

Financial Assistance Program			
Approved Date:	05/11/2024	Published Date:	05/11/2024
Review Date:	05/11/2024		
Approved by:	Ted Sirotta, Sr. VP, Chief Financial Officer		

PURPOSE

To establish a financial assistance program (FAP) and to ensure that patients and the community at large:

- Are aware that financial assistance is available
- Are provided adequate time to apply and submit required information and documentation
- Receive reasonable assistance with the application process; and
- Have the ability to search Shoppable Services on the hospital website:
<https://henrymayo.patientsimple.com/guest/#/index>

This policy shall apply to Henry Mayo Newhall Hospital, and any of its majority-owned not-for-profit entities (collectively referred to as “HMNH”). The policy shall also be provided to and apply to any contracted service that performs billing on behalf of HMNH.

POLICY

In accordance with federal and state laws and regulations, provide financial assistance to uninsured and under-insured patients who may not have sufficient financial resources to pay for services.

Definitions

- *AGB* - Amounts Generally Billed is the maximum amount that can be collected from patients that qualify for financial assistance or as otherwise allowed under this policy. This term is more fully defined under the Charge Limitation section below.
- *Application Period* – The period during which HMNH must accept and process an application for financial assistance under the FAP. The application period begins on the first post discharge billing statement date and ends the 240th day after HMNH provides the first post discharge billing statement.
- *Essential Living Expenses* – Expenses for any of the following: rent or house payments and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support,

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transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

- *Extraordinary Collection Actions* - Actions taken by HMNH against an individual related to obtaining payment of a bill for health care services provided by HMNH that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer reporting credit agencies or credit bureaus. Specific guidelines related to wage garnishments and noticing or conducting the sale of a patient's primary residence are provided in California law. Filing a claim in a bankruptcy proceeding is not deemed to be an Extraordinary Collection Action.
- *FPL* – Federal Poverty Level for the current year can be obtained from the following website: <https://aspe.hhs.gov/poverty-guidelines>
- *Extended Payment Plan* or *EPP* – A plan negotiated between a patient and HMNH to allow payment of a discounted price over time.
- *Gross Charge* - An established price, listed on HMNH's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any contractual allowances, discounts or deductions.
- *Household Unit* or *Family* - For patients 18 years of age and older, the Household Unit or Family includes the patient's spouse, registered domestic partner, and dependent children under 21 years of age whether living at home or not. For patients under 18 years of age, the family includes the patient's parent, caretaker relatives, and other children (under 21 years of age) of the parent or caretaker relative.
- *Income* - Income includes salary and wages, interest income, dividend income, workers compensation, disability payments, unemployment compensation, business income, farm income, rentals and royalties, inheritance, strike benefits, and alimony payments. Income is also defined as payments from the state for legal guardianship or custody.
- *Notification Period* – The Notification Period is defined as the period during which HMNH must notify an individual about its financial assistance policy in order to have been deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Notification Period begins the first date that an episode of care is provided and ends the 120th day of the first post-discharge billing statement.

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- *Plain Language Summary* - A statement written in clear, concise and easy to understand language notifying individuals that HMNH offers a financial assistance program and describing the program.
- *Uninsured* - A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of workers compensation, automobile insurance or other insurance or other source as determined and documented by HMNH.
- *Under-insured* - Annual out-of-pocket costs incurred by the patient at HMNH that exceed 10 percent of the patient's Family Income in the prior 12 months or annual out-of-pocket medical expenses that exceed 10 percent of the patient's Family Income, if the patient provides documentation of the patient's medical expenses paid by patient or the patient's Family in the prior 12 months.

PROCEDURE

Communication of Financial Assistance Policy to the Public

At each patient registration/admission interaction, and in all oral communications regarding the amount due that occurs during the Notification Period, HMNH shall advise the patient of the availability of HMNH's FAP, where to obtain additional information about eligibility, and how to apply. Such communication shall be documented in the patient account. In addition, all public areas of HMNH, including at a minimum, points of check-in/registration, the admissions office, as well as patient waiting areas for the main HMNH building, the emergency department and all of HMNH's outpatient locations (including observation units), shall have written paper materials regarding the FAP and such information shall be included in every inpatient admission guide.

