. Liquid assets (those which can readily be converted to cash) including a home, vehicle, savings, or personal property, are ***not*** considered. Scripps may consider liquid assets *only for the purpose* of waiving or reducing Medicare or Medi-Cal cost-sharing obligations or to comply with Medicare reimbursement and bad debt requirements.

f. Payments made by individuals who are not legally responsible for a patient's medical bills are not considered when determining eligibility for financial assistance. Scripps follows all applicable California laws governing billing, collections, and financial assistance.

E. **Financial Assistance Determination**

1. Eligibility Criteria

   A patient may qualify for charity care or discounted care when at least one of the following conditions apply:

   a. The patient's responsibility for payment is not covered or reimbursed by Medicare, Medi-Cal, or another third-party payer.

   b. The patient's documented annual out-of-pocket medical expenses during the preceding 12 months exceed 10 percent of family income.

   c. The patient has high medical costs, as defined by applicable state and federal law.

   d. The patient's family income is at or below 400 percent of the FPL.

2. Financial Assistance Levels

   The **Patient Financial Assistance Discount Schedule (Related Form B)** is updated annually using current FPL guidelines. Financial assistance may be granted as follows:

   a. *Charity Care*

      Uninsured and underinsured patients whose family income is 250 percent or less than the FPL are eligible for full or partial forgiveness of the patient's financial responsibility for covered services.

   b. *Discounted Care*

      Patients whose family income is between 251 percent and 400 percent of the FPL may be eligible for discounted care and may receive a reduction in their financial responsibility. They will not be charged more than the discounted financial assistance amount permitted under this Policy.

      Patients whose family income exceeds 400 percent of the FPL may still be considered for financial assistance based on extenuating circumstances, catastrophic medical expenses, or other demonstrated financial hardship. Additional documentation and management approval may be required.

   c. *Homeless Patients*

      Patients experiencing homelessness may be eligible for full financial assistance. Participation in another financial assistance program will be considered when determining eligibility and available benefits. When information necessary to establish the patient's ability to pay is unavailable, financial assistance may be granted after reasonable billing or collection efforts have been made.

3. Presumptive Eligibility and Automated Screening

   a. Scripps may use public information, income verification resources, credit-related data, and other electronic screening tools to identify patients who may qualify for financial assistance or government assistance programs. These tools may be used to qualify patients for assistance but will not be used as the sole basis to deny financial assistance.

b. Scripps may also review internal payment histories and prior financial assistance determinations to facilitate and expedite eligibility reviews. Patients who have been income-tested for a public assistance program within the previous 12 months may submit documentation of that determination to support their application.

c. Patients may be pre-screened for financial assistance when any of the following apply:

- The patient is uninsured.
- The patient is enrolled in Medi-Cal or qualifies under a Hospital Presumptive Eligibility program.
- The patient's household income is at or below 400 percent of the Federal Poverty Level.
- The patient participates in another qualifying means-tested public assistance program.
- The patient is experiencing homelessness.
- The patient's remaining hospital liability after insurance and other payments is $500 or more

4. Determination Timeframe

a. Whenever possible, Scripps will make a financial assistance determination within 20 business days after receiving all required information and supporting documentation, including any necessary language translations.

b. The Senior Director of Revenue Cycle is responsible for determining that reasonable efforts have been made to evaluate eligibility for financial assistance.

5. Effective Period of Eligibility

a. Patients will be notified of the financial assistance determination and the level of assistance approved.

b. Financial assistance determinations remain valid for 365 days, unless new information becomes available that affects eligibility.

6. Reassessment of Eligibility

Scripps may reassess a patient's eligibility for financial assistance when:

a. More than 365 days have elapsed since the previous determination; or

b. New information becomes available that may affect eligibility.

Patients are not required to submit a new application if sufficient information is available to determine eligibility through presumptive screening or other information already available to Scripps

F. **Denial and Appeal Process**

1. Scripps may deny financial assistance if:

a. The patient does not meet the eligibility requirements established under this Policy.

b. The patient fails to provide required proof of income or an acceptable attestation after reasonable requests by Scripps, and there is insufficient information available through presumptive screening methods to determine eligibility.

2. If an application is denied:

a. Scripps will maintain documentation supporting the denial decision.

b. Scripps will provide written notification of the denial by mail, email, patient portal, or another customary method of communication.

3. The denial notice will include:

a. The reason for the denial.

b. Information regarding the patient's right to appeal.

c. Instructions describing how and where to submit an appeal.

d. Information regarding language assistance and other available support services.

