



FINANCIAL ASSISTANCE POLICY

Department	Patient Access Services	Effective Date	03/2004
Campus	AHS System	Date Revised	12/2019, 03/2020, 01/2021
Category	Administrative	Next Scheduled Review	10/2025
Document Owner	Vice President Revenue Cycle	Executive Responsible	Chief Financial Officer

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PURPOSE

Alameda Health System (AHS) strives to provide quality patient care for the communities we serve. This Financial Assistance Policy (this “Policy”) demonstrates AHS’s commitment to our mission and vision by helping to meet the needs of the low-income, uninsured, and the underinsured patients in our community.

The purpose of this Policy is to provide patients with information on the availability of Financial Assistance at AHS, to outline the process for determining eligibility, and to establish guidelines and standards that AHS will follow with respect to the collection of patient debt, including patients who are eligible for Financial Assistance.

This Policy only addresses Financial Assistance at AHS hospital and hospital-based facilities; there are separate policies for Federally Qualified Health Center discounts (Sliding Fee Discount Policy & Procedure – FQHC and Other) and AHS’ Self-Pay and Prompt Pay Discount Policy.

POLICY

AHS offers Financial Assistance to ensure that no patient shall be denied service due to an individual’s inability to pay. Consistent with this commitment, it is the policy of AHS to provide Financial Assistance to qualified low-income, uninsured or underinsured patients to whom we provide services in our community. This Policy will be administered in a manner consistent with applicable laws and regulations.

As required by law, AHS shall provide patients with information regarding Financial Assistance and other programs during the patient intake process. It is imperative that the notification of availability, determination, reporting and tracking of Financial Assistance is in concert with our mission and our community obligations.

AHS’s Financial Assistance program is not a substitute for personal responsibility. Patients are expected to cooperate with AHS’s procedures for obtaining Financial Assistance and to contribute to the cost of their care based on their ability to pay as appropriate and consistent with this Policy. Additionally, this Policy is not intended to waive or alter any contractual provisions or rates negotiated by and between AHS and third-party payers, nor is the Policy intended to provide

discounts to a non-contracted third-party payer or other entities that are legally responsible for making payment on behalf of a beneficiary, covered person, or insured.

PROCEDURE

A. COVERED SERVICES

Financial Assistance pursuant to this Policy includes emergency health care services and other Medically Necessary Care provided at AHS owned or operated facilities. AHS has a policy governing the provision of emergency care without discrimination to all patients, regardless of eligibility for Financial Assistance in its Emergency Medical Treatment and Active Labor Policy.

Emergency room physicians, who provide emergency medical services in an AHS general acute care facility are excluded from this Policy. These emergency physicians are also required by California law to provide discounts to Uninsured Patients or patients with High Medical Costs who are at or below 400 percent of the Federal Poverty Level. Patients who receive a bill from an Emergency Room physician, and are uninsured, or underinsured with High Medical Costs, should contact that physician's office and ask about their financial assistance policy.

The following services are excluded as ineligible for the application of Financial Assistance under this Policy, except as required by law:

- Medi-Cal Patients with Share of Cost: Medi-Cal patients who are responsible to pay share of cost are not eligible to apply for Financial Assistance under this Policy to reduce the amount of share of cost owed.
- Not Medically Necessary Care
- Payer Pays Patient Directly: If a patient receives a payment for services directly from a payer.
- Insured patient does not cooperate with third-party payer: An insured patient who is insured by a third-party payer that refuses to pay for services because the patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability.

B. APPLYING FOR FINANCIAL ASSISTANCE

1) Access to Financial Assistance Policy and Application

AHS makes information about its Financial Assistance Policy and Application available through numerous means in compliance with applicable laws and regulations. Without limitation, information about this Policy is available on the AHS's website home page and on any website where the patient pays a bill or accesses information about the patient's account, posted in hospital areas that are accessible to the public, such as the emergency department, admitting office, other outpatient service settings, on each billing statement, and by plain language summaries provided to all patients. These notices, this Financial Assistance Policy and the Application shall be made available by mail upon request or as required by law or regulation. Hospital personnel shall direct patients, guardians, or family members who request financial assistance or information about financial assistance, or who the hospital personnel believe may be eligible for financial assistance to the AHS Customer Service Team or Financial Counselors to receive a paper or soft copy of this Policy and an application form.