All hospital postings shall use a white background and black text, use paper that is no smaller than 11" x 17", use a Sans Serif font, and meet other font and language requirements as noted within this policy.

All hospital documents provided or made available to a patient under the Act shall comply with the following accessibility requirements:

- Be designed and presented in a way that is easy to read and understand by a patient.
- Use a Sans Serif font in at least 12-point size, with section headings in a larger font size or bold/underlined font style to distinguish different sections of the document.
- Use plain, straightforward language that avoids technical jargon.
- Meet the language requirements outlined in Health and Safety Code section 127410(a).

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Applications shall be located in a conspicuous place easily viewable and accessible by patients.

HMNH's full financial assistance policy, along with a Plain Language Summary (see Appendix A) shall be available on HMNH's website with an ability to download and print the financial assistance application without any special hardware or software. The Plain Language Summary must include the physical location within HMNH where patients can obtain a copy of the financial assistance policy and application, as well as the contact information of the specific office or department of HMNH that can provide assistance with the financial assistance process. HMNH shall translate financial assistance program documents, including the full financial assistance policy and applications, into Spanish, as well as any other language that is the primary language of at least 5% of HMNH's patients.

Conspicuous notice of financial assistance availability shall be noted on every patient billing statement sent out from HMNH, which shall include notice about and how to get a copy of the FAP policy.

Written notice shall include a description of any Extraordinary Collection Actions that HMNH or its collection agencies intend to initiate and a statement that nonprofit credit counseling services may be available in the area. Efforts are deemed reasonable if HMNH notifies the patient about its FAP as described above, and follows the requirements for incomplete and complete financial assistance applications described in the Review and Approval section below. Written notification shall be deemed to have been provided at the date when mailed.

HMNH's FAP shall be widely publicized within the community in a manner that will reasonably reach those who are most likely to require financial assistance. This shall generally be accomplished by information about the program being posted on HMNH's web site, and at the local Federally Qualified Health Center and clinics within our community serving the uninsured/underinsured patients. In addition, information about HMNH's FAP shall be displayed (in both English and Spanish) in a conspicuous public display throughout all HMNH locations where visitors are likely to see it. Written materials about our financial assistance program shall include non-discrimination language as appropriate.

All notices will also include the following statement:

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

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Application Process

Once a patient initiates the application process, HMNH will be responsive to inquiries and offer the assistance of a financial counselor. If a patient provides HMNH with his or her contact information in connection with a financial assistance application, HMNH will follow up with the patient throughout the Application Period (as defined above) to encourage the patient to complete the application in full.

If a financial assistance application is received during the Application Period and deemed incomplete, a written notice to the patient (or guarantor) will be sent within 15 days of receipt of the incomplete application requesting that the missing information be returned within 30 days of the date of the notice. Such notice shall include contact information for the facility or department that can provide assistance with the financial assistance process, a copy of the Plain Language Summary, and information about potential Extraordinary Collection Actions HMNH or its credit agencies may initiate. Any Extraordinary Collection Actions in progress at the time an incomplete application is received must be suspended. Such collections may be initiated or resumed if a completed application is not received or after a request for additional information is not received after 30 days of notification. The Patient Financial Services (PFS) and Patient Access departments will create a tracking document to monitor all applications received.

As discussed below in the Verification of Information Provided section, HMNH may waive the requirement to submit a complete application if HMNH obtains certain other information predictive of the patient's ability to pay and uses that information to determine that the patient is eligible for financial assistance. The basis for any predictive determination shall be documented in the billing system.

HMNH must accept and process a financial assistance application during the Application Period.

Eligibility Requirements

Financial assistance is provided on a sliding scale basis (see Appendix C), based on the following eligibility criteria:

- Individual or household unit income - up to 400% of the FPL. Employment status shall be considered when determining income levels. Prior income levels may not meet the established poverty level guidelines; however, recent unemployment shall be considered when evaluating the current source of income.