4. Patients may request additional information or appeal a denial through the Scripps Business Office. Appeals may include consideration of clinical, social, and financial circumstances and will be reviewed in consultation with appropriate operational and clinical staff. Patients with questions or disputes may contact the Revenue Cycle Manager at 858-927-5115.

G. **Application of Financial Assistance, Reimbursements, and Payment Plans**

Financial assistance approvals apply to the patient's current account balance and any outstanding balances for medically necessary services that qualify under this policy.

1. Reimbursement of Overpayments

a. If a patient is determined to be eligible for financial assistance after making payments more than the amount owed under this policy, Scripps will reimburse the overpayment, including any required interest under applicable law.

b. Reimbursement will be issued within 30 days of the determination. Scripps is not required to reimburse or pay interest when the total reimbursement due is less than $5.

c. If five or more years have passed since the patient's last payment to a hospital [just a hospital, or to any Scripps account?], its assignee, Scripps may, but is not required to, provide reimbursement as permitted by law.

2. Discounted Care Billing Limitation

If a patient qualifies for discounted care and the patient's insurer has already paid the Amount Generally Billed (“AGB”) or the applicable Medicare rate, the patient will not be responsible for additional copayments, coinsurance, deductibles, or remaining balances for that service.

3. Payment Plans

   Scripps offers interest-free extended payment plans. Payment terms will be based on the patient's financial circumstances. If the Scripps and the patient cannot agree on payment terms, Scripps will establish a reasonable payment plan in accordance with applicable California law.

H. **Prohibition on Preferential Discounts**

1. Scripps does not provide special discounts or professional courtesies to friends, family members, employees, providers, referral sources, or other individuals outside the discounts authorized under approved Hospital policies.
2. All discounts must be applied consistently and in accordance with established financial assistance and discount policies. Preferential discounts may create compliance risks under federal and state laws, including the Anti-Kickback Statute, Beneficiary Inducement Civil Monetary Penalty provisions, and the False Claims Act.

ATTACHMENT

Patient Financial Services Glossary of Terms

REFERENCES

A. Federal Poverty Level, current publication

B. 26 U.S.C. 501 (r)

C. 26 C.F.R. § 1.501(r)

D. CCR Title 22 § 96000-96051.37

E. CA Health & Safety Code § 127400-127466

F. CA Civil Code sections 1788.14, 1788.52, 1788.58, 1788.185

G. INSURANCE CODE, Chapter 4, [12693.25 - 12693.55], Chapter 17.5. [7290 - 7299.8]

RELATED PRACTICE DOCUMENTS

A. Patient Account Management, Billing and Collections; S-FW-LD-5400

B. Patient Account Management, Extended Payment Plan; S-FW-LD-5404

C. Patient Account, Self-Pay Discount; S-FW-LD-5407

RELATED FORMS

A. Scripps Financial Assistance Discount Schedule, FPL, current edition.

B. Scripps Financial Assistance Notice and Policy Plain Language Summary, 100-8560-235, 100-8560-235 (Spanish)

C. Financial Assistance Application with Instructions; 100-8560-019SW, 100-8560-019SW (Spanish)

D. Scripps Language Assistance; 100-NS8720-987SW

E. Financial Assistance Poster; 100-NS8560-2005

SUPERSEDED

Patient Financial Assistance Policy, including Discounted Payments and Charity Care (FAP) S-FW-LD-5406, 11/25

Document Chronology		
Original: 07/26	**Revised:**	**Reviewed:**

Development Summary
07/26 New: Content of superseded policies combined to one policy and reorganized.

Development Workgroup		
Representation	**Member Name**	**Title/Discipline**
Owner	Alicia Kintzele	Sr. Director, Revenue Cycle
Workgroup Leader	Renata McLaughlin	Project Manager
Workgroup Member	Anette Blatt	Director, Community Benefits
Workgroup Member	Carolyn Launer	Sr. Director, Internal Audit
Workgroup Member	Tammy Bratton	Supervisor, Revenue Cycle
Workgroup Member	Kendra Anderson	AVP, Assoc General Counsel
Workgroup Member	Andrew Dreyfus	Sr Director, Reimbursement
Workgroup Member	Soraya Pantoja	Manager, Revenue Cycle

Endorsements & Approvals		
Function	**Chair Name/Title/Position**	**Dates**
Executive Sponsor	Joanna Caballero, CVP, Rev Cycle/ CBO	07/24/26
Corporate Audit, Compliance & Risk Services	Gerald Soderstrom, Corp. SVP, Chief Audit, Compliance & Risk Officer	07/23/26
RC Leadership	Joanna Caballero, CVP, Rev Cycle/ CBO	07/23/26
Corporate Finance	Brett Tande, Corp EVP, CFO	07/24/26
Executive Cabinet	Chris Van Gorder, President & CEO	07/28/26