Patients who may be uninsured patients shall be interviewed and screened by a Financial Counselor who shall visit the patients in person at the hospital. Financial Counselors shall give such patients a Financial Assistance and Charity Care Application and screen the patient for other government programs.

The AHS standardized application form (referenced in this Financial Assistance Policy as the “Application”), shown as the “Financial Assistance and Charity Care Application” (see Attachment A), will be used to document each patient’s overall financial situation. This application is available in the primary languages of the service area. For applicants who speak other languages, AHS will provide interpreter assistance for applicants to complete the form. AHS shall make this form accessible to all patients, including in alternative accessible formats.

2) Other Forms of Health Coverage

AHS shall assist patients in exploring appropriate alternative sources of payment and coverage from public and private payment programs and also assist patients in applying for such programs. Other county or governmental assistance programs besides Financial Assistance should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, Health PAC, Victims of Crime, California Children Services, or a Covered California plan.

If the patient applies or has a pending application for another health coverage program at the same time that he or she applies for Financial Assistance, neither application shall preclude eligibility for the other program.

3) Application Process

To be considered for Financial Assistance under this Policy, a patient must submit a true, accurate, and complete confidential Financial Assistance and Charity Care Application (see Attachment A) [by email, mail or online submission]. The Financial Assistance and Charity Care Application must be completed in writing and may be completed by or with the assistance of a staff or management member of the Customer Service Team. The Financial Assistance and Charity Care Application must be signed by the patient or the patient’s legal representative and accompanied by the following documentation:

- Recent pay stubs from within the 6 months before or after the patient is first billed (or in preservice when the Application is submitted); or
- Copy of Federal Income Tax Return (Form 1040) for patient and spouse or domestic partner from the year the patient was first billed or 12 months prior to when the patient was first billed.

A patient, or patient’s legal representative, who requests financial assistance shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. These documents provided for the Application will only be used in reaching a determination of financial assistance and will not be used for collection activities.

An individual is considered to have submitted a complete Financial Assistance and Charity Care Application if he or she provides information and documentation sufficient for the hospital to determine whether the individual is eligible for Charity Care. An application is incomplete if he or she provides some, but not sufficient, information and documentation to determine eligibility for Charity Care. Failure to complete and return the Application and attempt in good faith to settle the bill within 180 days of the date AHS first sent a post-discharge bill to the patient may result in AHS pursuing collection actions to collect the amount owed, as described in AHS’s Debt Collection Practices Policy.

AHS may from time-to-time contract with other organizations that specialize in assisting patients and their families with qualifying for Financial Assistance or other sources of funding or insurance enrollment. Organizations/Contractors are required to abide by the policies set forth by AHS. Patients are given information regarding the availability of assistance from these other organizations and are encouraged to cooperate with the qualifying process. Patients are not expected to incur any costs when utilizing these services.

4) Notification of Charity Care Determination

Once AHS has reviewed the Financial Assistance and Charity Care Application and has made a determination based on the Charity Care eligibility requirements stated below, AHS shall notify the individual in writing by mail of this eligibility determination and the basis for this determination. AHS will make every effort to provide a determination of eligibility within 30 days of receiving all requested information and documentation from the patient. AHS shall not engage in any collection activities for patients attempting to qualify for eligibility under this Policy in good faith. The collection of any remaining Patient Responsibility shall be subject to the AHS Debt Collection Practices Policy. AHS' Debt Collection Practices Policy is available by visiting or contacting AHS Patient Access or Patient Financial Services Departments, and by various means including the AHS website.

5) Effect of Determination

If found eligible for Charity Care, AHS shall provide the individual with a billing statement that states the amount the individual now owes for the care, if any, and how that amount was determined.