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- Individual or household unit net worth - up to \$250,000 (excluding net worth in primary homes of up to \$500,000 and retirement or deferred compensation plans; disregard the first \$10,000 of a person's monetary assets (i.e., cash and investments) and half of monetary assets thereafter). When reviewing net worth, other financial obligations such as high medical bills should be considered. Patients with high net worth that would otherwise disqualify them for financial assistance may be considered for eligibility if they have, for example, uninsured catastrophic health care costs that would significantly reduce their net worth. High medical costs shall mean:
 - i Annual out-of-pocket costs incurred by a patient at HMNH that exceed the lesser of 10% of the patient's current Family Income or Family Income in the prior 12 months;
 - ii Annual out-of-pocket medical expenses that exceed 10% of the patient's Family Income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's Family in the prior 12 months.
- Self-pay patients admitted through the Emergency Department with insufficient information provided to fully evaluate financial assistance and eligibility tests, for whom the ability to pay cannot be reliably determined, will be classified as charity. If information becomes available later that would disqualify the patient from meeting the financial assistance criteria, then the patient account will be reclassified to the appropriate payer class.
- Patients who presumptively qualify for Medi-Cal, but where HMNH does not receive payment for their entire stay are eligible for charity care for denied stays, denied days of care, and non-covered services. These denials and any lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity. These patients are receiving the service, and they presumptively do not have the ability to pay for it. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/deductibles, for which Medi-Cal does not make payment, and Medicare does not ultimately provide bad debt reimbursement will also be included as charity. These patients are receiving a service for which a portion of the resulting bill is not being reimbursed.
- Trauma services rendered for patient medical conditions meeting the definition of billable trauma care, per our trauma care agreements with the County of Los Angeles and the State of California, will be classified as charity care. These patients will not be billed for their services.

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- Patients who are eligible for government sponsored, low-income assistance programs (i.e., Medi-Cal, out of state Medicaid, California Children's Services and any other applicable Federal, State or local low-income program) are presumed to be indigent. Therefore, such patients may be considered as presumptively eligible under the FAP when payment is not made by the governmental program. Rationale for such presumptive determination shall be documented in the patient account.

Financial assistance is available to all individuals regardless of where they live for medically necessary services; this does not include cosmetic surgery or other cosmetic services. All services performed within the hospital are presumed to be medically necessary unless the hospital provides an attestation signed by the provider who referred the patient or by the supervising health care provider for the services that the hospital services were not medically necessary. Financial assistance eligibility for medical necessity cannot be denied unless such signed attestation is obtained. An attestation signed by the referring provider will be provided to the patient for all cosmetic services stating that services were not medically necessary.

Guidelines for determining eligibility for financial assistance shall be applied consistently. HMNH shall not discriminate against patients applying for financial assistance based on race, color, creed, national origin, sex, age, or disability. In determining a patient's eligibility for financial assistance, HMNH's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange. Patients can also obtain information for the Covered California Health Insurance Exchange through their website at coveredca.com and can obtain further health consumer assistance from Health Consumer Alliance whose website is healthconsumer.org.

The Financial Assistance Application Form (see form in Appendix B) shall be completed for all requests for financial assistance (other than if a presumptive determination as described in this policy is made), and be submitted to a financial counselor. All requests for financial assistance must be signed by either the patient or authorized patient representative attesting that the information provided on the application is true and accurate. When possible, HMNH shall screen each uninsured patient for eligibility for financial assistance.

Partial financial assistance provided under this policy is considered partial charity care.

Verification of Information Provided

Data used to determine eligibility for financial assistance should be verified to the extent practical in relation to the amount of financial assistance involved and the significance of an

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element of information in the overall determination. In all cases, the minimum verification shall include:

- Income, by reviewing sources such as a W-2, recent pay stub showing year-to-date totals and/or income tax returns as well as unemployment statements, if applicable.
- An individual's net worth, by reviewing applicable supporting documentation (bank statements, investment statements, loan documents).

Except for patients with Medicare coverage, submission of a Financial Assistance Application Form and related required supporting documentation described above may be waived in lieu of information HMNH obtains through use of technology tools or other methods of presumptive assumptions as predictive measures of a patient's ability to pay and financial status. See discussion in the Eligibility Requirements section above. Financial assistance may not be denied based on information that is not specifically listed as required in the Financial Assistance Application Form.