Charity Care	Charity care (no-cost) is a program that provides a 100% discount for eligible medical services to patients who meet established financial assistance criteria, resulting in no financial responsibility for the patient or their guarantor. This includes the portion of charges for which a third-party payer is not responsible. Charity care (no-cost) does not reduce the amount, if any, that a third-party payer or other health coverage is required to pay for services provided to the patient.
Discounted Financial Assistance Amount (AGB)	The amount generally billed represents the maximum amount a patient eligible for financial assistance will be required to pay for emergency and medically necessary services. This amount includes both the portion expected to be paid by a third-party payer and any applicable patient responsibility, such as copayments, coinsurance, and deductibles, and is typically expressed as a percentage of gross charges. This reduced amount is defined in accordance with Internal Revenue Service (IRS) requirements. Scripps uses the prospective method for determining AGB and estimates the amount it would be paid by Medicare, including amounts payable by a Medicare beneficiary. In accordance with applicable federal and California state law, patients eligible for financial assistance will not be charged more than this amount. **Tax-exempt non-profit hospitals.** If this facility is a tax-exempt non-profit hospital, Scripps also follow the federal Amount Generally Billed rule for emergency or other medically necessary care. Scripps uses the Prospective Medicare method to set that amount. If both rules apply, Scripps will bill the lower of the two amounts.
Established Cash Price	Established Cash Price is the expected payment amount after applying a discount to its full charges for services. This amount is offered to patients who have no insurance and qualify under the hospital's discount payment policy, but who have not been determined eligible for financial assistance. Patients determined eligible for financial assistance will not be required to pay more than the Discounted Financial Assistance Amount. Discounted Care is a program that offers partial financial assistance to qualifying patients based on financial need, reducing the amount they and their guarantor owe for eligible medical services. This assistance does not affect payments from health insurance or other third-party payers for these services. The amount paid by patients who are eligible for Discounted Care cannot exceed the AGB.
Extraordinary Collection Activities	Per the IRS Extraordinary Collection Activities are those that require legal or judicial process or involve selling an individual's debt to another party, deferring or denying, or requiring a payment before providing medically necessary care because of an individual's non-payment of one or more bills for previously provided care or reporting adverse information about the individual to consumer credit reporting agencies.
Family Income	Determined by recent pay stubs or tax returns.
Federal Poverty Level	The most recent poverty guidelines periodically adopted by the federal Department of Health and Human Services for determining financial eligibility for participation in various programs based upon family size as applicable to California.

	(at the time the patient was first billed): Dollar amount cut-off of income set by the U.S. Department of Health and Human Services to define poverty. Federal Poverty Level for the current year can be obtained from the following website: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Financially Qualified patient	Financially qualified patient" means a patient who is both of the following: A patient who is either: a. A **self-pay patient**, as defined in subdivision (f) of **California Health and Safety Code Section 127400**: A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance. b. A **patient with high medical costs**, as defined in subdivision (g) of **California Health and Safety Code Section 127400**: A patient whose family income is at or below 400 percent of the federal poverty level and whose unreimbursed medical costs exceed 10 percent of the family income in the prior 12 months.
Guarantor	The person with financial responsibility for the patients' health care services, usually the patients' parent or legal guardian.
Homelessness	A person is homeless if they live: 1. In a place not meant for human habitation such as: streets, cars, abandoned buildings, parks; 2. In an emergency shelters; 3. In transitional or supportive housing (for people coming from street or shelter) and; 4. In any of the above places, but is in a hospital/institution short-term (30 days or less) Or if they are: 5. Evicted within a week from a private dwelling. 6. Discharged within a week from an institution that does not provide housing as part of discharge planning. 7. A victim of Domestic Violence who does not have a secure living environment. 8. Or no subsequent residence has been identified and has no resources and support networks to obtain housing. Source: HUD gov offices http://www.dmh.co.la.ca.us/HaH/documents/COUNTYS_3_%20Homelessness_%20Eligibility_%20Doc_Guide.pdf#search=%22defining%20homelessness%22
Liquid Assets	Refers to assets that can readily be converted to cash. Liquid assets do not include retirement plans, deferred compensation accounts, or assets protected for a spouse under federal Medicaid rules.

