# Community Health System Financial Assistance Policy #24817

**Effective: 12/16/2024 Edited 2/11/2026 Next Review: 12/16/2027**
**Owner: Vice President of Revenue Cycle**

## I. PURPOSE

A. To define the forms of Financial Assistance available to patients.
B. To describe the eligibility criteria for each form of Financial Assistance.
C. To establish the procedure that Patients must follow in applying for Financial Assistance.
D. To establish the process that Community Medical Centers (CMC) will follow in reviewing applications for Financial Assistance.
E. To provide a means of review in the event of a dispute over a Financial Assistance determination.
F. To provide administrative and accounting guidelines to assist with identifying, classifying, and reporting Financial Assistance.
G. To establish the process that Patients must follow to request an estimate of their financial responsibility for services, and the process CMC shall follow to provide Patients with these estimates.

## II. DEFINITIONS

A. Financial Assistance: Full Charity Care, Discount Payment High Medical Costs Charity Care, Bankruptcy, and Uninsured Discounts, as these terms are defined below. Guidelines for determining when Financial Assistance should be provided to patients are set forth in this policy.
B. Community Medical Centers Licensed Hospital Facilities: Community Regional Medical Center, including its remote location of Fresno Heart & Surgical Hospital, and Clovis Community Medical Center.
C. Patient: An individual who received services at CMC.
D. Uninsured Patients: A Patient who has no third-party source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third-party liability. Patients whose benefits under insurance have been exhausted prior to the admission will also be considered uninsured for purposes of this policy.
E. Insured Patients: A Patient who has a third-party source of payment which has paid for a portion of their medical expenses.
F. Covered Service(s): Covered Services for Full Charity Care, Discount Payment, High Medical Costs Charity Care, Bankruptcy, and Uninsured Discounts are all inpatient services, emergency care and other medically necessary care provided by CMC.
G. Full Charity Care: Full Charity Care is free care, which means it is a complete write-off of CMC's undiscounted charges for Covered Services. Full Charity Care is available to patients:

1. Who are Uninsured, as defined above; and Who have a family income at or below 400% of the Federal Poverty Level (FPL); or
2. Who can provide proof of eligibility and current enrollment in a form acceptable to CMC in one of the following government programs: Medicare Savings Program, CalWORKS, CalFresh (Food Stamps), SSI/SSP, or WIC.

H. Discount Payment: Discount Payment is a partial write-off of CMC's undiscounted charges for Covered Services available to patients:
   1. Who have a family income between 401-450% of the FPL; and
   2. Who are Uninsured, as defined above.
   3. For Discount Payment, CMC shall limit the expected payments for inpatient services to the Medicare inpatient Diagnosis-Related Group (DRG) for the Covered Service(s) provided (or the highest rate CMC would expect in good faith to be paid by a government program in which CMC participates), or for services where there is no established Medicare DRG, an appropriate discounted amount, provided the services are not already discounted.
   4. For Discount Payment for outpatient services, CMC shall limit expected payments to the Medicare fee schedule, or where there is no Medicare fee schedule rate, CMC's undiscounted charges multiplied by CMC's Medicare to cost charge ratio for outpatient services.

I. Bankruptcy: Community Medical Centers will allow Uninsured Patients who are currently in bankruptcy proceedings or whose debts have been discharged in bankruptcy within three (3) months of their last date of service to receive a full write-off of CMC's undiscounted charges for Covered Services.

J. High Medical Costs for Insured Patients Charity Care ("High Medical Costs Charity Care"): A complete write-off of the Patient Responsibility Amount for Covered Services. This discount is available to patients who meet the following criteria:
   1. The Patient is an Insured Patient.
   2. The Patient's family income is less than 400% of the FPL; and
   3. The Patient's, or the Patient's family's out of pocket expenses for Covered Services (incurred at CMC or other providers in the past twelve (12) months,) exceed the lesser of 10% of the Patient's family income or the Patient's family income in the last twelve (12) months. ("High Medical Costs"). Out of pocket expenses include any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

K. Uninsured Discount: A partial write-off of undiscounted charges for patients that meet the following criteria:
   1. The Patient is an Uninsured Patient.
   2. The Patient has not previously negotiated a fee with CMC for the services that are the subject of the current charges.
   3. The Patient does not have medical insurance provided by an insurer outside of the United States; and

4. The Patient does not qualify for other types of Charity Care outlined in this policy or the Patient has not returned a Financial Assistance Application for other types of Charity Care outlined in this policy.