Extended Payment Plans:

If a patient qualifies for financial assistance under this policy, the patient may elect to pay any amounts the patient is financially responsible for, after any financial assistance discounts and charge limitations have been applied, in accordance with this policy based on the payment plan program offered by HMNH. In the event that such program does not meet the patient's needs, HMNH will discuss with the patient other payment options, taking into consideration the patient's family income and essential living expenses. If HMNH and the patient cannot agree on a payment plan, the patient's monthly payments will be limited to no more than 10% of the patient's Household Unit Income for a month, excluding deductions for Essential Living Expenses. HMNH cannot undertake any Extraordinary Collection Actions while it is in the process of establishing an extended payment plan or to settle an outstanding bill, or if the patient is making regular partial payments of a reasonable amount as solely determined by HMNH.

Enrollment in an extended payment plan can occur in person or over the phone at any point in the revenue cycle, during pre-registration, registration, discharge, billing and follow-up.

In the event that a patient that qualifies for financial assistance defaults on an amount due under a payment plan (patient fails to make all consecutive payments due during a 90-day period), the patient has one opportunity to renegotiate their extended payment plan before HMNH may declare the payment plan inoperative and begin collection activities. More specifically, HMNH must make a reasonable attempt to contact the patient by telephone and to give notice in writing that the payment plan may become inoperative, and of the opportunity to renegotiate the payment plan.

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Review and Approval:

Financial assistance must be documented on the Financial Assistance Application Form and shall be approved by the Director or Manager of PFS per policy guidelines. Documentation of receipt, review and approval of the Financial Assistance Application Form shall be made by the financial counselors or PFS.

At the time a decision is made for the approval or denial of an account for financial assistance, a letter shall be sent to the patient or responsible party as notification of the decision made. The letter, which generally shall be sent within 30 days of receiving the Financial Assistance Application Form, should be typewritten and should include the following information:

- Patient name
- Account number(s) for HMNH account
- A clear statement of HMNH's determination of the patient's eligibility for financial assistance
- Current outstanding balance of the account(s)
- Any balance which will be due on the account (if only a portion of the account is covered by financial assistance)
- Detail of arrangements to pay for any remaining balance on the account after financial assistance is provided, including a reasonable payment plan, if applicable
- If the patient was denied eligibility for financial assistance, a clear statement explaining why the patient was denied
- Appeal process, including the HMNH office, contact name, and contact information where the patient may appeal HMNH's decision.
- Information on the hospital bill complaint program, as indicated above; and,
- Information on the Health Consumer Alliance, including the following statement:
 "There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information."

Upon approval of a financial assistance request, HMNH shall:

- If any amount is due from patient, provide a billing statement to the patient showing the amount due, how the AGB was determined, and how the amount due was arrived at;
- Include all patient due amounts covered by the FAP in the approval.
- Refund any patient payments per the separate patient refund policy once financial assistance is granted; and
- Take reasonable measures to vacate or reverse any Extraordinary Collection Actions, such as lifting a lien and removing adverse information on credit reports.

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Approval of financial assistance and application of any AGB charge limitation will be denied if Medi-Cal or other health and welfare eligibility application is refused by patient, if HMNH reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with HMNH in reviewing affordable insurance coverage options offered through the Covered California Health Insurance Exchange. If the patient chooses not to purchase insurance coverage through the Covered California Health Insurance Exchange and does not qualify for Medi-Cal, then the patient will be required to submit a Financial Assistance Application Form. Assignment to HMNH of all insurance payments, including liability settlements, is required, up to the amount of Gross Charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting reevaluation (see appeal form in Appendix D). The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred to and reviewed by the Director of PFS within thirty (30) days of being received. If the Director of PFS feels additional input is needed in making a determination, the Chief Financial Officer will be asked to review and assist with the determination.

If subsequent to review and determination of financial assistance, it is found that the information relied on was in error, the following shall occur:

- If the corrected information in a prior denial of financial assistance now qualifies the patient for financial assistance, the patient will be notified that they are now eligible for financial assistance and the account(s) will be processed as described above.
- If the corrected information in a prior granting of financial assistance now disqualifies the patient for financial assistance, the patient will be notified that they are not eligible for financial assistance and payment is expected on their account(s).

