Barlow
RESPIRATORY HOSPITAL

PURPOSE

Barlow Respiratory Hospital (the "Hospital") is a non-profit organization. In keeping with the Hospital's mission and values, the Hospital provides necessary services to its patients without regard to their ability to pay. This Financial Assistance-Charity Care and Discount Policy ("Financial Assistance Policy") establishes the guidelines, policies, and procedures for use in determining patient qualification for financial assistance, including both charity care and discounted care for patients with low income with respect to all medical care provided by the Hospital to patients. This Financial Assistance Policy is intended to ensure compliance with all applicable federal and California laws regulating charity care provided by the Hospital, including Article 1 of Chapter 2.5 of Part 2 of Division 107 of the California Health and Safety Code, commencing with Section 127400, and Internal Revenue Code Section 501(r) and its implementing regulations.

DEFINITIONS

"***Family Income***" means the patient's income, together with the income of the following: (1) for patients 18 years and older: the patient's spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not; and (2) for patients under 18 years old: the patient's parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

"***Federal Poverty Level Guidelines***" means the most recently issued poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

"***Financially Qualified Patient***" means a patient whose Family Income does not exceed 400 percent of the federal poverty level, and who is: (1) a self-pay patient (defined as a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not covered by worker's compensation, automobile insurance, or other insurance as documented by the hospital), or (2) a patient with "high medical costs" (defined as annual out-of-pocket expenses incurred by the individual at the hospital and/or documented costs paid to other providers by the patient or patient's family that exceed 10% of the patient's family income in the prior 12 months).

"Amount Generally Billed"—in determining the payment due for services provided to a patient qualifying for the low income financial assistance, the Hospital will first reduce its billing from full charges to the amount that the Hospital would have been paid by Medicare if the services were covered and then may provide an additional discount on a case-by-case basis depending on the patient's circumstances. If the Hospital provides a service for which there is no established payment by Medicare, it will reduce its billing to the amount that the Hospital would have been paid by Medi-Cal or another government-sponsored program of health benefits in which the hospital participates. If the hospital provides a service for which there is no established payment by any government-sponsored program of health benefits in which the Hospital participates, it shall establish an appropriate discounted payment that is not more than the amounts generally billed to individuals who have insurance covering such care.

"Extraordinary Collection Actions" means the following actions taken against an individual related to obtaining payment of a bill for care covered under the Hospital's Financial Assistance Policy:

- Selling the individual's debt to another party.
- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

- Deferring or denying, or requiring a payment before providing, medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the Hospital's Financial Assistance Policy, unless the Hospital can demonstrate that it required the payment from the individual based on factors other than, and without regard to, the individual's nonpayment of past bills.
- Actions that require a legal or judicial process and that are not otherwise prohibited by this policy or applicable law, including attaching or seizing the individual's bank account or any other personal property, commencing a civil action against the individual, causing the individual's arrest, or causing the individual to be subject to a writ of body attachment.
- Other actions that may not be taken by the Hospital, but may be taken by a collections agency or other assignee that is not a subsidiary or affiliate of the Hospital in certain circumstances, including placing a lien on an individual's property (other than a lien that a hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which the hospital provided care), foreclosing on an individual's property, or garnishing an individual's wages upon order of a court.

*"**Reasonable Payment Plan"*** means monthly payments that are not more than 10% of a patient's family monthly income, after deducting essential living expenses-which include: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses-including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

HOSPITAL POLICY

Financial Assistance Program- includes both Charity Care and Low Income Financial Assistance.

Charity Care is available for patients whose Family Income is equal to or less than four-hundred percent (400%) of the then current Federal Poverty Level Guidelines and do not have sufficient resources to satisfy the Hospital bill for services provided. Care will be provided at no charge for patients who qualify for charity care. When determining eligibility for Charity Care, the Hospital may consider income and certain monetary assets of the patient, as defined in this Policy.

Low Income Financial Assistance is available to Financially Qualified Patients who do not qualify for Charity Care. The Hospital will adjust the gross charges billing to the Amount Generally Billed and negotiate a Reasonable Payment Plan with Financially Qualified Patients. The Hospital may require recent pay stubs or income tax returns from the patient to document family income.

Extended Payment Plans are available to patients that receive Low Income Financial Assistance to allow payment of the discounted price over time. Extended Payment Plans shall be negotiated by the Hospital and patient, and shall take into account the patient's Family Income and essential living expenses. Patients on an Extended Payment Plan will not be charged interest during the duration of the plan. If a patient under an Extended Payment Plan fails to make all consecutive payments for 90 days, the Hospital may end the plan, but before ending the plan it will make reasonable efforts to contact the patient by telephone and give notice in writing that the plan will become inoperative if it is not renegotiated.