If appropriate, AHS shall refund the individual any amount over \$5.00 he or she has paid for the care (whether to the hospital or any other party to whom the hospital has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying after financial assistance has been applied. AHS shall make any refunds under this section within 30 days of the determination of eligibility for Charity Care. AHS shall pay interest on any refunds to the patient at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital.

The Charity Care approval is good for one year after the approval is granted. The adjustment will be applied to all eligible patient account balances, including those received before the application approval date. For bills received after one year from when Charity Care is approved, a new Financial Assistance and Charity Care Application will need to be filled out if the patient is seeking Financial Assistance for those bills. If at any time information relevant to the eligibility of the patient changes, it is the patient's responsibility to notify AHS of the updated information.

A review will include any other outstanding accounts for the patient that may also be eligible for the Charity Care approval timeframe.

6) Appeal of Determination

Patients may submit a written request for reconsideration to the Director of Patient Financial Services or the Director of Patient Access. Such an appeal should demonstrate that the individual either:

- Believes their Financial Assistance and Charity Care Application was not approved according to this Policy; or
- Disagrees with the way the Policy was applied to their case

Appeal must be submitted within 30 days of the date of the decision letter. The Director of Patient Financial Services will be the final level of appeal.

7) How to Ask for Help

Financial assistance applications are available free of charge by visiting or contacting:
Visit our website: <https://www.alamedahealthsystem.org/patients-visitors/>
Contact Financial Counselors at 510-437-4961

C. ELIGIBILITY

Eligibility for Charity Care will be considered for those individuals who meet income guidelines and are either Uninsured Patients or have High Medical Costs. The granting of Charity Care shall be based on an individualized determination of Family Income and medical costs, and shall not consider age, gender, race, social or immigrant status, sexual orientation, or religious affiliation.

1) Standard Eligibility

Eligibility for Financial Assistance is based on Family Income, family size, uninsured status, and whether the patient has High Medical Costs, as set forth in the table below.

Financial Assistance Category	Patient Eligibility Criteria	Available Discount
Full Charity Care	Patient is an Uninsured Patient with a Family Income at or below 400% of the most recent FPL	Full write-off of all charges for Medically Necessary Care
High Medical Cost Charity Care (for Insured Patients)	Patient is an Insured Patient with a Family Income at or below 400% of the most recent FPL and is a High Medical Cost Patient, i.e., medical expenses for themselves or their family (incurred at AHS or other providers in the past 12 months) exceed 10% of the patient's Family Income	A write-off of the Patient Responsibility amount for Medically Necessary Services

The full charity care amounts described in the above table are less than the greater of the amount that AHS would reasonably expect under Medicare and Medi-Cal.

Non-covered and denied services and related services provided to Medicaid-eligible beneficiaries are considered a form of Charity Care. Medicaid beneficiaries are not responsible for any patient financial liability besides "Share of Cost." Examples of this include but are not limited to services provided to Medicaid beneficiaries with restricted Medicaid, Medicaid pending accounts, Medicaid of other indigent care program denials, charges related to days exceeding length-of-stay limits, Medicaid claims (including out-of-state Medicaid claims) with "no payments," and any service

provided to a Medicaid-eligible patient with no coverage and no payment.

2) Presumptive Eligibility

AHS reserves the discretion to grant presumptive Charity Care for individuals if it determines that the individual is eligible for Charity Care based on information other than that provided by the individual or based on a prior financial assistance determination.

If the patient does not or cannot respond to the application process, AHS will screen the patient for certain life circumstances or financial factors described below. AHS may utilize other sources of information to make an individual assessment of financial need to determine whether the patient is eligible for Charity Care and approval. The AHS Director of Patient Financial Services or designee will determine whether a patient receives the presumptive Charity Care determination. AHS must document the decision, including the reasons why the patient did not meet the regular criteria. This information will enable AHS to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient. Examples of the life circumstances or financial factors AHS considers for presumptive eligibility for Charity Care include but are not limited to:

- Deceased. Deceased patients without insurance, an estate, or third-party coverage.
- Bankruptcy. Patients who are in bankruptcy (filed but an open case) or completed bankruptcy in the past three (3) months.
- Homelessness. Homelessness or receipt of care from a clinic serving those experiencing homelessness. Emergency room patients without a payment source, if they do not have a job, mailing address, residence, including temporary residence, or insurance, will be considered homeless; however, all other county, state, or government programs must be considered as part of enrollment screening.
- Qualification for Government Assistance Programs: Current qualification for a public benefit program including Social Security Insurance, Unemployment Insurance Benefits, Medicaid, County Indigent Health, TANF, food stamps, WIC, or free lunch, or living in low-income or subsidized housing.