The completed Financial Assistance Application Form and all related supporting documentation will be scanned into the patient's accounts in the patient billing system. Notwithstanding the above, HMNH must accept and process a financial assistance application during the Application Period.

Extraordinary Collection Actions:

HMNH shall not undertake an Extraordinary Collection Action at any time prior to 180 days after HMNH provides the first post discharge billing statement if HMNH is aware that the patient lacks coverage or if the patient has provided information that indicates that he or she may be a patient with high medical costs.

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HMNH may initiate or resume Extraordinary Collection Actions against an individual who has submitted an incomplete financial assistance application and who has not provided the missing information necessary to complete the application any earlier than the later of:

- 30 days after HMNH provides written notice that the additional information is required, or
- The last day of the Application Period

Accounting for and Tracking Financial Assistance Data:

Approved financial assistance, along with any write-offs as a result of applying AGB amounts, shall be classified and recorded as charity care, because, by definition, charity care is "demonstrated inability to pay". The amount of charity care provided will be reported separately in the monthly financial statements.

PFS and Patient Access will be responsible for maintaining the following data monthly:

- Number of applications for financial assistance received
- Number of individuals granted financial assistance
- Number of appeals received
- Percentage of appeals reviewed with a reversed decision; and
- Number of completed applications not processed within 30 days of receipt

Finance shall calculate the cost associated with the services approved for financial assistance for disclosure in the annual financial statements and tax return.

Frequency of Re-Evaluation of Eligibility:

Once a patient has been approved for financial assistance, PFS will rely upon that approval for subsequent services rendered by HMNH from initial approval date for up to six months, except as follows:

- There is a change in patient financial status as described below. It is the responsibility of the patient/guarantor to advise HMNH of such change. After six months, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.
- In HMNH's reasonable estimation, patient can afford to purchase insurance coverage through the Covered California Health Insurance Exchange and the period for which such coverage can be obtained is in less than six months from the time financial assistance is granted by HMNH and it is during an open enrollment period.

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If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, HMNH will not reverse the amount of financial assistance granted.

Changes in Patient Financial Status:

Patients may have unexpected changes to their ability to pay that occur after the time service is rendered and after either a payment plan or financial assistance has been granted. If a patient agreed to a payment plan (see separate Patient Payment Plans policy) that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job or had some other financial hardship occur and became unable to pay under the plan, the patient may apply for financial assistance under the guidelines of this policy.

Alternatively, if a patient who was granted financial assistance but subsequently experiences a positive change to his or her ability to pay for the services rendered, HMNH may bill the patient for the services rendered and advise the patient of their change in status.

Charge Limitation:

HMNH will utilize AGB via the Prospective Medicare methodology for inpatient and outpatient accounts when determining patient liability, for individuals who qualify for financial assistance, or uninsured individuals who do not qualify for financial assistance. Specifically, HMNH will limit charges for a particular service to the AGB, which will be equal to the amount that would be paid for the services if the patient were Medicare-eligible. The billed amount will not exceed the AGB or gross charges.

The billing statement to a patient may state HMNH's standard Gross Charges but must show a write-off to get to the AGB. The difference between HMNH's standard Gross Charges and the AGB or financial assistance discount amounts, will be accounted for as a charity care write-off.

This policy is not required to be approved by the Board each year for updates to the AGB. The Director of PFS is responsible for ensuring that the AGB is updated annually.

Medi-Cal and Medicaid Coverage:

Medi-Cal Share of Cost or Medicaid copays not paid at the time of service will be billed to the patient. If unable to collect the copays by the end of the Application Period, the copays will be written off as a charity write-off based on presumptive eligibility. Patients who have Medicaid coverage and have balances due for service dates up to six months prior to the effective date of their coverage will be granted 100% financial assistance on such balances without further review or documentation from the patient based on presumptive inability to pay.

For current policy refer to Policy Management System
Official copy at <https://henrymayo.policytech.com>
(Department Owner: Administration) (Reference # 9154)

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Other:

Generally, the determination that a patient stay qualifies for financial assistance will be made upon pre-admission, admission or as soon as possible thereafter. A financial counselor is available to assist patients with settlement of their accounts including applications for financial assistance, government-sponsored programs and referral to outside resources. However, in some cases qualification for financial assistance may be made after rendering services and in some circumstances, even after rendering of the bill. Collection efforts, including the use of a collection agency, are part of the information collection process and can appropriately result in identification of eligibility for financial assistance.