Patients Family	1. For persons 18 years of age and older, spouse, domestic partner, dependent children under age 21 whether living at home or not and disabled children of any age. 2. For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative. For patients (1) under 18 years of age or (2) who are 18-20 years of age and are a dependent child, the patient's family also includes, other dependent children of the patient's parents or caretaker relatives if those other children are disabled. Household is a single individual aged 18 years and older, the patient, spouse, domestic partner, and dependent children under 21 years of age whether living at home or not, or any age if disabled, plus any other individual for whom the patient bears financial responsibility and claims as a tax dependent regardless of residence; 3. a domestic partnership is a committed relationship between two adults who mutually care for each other, with both at least 18 years old if of the same sex, or if of opposite sexes, both persons capable of consenting to the domestic partnership; for patients under 18 years of age or for dependent children 18 to 20 years of age, the household includes parents, caretaker relatives, and the parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled; use the definition of "disabled" from Section 1614(a) of Part A of Title XVI of the Social Security Act.
Patient High Medical Costs	A patient with high medical costs" means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, "high medical costs" means any of the following: 1. Annual out-of-pocket costs incurred by the individual at the hospital exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. 2. Annual out-of-pocket expenses that exceed 10 percent 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. 3. A lower level determined by the hospital in accordance with the hospital's Charity care policy.
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. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation, and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
Self-Pay Patient	A patient who meets the following criteria: • No third-party insurance

	• No Medi-Cal • No compensable injury for purposes of Workers Compensation, automobile insurance, or other insurance as determined and documented by the hospital. A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal, or whose health insurance does not cover all services provided during a hospital stay, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
Total Charges	Total charges are the hospital's full established rates for patient care services
Reasonable Efforts	A certain set of actions a healthcare organization must take to determine whether an individual is eligible for financial assistance under Scripps financial assistance policy (FAP). In general, reasonable efforts may include providing individuals with written and oral notifications about the FAP and Application process or Scripps Policies A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal, or whose health insurance does not cover all services provided during a hospital stay, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
Limited English Proficiency (LEP) Group	A group of people who either do not speak English, or who are unable to effectively communicate in English because it is not their native language. The size of the group is the lesser of either 1,000 individuals, or five percent (5%) of the community served by the facility, or the non-English speaking populations likely to be, affected or encountered, by the facility. The facility may use any reasonable method to determine the number, or percentage, of LEP patients that may be affected, encountered, or are served by the facility.
Medi-Cal Presumptive Eligibility	Provides qualified individuals with immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.
Medically Necessary	Refers to inpatient or outpatient health care services provided to evaluate, diagnose, or treat an injury, illness, disease, or its symptoms, where without treatment The patient's health would be at risk. For individuals 21 years of age or older, a service is medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (Welf. & Inst. Code § 14059.5). For individuals under 21 years of age, medically necessary services include those needed to treat, correct, or ameliorate conditions identified by screening services, consistent with the EPSDT standard at 42 U.S.C. § 1396d(r)(5). All medically necessary services are eligible for the Discount Payment Program. Hospitals may, but are not required to, provide discount payment for non-emergency services provided to patients with high medical costs for out-of-network care not covered by a third-party payer if the patient declines transfer to an in-network facility. For purposes of patient complaint investigations, services performed within the hospital are presumed to be medically necessary unless the hospital provides the Department an attestation that the hospital services at issue in the complaint

	Scrippsre not medically necessary; an attestation is valid if it is signed by the provider who referred the patient for the hospital services at issue in the complaint or by the supervising health care provider for the hospital services at issue; the hospital must obtain the required attestation before denying a patient's eligibility for the Discount Payment Program on the basis that the services at issue Scrippsre not medically necessary.
Presumptive Financial Assistance Eligibility	Eligibility determined or assumed through means other than patient-provided information in an application. This may include utilizing a scoring tool or leveraging existing means-tested qualifications for government or FQHC services designed for lower-income individuals. Additionally, financial assistance qualifications may be assumed based on certain criteria, such as currently unhoused or suffering housing instability, current Medicaid/Medi-Cal program status, or credit-based financial assessments. Hospitals may employ an automated scoring tool to assess patients' eligibility for financial assistance, utilizing publicly available data sources to predict the likelihood of qualification. This tool offers estimates of the patient's financial status and household income, thereby streamlining the assessment process. Scoring tools may be used to qualify a patient for assistance but will not be used to disqualify a patient from applying for financial assistance.
Reasonable Payment Plan	Monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses for any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school or childcare; child or spousal support; transportation and auto expenses, including insurance, gas, and repairs; installment payments; laundry and cleaning; and other extraordinary expenses. Payment plans shall be interest-free and include no additional fees**.**
Uninsured Patient	A patient with no level of health coverage or insurance to help pay their medical bills.
Underinsured Patient	A patient who has some amount of insurance or health coverage but still has out-of-pocket expenses that exceed their ability to pay**.**