Charity Care Reporting—charity care will include all amounts written off for services provided to patients that qualify for charity care under this policy. In addition, patients who qualify for Medi-Cal but do not receive coverage for their entire stay are eligible for a charity care write-off. These include charges for non-covered

services, denied days or denied stays. Treatment Authorization Request (TAR) denials and other nonpaid services provided to Medi-Cal eligible patients will be written off as charity.

Asset Qualification for Charity Care—patient owned monetary assets may also be considered to determine if sufficient patient household assets exist to satisfy all or some of the Hospital's bill for services provided. Patients with sufficient monetary assets may be denied eligibility for charity care even if they meet basic income qualification requirements. Evaluation of patient monetary assets will consider both the monetary asset value and amounts owed (net worth) in establishing a patient's payment obligation. The asset review will exempt the following assets:
-Retirement or deferred compensation plans qualified under the Internal Revenue Code
-Non qualified deferred compensation plans
-First ten thousand dollars ($10,000) and fifty percent (50%) of a patient's monetary assets over the first ten thousand dollars ($10,000)

Covered Providers—this Financial Assistance Policy does not cover any providers other than the Hospital facility itself.

Emergency Physicians—an emergency physician who provides emergency medical services in a hospital that provides emergency care is required by law to provide discounts to financially qualified patients.

COMMUNICATION

-The Financial Assistance- Charity Care and Discount Policy, the Policy's application form, and a plain language summary of the Policy are posted on the Barlow Respiratory Hospital website [barlowhospital.org] in English, Spanish, and Armenian. Paper copies of the Financial Assistance Policy, the Policy's application form, and a plain language summary of the Policy are available upon request and without charge by mail and in the Hospital's Social Services Department.

-A notice of the existence of the Financial Assistance Policy is posted in the main lobby at the Barlow Main campus, in the visitor waiting room at the BRH@VPH location, in the hallway outside the nursing station at the BRH@PIH campus. The notices are posted in English, Spanish, and Armenian.

-All patients admitted to the Hospital are given an admission packet that includes notice of the availability of financial assistance and information on how to apply.

-If a patient does not provide coverage information or requests financial assistance information, the Social Service and Case Management Departments' staff are available to assist patients and their families with completion of the Application for Financial Assistance and will provide directions and/or application assistance to a patient who wishes to apply for Medi-Cal, California Health Benefit Exchange, California Children's Services Program coverage, or will provide a referral to a local customer assistance center that can assist with the application to any of these programs.

-The first billing from the Hospital to a patient includes additional insurance coverage information not previously supplied and includes a statement that the patient may be eligible for Medicare, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services Program, other state or county-funded health care coverage or financial assistance or charity care from the Hospital. It includes the name and telephone number of a Hospital employee from whom the patient may obtain further information about the Hospital's Financial Assistance Policy. It also explains that the patient can simultaneously apply for

both Hospital charity care or low income financial assistance and another health coverage program. Also included are phone numbers and internet addresses for Covered California, the California Department of Health Care Services and a local legal assistance resource that is available to assist a patient in gaining access to health care coverage.

-Any subsequent billing statements from the Hospital include a written notice that informs recipients about the availability of financial assistance and includes the telephone number of a department or Hospital employee who can provide information about applying for financial assistance. The statements also include the website address where copies of the Financial Assistance Policy, the Policy's application form, and a plain language summary of the Policy are available.

PROCESS

The Financial Assistance Policy relies on the cooperation of patients and their families for accurate and timely submission of insurance coverage information and for income and asset financial screening information. The hospital uses a financial assistance application to collect information from patients who may potentially qualify for financial assistance. Completion of the financial assistance application and submission of any and all required supplemental information may be required in order to establish eligibility for Financial Assistance. The Hospital may require recent pay stubs or income tax returns from the patient to document family income.

With respect to qualification for Charity Care, the Hospital may require verification of financial information by a third party service if there is reason to believe the patient has substantial monetary assets despite a low family income. The Hospital may require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets to verify their value. Information obtained in determining eligibility for charity care shall not be used for collection activities.

Approval of financial assistance will be denied if a Medi-Cal or other health and welfare eligibility application is refused by the patient or if the patient is uncooperative or delays the process. Generally, the patient will be given 30 days to complete the necessary paperwork to apply for financial assistance, including providing supporting documents. In addition, assignment to Hospital of all insurance payments, including liability settlements, is required, within the guidelines of the Hospital Lien Act (Cal. Civil Code Section 3045.1).

Presumptive eligibility may be determined (application not required) for patients enrolled in Medi-Cal (charges for services provided to Medi-Cal enrolled patients that are not covered or denied due to the denial of a Treatment Authorization Request will be considered charity care) and for deceased patients with no known estate.