For financial assistance granted to patients with Medicare coverage meeting the IRS criteria, but not meeting CMS requirements for charity care, a transaction non-charge procedure code of "CMS IRS" shall be used in the billing system. For all other patient financial assistance granted, the code of "CMS CHAR" shall be used.

As required by California State law, HMNH provides the Department of Health Care Access (formerly the Office of Statewide Health Planning and Development (OSHPD)) its Financial Assistance Program Policy and application forms, as well as its debt collection policy at least biannually on January 1, or when there is a significant change. If there has been no significant change since the information was previously provided, HMNH notifies the Department of Health Care Access of the lack of change.

Emergency physicians who provide emergency medical services at HMNH are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the FPL. The HMNH FAP does not include professional services provided by our medical staff.

A list of HMNH physicians is available at <https://www.henrymayo.com/physicians/>.

To assist patients in determining HMNH pricing, HMNH has provided a pricing estimate tool that can be located at [Henry Mayo Newhall Hospital \(patientsimple.com\)](https://patientsimple.com)

Any patient without health coverage shall be provided with a written estimate of the amount HMNH will require the patient to pay for health care services, procedures, and supplies that are reasonably expected to be provided to the patient by HMNH, based upon the average length of stay and services provided for the patient's diagnosis. This estimate may be provided during normal business hours. In addition to the estimate, the patient shall be provided information about HMNH's financial assistance policy and Financial Counselor contact information to obtain further information about this policy. This written estimate requirement does not apply to ER patients.

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REFERENCES:

HealthCare Financial Management Association Principles and Practices Board Statement 15,
"Valuation and Financial Statement Presentation of Charity Care and Bad Debts
American Hospital Association Hospital Billing and Collection Practices Statement of
Principles and Guidelines May 5, 2012
Patient Protection and Affordable Care Act
IRS Requirements for 501(c) (3) Hospitals under the Affordable Care Act – Section 501(r)
Affordable Care Act Section 1557
California AB-774 Hospitals Fair Pricing Policies
California Health & Safety Code Section 127425
California AB 532
Department of Health Care Access and Information, Title 22, California Code of Regulations,
Section 11349.3

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APPENDIX A

PLAIN LANGUAGE SUMMARY OF HMNH FINANCIAL ASSISTANCE POLICY

As a non-profit organization, Henry Mayo Newhall Hospital (“HMNH”) provides financial assistance to uninsured and under-insured patients that may not have sufficient financial resources to pay for services.

HMNH’s financial assistance does *not* include the cost of professional services provided by our medical staff. However, emergency physicians who provide emergency medical services at HMNH are required by law to provide discounts to uninsured or underinsured patients.

A list of HMNH’s medical staff members is available at <https://www.henrymayo.com/physicians/>

Financial Assistance Eligibility Requirements

Eligibility for financial assistance is both income and asset based, using a sliding scale. Income level eligibility is up to 400% of the federal poverty level. Asset level eligibility is up to \$250,000 (excluding net worth in primary homes of up to \$500,000 and retirement or deferred compensation plans).

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, HMNH's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange.

Application Process

Financial Assistance Applications may be requested:

- (1) In person at Patient Access Services, Main Admitting
- (2) by phone at (661)200-1050 or (661)200-1110
- (3) [FAP Application English](#) [FAP Application English](#) or [FAP Application Spanish](#) [FAP Application Spanish](#) or
- (4) by mail to Henry Mayo Newhall Hospital, 23845 McBean Pkwy, Valencia, CA 91355: Attn: Patient Financial Services. The Financial Assistance Policy (“FAP”) may be obtained at [https://www.henrymayo.com/documents/POLICY-with-Eng-application\[1\].pdf](https://www.henrymayo.com/documents/POLICY-with-Eng-application[1].pdf).