If AHS determines the patient is presumptively eligible for Charity Care, the patient will not be required to take further action and assistance will be applied to patient's past bills.

DEFINITIONS

For the purpose of this Policy, the terms below are defined as follows:

- 1) **Charity Care**: Free care for the patient, including full charity care and high medical cost charity care as outlined in Eligibility section in this Policy.
- 2) **Family Income**: Determined consistent with the IRS definition of Modified Adjusted Gross Income for the patient and all members of the Patient's Family.
- 3) **Federal Poverty Level (FPL)**: FPL means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.
- 4) **Financial Assistance**: Charity Care or other discounted care.

- 5) **Financially Qualified Patient:** A patient who is a Self-Pay Patient or is a High Medical Cost Patient, and who has a Family Income that does not exceed 400 percent of the federal poverty level.
- 6) **High Medical Cost Patient:** A patient whose Family Income is at or below 400 percent of the FPL; and has total out-of-pocket medical expenses at AHS that exceed 10 percent of the patient's current Family Income or Family Income in the prior 12 months.
- 7) **Medically Necessary Care:** Any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers the life, cause suffering or pain, results in illness or infirmity, threaten to cause or aggravate handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures. Hospital services are presumed to be Medically Necessary Care unless either the provider who referred the patient for the hospital services or the supervising health care provider for the hospital services attests that the hospital services were not medically necessary.
- 8) **Patient Responsibility:** Any remaining balance due for the billed charges that a patient must pay out-of-pocket, including but not limited to deductibles, coinsurance and copays, exclusive of Medi-Cal share of cost. Patient Responsibility may include the total billed charges for Self-Pay or Uninsured Patients.
- 9) **Patient's Family:** For patients 18 years of age and older, Patient's Family is defined as their spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not. For persons under 18 years of age or for a dependent child 18-20 years, Patient's Family includes a parent, caretaker relatives and other children under 21 years of age, or any age if disabled, of the parent or caretaker relative.
- 10) **Self-Pay Discount:** Describes the situation where the hospital has determined that the patient does not qualify for Charity Care but is eligible for a Self-Pay Discount and is expected to pay only a part of the bill. The Self-Pay Discount is described more fully in the AHS policy, "Self-pay and Prompt Pay Discount Policy."
- 11) **Self-Pay Patient:** 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 Worker's Compensation, automobile insurance, or other insurance (third-party liability) as determined and documented by the hospital.
- 12) **Uninsured Patient:** A patient who has no third-party source of payment for any portion of their medical expenses, including but not limited to, commercial or other health insurer, health care service plan, Medicare, or Medicaid/Medi-Cal, or third-party liability. For the purpose of this Policy an "uninsured patient" may include a "self-pay" patient and/or a patient whose benefits under all potential sources of payment have been exhausted prior to admission.

ATTACHMENTS

1. Attachment A: Financial Assistance and Charity Care Application

REFERENCES

1. California Health and Safety Code Sections 127400 through 127446
2. California Code of Regulations, Title 22, Sections 96051 through 96051.37

APPROVALS

		System	Alameda	AHS/Highland/John George/San Leandro
Department	Date:	N/A	01/2021	01/2021
Pharmacy and Therapeutics (P&T)	Date:	N/A	N/A	N/A
Clinical Practice Council (CPC)	Date:	N/A	N/A	N/A
Medical Executive Committee	Date:	N/A	02/2021	02/2021
Board of Trustees	Date:	02/2021	N/A	N/A