If a patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

<u>Final Approval and Notification of Financial Assistance Eligibility Decision</u>

Financial Assistance Eligibility must be approved by either the Chief Executive Officer ("CEO") or Chief Financial Officer ("CFO") and documented on the Financial Assistance Approval Form. At the time a decision is made for the approval or denial of an account for charity, a letter should be sent to the patient or responsible party as notification of the decision made. The letter should be written and should include the following information:

- Patient name
- Account number(s)
- Current outstanding balance of the account(s)
- Dollar amount or number of days stay granted for charity (which generally will be all amounts)
- Any balance which will be due on the account (if only a portion of the account is to be written off, for example, amounts incurred after the patient has reached a lifetime limit under his or her insurance policy)
- Appeal process if a request for financial assistance was denied.

The letter should be signed by the CEO or CFO.

A Financial Assistance Committee shall be established and consist of the CEO, Medical Director, Vice President of Business Development, and the Chief Operating Officer. The duties of the Committee are to:

- Review appeals of denials of financial assistance, including the following documentation:
    - Appeal letter from the patient or financially responsible party requesting re-evaluation of denial of financial assistance.
    - Supporting documents that may provide proof of inability to pay that were not part of the documentation available during the initial consideration.
- Make recommendations to the CEO or CFO for final approval.

Other

Normal charging procedures will be followed by the Hospital for recording services provided to charity care patients.

Collection activity by the Hospital will cease when the patient is declared eligible for charity care and will be suspended during the period that the patient is attempting to qualify under the Hospital's Financial Assistance Policy. For a patient who lacks insurance coverage or indicates that he or she may have high medical costs, neither the Hospital nor any other owner of the patient's debt shall report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment prior to 150 days after the first billing.

In the event of nonpayment, the Hospital will follow the practices set forth in its Discount and Charity Care Billing and Collections Practices Policy. The Hospital will take reasonable efforts to determine whether an individual is eligible under this Financial Assistance Policy before engaging in any Extraordinary Collection Actions. Reasonable efforts include notifying individuals orally and in writing about how to apply for charity care and low income financial assistance, giving individuals a reasonable period of time to apply for assistance before initiating Extraordinary Collection Actions, evaluating submitted applications for financial assistance in a timely manner, and notifying individuals who submit an incomplete application about how to complete the application.

The Hospital will require each collection agency it uses to agree to comply with the Hospital's Financial Assistance Policy and Discount and Charity Care Billing and Collections Practices Policy. The Hospital will not send any unpaid bill to a collection agency unless that agency has agreed in writing to comply with California Health & Safety Code § 127400 *et seq.* and 26 U.S.C. § 501(r), including the implementing regulations at 26 C.F.R. § 1.501(r) *et seq.*

The completed Financial Assistance Approval Form will be filed in the Social Services Department.

The amount of charity care provided will be reported separately in the monthly financial statements.

Prepared by: Chief Financial Officer

Approved by: Hospital Board of Directors on September 24, 2015.

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FINANCIAL ASSISTANCE CHECKLIST

The attached financial assistance application is to determine your eligibility for charity care or discounted medical services at our facility. You must complete this form and return it with copies of all the required documentation (see list and the attached application). Items required for your specific application are marked with an "X." If we do not receive the completed application by the date specified, your application may be denied.

Financial assistance application must be returned by: _____

Application must be delivered to the Business Services Department at our Barlow Main location, or mailed to:

BARLOW RESPIRATORY HOSPITAL
ATTENTION: BUSINESS SERVICES
2000 STADIUM WAY
LOS ANGELES, CA 90026-2696

Checklist of required information: (Copies only - no originals):

____ Recent pay stubs or the most recent income tax return.

____ Medi-Cal denial notice.

____ Unemployment compensation determination or termination notice.

____ Complete listing of all currently outstanding medical debt.

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____ Complete listing of all out-of-pocket costs incurred over past 12 months.

Have you:

1. Completed the financial assistance application?___

2. Signed the financial assistance application?_____

Please use this checklist to make sure your application is complete.

Please note that your signature verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify any and all information provided

Signature:_____

FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____ Spouse:_____

Address: .....

Phone: .....

Social Security Number:_____ Driver License #: _____

If you are **over** 18, please list (i) your spouse (or domestic partner) and (ii) dependent children who are under the age of 21

Name	Age	Relationship (spouse, domestic partner, dependent)	Annual Income of such person

If you are **under** 18, please list (i) your parents (or if other relatives take care of you, list them) and (ii) any other children under the age of21 of your parents or relatives who take care of you

Name	Age	Relationship (parent, caretaker relative, children)	Annual Income

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Family Income

What is your total family income (taking into account your income as well as the income of those family members listed above)?_____

Please attach recent pay stubs or your most recent income tax return.