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The application specifies certain information that is required to be submitted with the application. This information may be independently verified by HMNH to ensure its completeness and accuracy. If a financial assistance application is received within 240 days of HMNH's initial billing for a service and is deemed incomplete, a written notice to the patient/guarantor will be sent within 15 days of receipt of the incomplete application requesting the missing information be returned within 30 days of the date of the notice. Notice of approval or denial of an application shall generally be sent to the patient within 30 days of receipt of application.

Approval of financial assistance will be denied if Medicaid or other health and welfare eligibility application is refused by the patient, if HMNH reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with HMNH in reviewing affordable insurance coverage options offered through Covered California Health Insurance Exchange. If the patient chooses not to purchase insurance coverage through the Covered California Health Insurance

Exchange and does not qualify for Medicaid, then the patient will be required to submit a Financial Assistance Application Form. Assignment to HMNH of all insurance payments, including liability settlements, is required up to the amount of gross charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting re-evaluation. The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred and reviewed by the Director of Patient Financial Services within thirty (30) days of being received. If the Director of Patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer will be asked to review and assist with the determination.

Period that Approved Financial Assistance Will Be Provided

Once a patient has been approved for financial assistance, the patient will be deemed to have approval for services rendered by HMNH for six months subsequent to initial approval date, except as follows:

- There is a change in financial status. After six months, the patient will be required to reapply for financial assistance, and the appropriate verifications of information will need to be made.
- In HMNH's reasonable estimation, patient can afford to purchase insurance coverage through the Covered California Health Insurance Exchange and the period for which such coverage can be obtained is less than six months from the time financial assistance is granted by HMNH, only the timeframe that is non-covered will be approved.

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If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, HMNH will not reverse the amount of financial assistance granted.

Charge Limitation

HMNH will utilize the Prospective Medicare methodology to determine the Amounts Generally Billed (AGB) for inpatient and outpatient accounts when determining patient liability for individuals who qualify for financial assistance. The billed amount will not exceed the AGB.

This document (The Plain Language Summary) summarizes the HMNH FAP and is not intended to represent a complete explanation of the FAP. Our financial counselors can be reached Monday through Friday from 8:00 am to 5:00 pm at (661) 200-1050 and are available to assist patients with the financial assistance application process.

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APPENDIX B

HENRY MAYO NEWHALL HOSPITAL FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date:

Patient Name
Patient Address
City, State, Zip

Patient Name:
Patient Account:
Date of Service:

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Thank you for choosing Henry Mayo Newhall Hospital (HMNH) for your health care needs, where we strive to improve the health of our community through compassion and excellence in health care services. You may be eligible for financial assistance to assist you in paying health care services you will or have received at HMNH. This financial assistance applies to your hospital bill only, and does NOT apply to bills you may receive from your physicians or surgeons, although if this application is approved, some providers may extend a full or partial courtesy discount based upon the hospital acceptance determination letter.

Enclosed, please find an application for financial assistance which must be filled out in its entirety, proper documentation enclosed, signed and dated so that the review process may commence.

The application and required information are provided below. Please submit the requested documents to Patient Access Services in person located in the main admitting area of the hospital, or by mail to:

Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy Valencia,
CA 91355.
Attn: Patient Financial Services

Financial Assistance Program

You will receive a determination of Eligibility for Financial Assistance letter within thirty days after we receive a completed application with appropriate supporting documents. Completion of this application is not a guarantee of eligibility or qualification for financial assistance or any other program. Financial assistance is considered after all possible sources of potential payment (for example, health insurance, Medicare, Medicaid, liability insurance) have been exhausted. Failure to provide requested documents may result in denial of the application.

Help Paying Your Bill

There are fee consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

If you need any further information or assistance in completing the application, please make an appointment to come to the hospital at Patient Access Services, Main Admitting, or call 661-200-1050, Monday through Friday, 8:00 AM through 5:00 PM and a representative will assist you. For more information about the Financial Assistance Program, you may visit our website at: [https://www.henrymayo.com/documents/POLICY-with-Eng-application\[1\].pdf](https://www.henrymayo.com/documents/POLICY-with-Eng-application[1].pdf)

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

(Signature line)

(Printed name of financial counselor)

Financial Counselor

Financial Assistance Program



Financial Assistance Application

Henry Mayo Newhall Hospital's Financial Assistance Program provides financial assistance to patients with medically necessary health care needs who are low-income, uninsured or underinsured, ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete this form and provide the most recent supporting documentation: Income tax filings (which document the patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed), 2 most recent bank statements, and 2 pay check stubs within a 6-month period before or after the patient is billed by the Hospital, or in the case of pre-service, when the financial assistance application is submitted.

Please submit the completed forms and supporting documentation to Patient Financial Services using enclosed envelope.

Patient Name _____ Account Number _____
 Address _____ Phone number _____
 _____ Social Security
 # _____

Date of Birth ___/___/___ Sex ___ M=Male F=Female Do you own a home? Yes () No ()

Number of dependents filed on tax return: _____ Do you own other property? Yes () No ()

List Dependents: Do you own automobiles? Yes () No ()

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Household Banking Information Name _____ Balance _____
 Business Banking Information Name _____ Balance _____

Wages/Income Monthly Annually
 Total Household Wages* _____

* Wages should include income from employment, self-employment, public assistance, social security, unemployment benefits, retirement/pension, alimony, child support, etc.

Financial Assistance Program

<u>Expenses</u>	Monthly	Annually
Mortgage / Rent	_____	_____
Utilities	_____	_____
Auto Loans	_____	_____
Hospital Bills	_____	_____
Other Expenses**	_____	_____

** Include credit card payments, food, telephone, gasoline, child care expenses, etc.

My signature attests that the information I have provided on this form and the additional supporting documentation is accurate and true to the best of my knowledge.

_____	_____	_____
Print Name	Signature	Date

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Financial Assistance Program

APPENDIX C

SLIDING SCALE FINANCIAL ASSISTANCE

Income / Net Asset Levels	Discount from Total Charges							
	< \$1,000	\$1,000 - \$2,500	\$2,501 - \$5,000	\$5,001 - \$10,000	\$10,001- \$25,000	\$25,001- \$50,000	\$50,001- \$100,000	>\$100,000
0 - 200% FPL Net assets:								
<\$100,000	100%	100%	100%	100%	100%	100%	100%	100%
\$100,000 - \$150,000	85%	85%	85%	85%	100%	100%	100%	100%
\$150,001 - 250,000	75%	75%	75%	75%	75%	100%	100%	100%
201 - 400% FPL Net assets:								
<\$100,000	75%	75%	75%	100%	100%	100%	100%	100%
\$100,000 - \$150,000	75%	75%	75%	75%	75%	75%	75%	75%
\$150,001 - 250,000	50%	50%	50%	50%	50%	50%	50%	50%

NOTE: The AGB is the maximum amount that can be collected from patients that qualify for financial assistance or as otherwise allowed under this policy, regardless of the percentages shown above.

The FPL for the current year can be obtained from the following website:

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

The total charges to be used for purposes of determining the initial level of financial assistance to be provided shall be the total charges outstanding and due from the patient at the time the application for financial assistance is received. This could include more than one bill.

Financial Assistance Program**APPENDIX D****HENRY MAYO NEWHALL HOSPITAL
FINANCIAL ASSISTANCE APPEAL FORM
REQUEST FOR RE-EVALUATION ON FINANCIAL ASSISTANCE DENIAL**

General Information Date:

Name of Patient:

Date of Birth:

Address:

City, State, Zip Code:

Phone Number:

Guarantor Name (if different than patient): Relationship:

Date of Birth:

Guarantor Address:

City, State, zip Code:

Phone Number:

Please list reason of your request to appeal your Financial Assistance Denial (appeal letter must include supporting documents that may prove inability to pay that was not part of the initial consideration):

Please submit your appeal letter and supporting documents in person or by mail

Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy
Valencia, CA 91355
Attn: Patient Financial Services

You will receive a determination of your request to re-evaluate the denial decision of your financial assistance application within thirty days after receiving your appeal letter with appropriate supporting documents.

Help Paying Your Bill

There are fee consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

Financial Assistance Program

If you have any questions, please contact one of our Patient Financial Services representatives at (661) 200-1112 or our Director of Patient Financial Services at (661) 200-1111. Thank you for choosing HMNH as your health care provider.

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.