Existing Insurance

Do you have any health insurance, such as Medicare, Medi-Cal or private health insurance?

Yes:_____ No:_____ Payor:_____

Is your injury covered by workers' compensation, automobile insurance, or other insurance?

Yes:_____ No: _____

Please provide any documentation in support of your answers above.

Annual Medical Costs

How much have you paid in medical costs over the past 12 months to:

Barlow Respiratory Hospital:_____ (please attach supporting documentation)

Other Providers:_____ (please attach supporting documentation)

My signature on this form verifies the accuracy of the information provided and authorizes Barlow Respiratory Hospital to verify any and all information provided.

I understand that any financial assistance is intended solely for my benefit and does not relieve third parties or liability for payment.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by Barlow Respiratory Hospital. It is also understood that I may appeal the determination of whether I qualify for financial assistance in writing with additional documentation.

_____ _____

Date Signature of Patient or Legal Guardian

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FINANCIAL ASSISTANCE APPROVAL FORM

Department Requesting Charity Care or Discount: Date Requesting_____

Admitting:_____ Business Services:_____ Physicians____ Social Services_____
Case Management _____

Patient Name: _____ Account #: _____

Social Security #: _____
Admit Date: _____ Discharge/Expected Discharge Date_____

Patient Type: ICU ICUV MedV Med Rehab

Patient Resources:

Is the patient's ***Family Income***[1] equal to or less than 350% of the ***Federal Poverty Level***?[2]

Yes:_____ No:_____

Is the patient's ***Family Income*** equal to or less than 200% of the ***Federal Poverty Level***?

Yes:_____ No:_____

Is the patient a ***Self-Pay Patient***?[3]

Yes:_____ No:_____

Is the patient a ***Patient with High Medical Costs***?[4]

Yes:_____ No:_____

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[1] "***Family income***" means the patient's income, together with the income of the following: (1) for patients 18 years and older: the patient's spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (2) for patients under 18 years old: the patient's parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

[2] "***Federal poverty level***" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

[3] "***Self-pay patient***" means a patient who does not have a third-party coverage from a health unsurer, health care service plan, Medicare, or Medicaid, 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.

[4] "***Patient with high medical costs***" means a person who does not receive a discounted rate from the Hospital as a result of his or her third-party coverage, when either of the following apply: (1) annual out-of-pocket costs incurred by the patient, at the Hospital, exceed 10% of the patient's ***family income*** in the prior 12 months, or (2) annual out-of-pocket medical expenses incurred by the patient, anywhere, 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.

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Patient Eligibility

Based on the forgoing, the patient is eligible for (check which applies):

Charity Care:___. The patient is eligible for charity care because he or she has a ***Family Income*** equal to or less than 400% of the ***Federal Poverty Level*** and is either a ***Self-Pay Patient*** or is a ***Patient with High Medical Costs.*** If the patient is eligible for charity care, the patient will not be charged for any medical services rendered.

Discount Care:___ . The patient is eligible for discounted care because he or she has a ***Family Income*** equal to or less than 350% of the ***Federal Poverty Level*** and is either a ***Self-Pay Patient*** or is a ***Patient with High Medical Costs.***

Comments:_____

_____

_____

_____

CEO or CFO Approval _____ _____

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PATIENT NOTIFICATION LETTER

Date: _____

Guarantor Name: _____

Patient Name: _____

Guarantor City, State and Zip Code: _____

_____

Dear Mr. / Mrs. / Ms.: _____

We have carefully reviewed your application for financial assistance and have determined that your account:

( ) Meets the hospital's established guidelines for financial assistance.

( ) Meets the hospital's established guidelines for financial assistance pending outcome/resolution of your Medi-Cal application/financial review.

( ) Approved amount $_____ . Your account will be reduced by _____ %, and the guarantor is responsible for $_____ .

( ) Does not meet the hospital's established guidelines for financial assistance.

Reason for Denial:

_____ Family income exceeds qualifications.

_____ Potential third-party payer source.

_____ Application not complete.

_____ Supporting Documentation not adequate.

(Use this language in denial letters only)

If you wish to appeal this decision, please call the Manager, Patient Financial Services At: 213-202-6884 to initiate the appeals process.

(Use this letter for qualifying individuals only)

As a nonprofit hospital, we are proud of our support of the community and the charity care and discounted care we provide to you and others. We appreciate your choosing Barlow Respiratory Hospital for your health care needs and we welcome the opportunity to provide services to you in the future.

Sincerely,

BUSINESS SERVICES DEPARTMENT
BARLOW RESPIRATORY HOSPITAL