L. Medicare Denied Services: Income-eligible Medicare Patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services.

M. Medi-Cal Denied Services: Income-eligible Medi-Cal Patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services. Patients may receive Financial Assistance for their Medi-Cal share of cost.

N. Emergency Physician: A physician who provides emergency medical services in a hospital.

O. Federal Poverty Level (FPL): The measure of income level that is published annually by the United States Department of Health and Human Services (HHS) and is used by CMC for determining eligibility for Financial Assistance.

P. Patient Responsibility Amount: The amount that an Insured Patient is responsible to pay out-of-pocket after the Patient's third-party coverage has determined the amount of the Patient's benefits.

Q. Patient's Family: The Patient's Family shall be determined as follows:
   1. Adult Patients: For Patients 18 years of age or older, the Patient's Family includes their spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled (consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.
   2. Minor Patients: For Patients under 18 years of age, or a dependent child 18 to 20 years of age, the Patient's Family includes their parents, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled (consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

R. Plain Language Summary of the Financial Assistance Policy: A written statement that notifies a Patient that CMC offers financial assistance and provides the following additional information in language that is clear, concise, and easy to understand, including but not limited to:
   1. A brief description of the eligibility requirements, which advises the Patient of the maximum gross monthly household income per family size to qualify for Financial Assistance, as well as the assistance offered.
   2. A summary of how to apply for assistance.
   3. Contact information, including telephone number, website and physical location of the hospital department that can provide information about CMC's policy and assistance with the application process.
   4. The internet address for the Health Consumer Alliance (https://healthconsumer.org).
   5. An explanation that there are organizations that can help the Patient understand the billing and payment process.
   6. Information regarding Covered California and Medi-Cal presumptive eligibility; and
   7. The internet address for CMC's list of shoppable services, under 45 CFR § 180.60.

S. Reasonable Payment Plan: Monthly payments that are not more than 10 percent of a Patient's family income for a month, excluding deductions for essential living expenses.

Essential living expenses means, for purposes of this subdivision, expenses for all of the following, as applicable to the Patient's individual circumstances: 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, the availability of a health savings account held by the Patient or Patient's Family, and other extraordinary expenses.

T. Tortfeasor: A person who commits a tort (civil wrong), intentionally or through negligence.

U. Extraordinary Collection Action: Any of the following actions to collect a debt:
   1. Deferring or denying or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under CMC's Financial Assistance Policy.
   2. Actions that require a legal or judicial process, including but not limited to:
      i. Attaching or seizing an individual's bank account or any other personal property.
      ii. Commencing a civil action against an individual.
      iii. Causing an individual's arrest.
      iv. Causing an individual to be subject to a writ of body attachment.
      v. Garnishing an individual's wages.

V. Financially Qualified Patient: (Also known as a FAP-eligible Patient in IRS rules and regulations): A Patient who, according to CMC's Financial Assistance Policy, is a Patient for whom both of the following are true:
   1. The Patient is an Uninsured Patient or a Patient with High Medical Costs; and
   2. The Patient has a family income that does not exceed 400% of the FPL.

W. Notice of Rights: A clear and conspicuous notice drafted by CMC that includes all the items required by California Health 8: Safety Code 127420(b)(1) -(5).

## III. POLICY

A. Community Medical Centers shall provide Financial Assistance, consistent with this policy, in the form of discounted medical care, to patients who are eligible under the terms of this policy.

B. Community Medical Centers shall provide Patients with an application enabling them to apply for Financial Assistance if they indicate at any time the financial inability to pay a bill for hospital services or if CMC is aware their household income is less than 400% FPL.

C. Community Medical Centers shall provide low-income Patients and Patients with High Medical Costs information required by law regarding their estimated financial responsibility for services and the availability of Financial Assistance and discounts, consistent with this policy.

D. Financially Qualified Patients who can establish eligibility for Financial Assistance in accordance with this policy by providing insurance status and income information shall receive Financial Assistance. Financially Qualified Patients who do not apply for Financial Assistance but are uninsured may qualify for Full Charity Care based on demographic analysis performed by CMC.

E. This policy applies to all CMC Licensed Hospital Facilities. Unless otherwise specified, this policy does not apply to physicians or other medical providers whose services are not

included in CMC's bill. In California, an Emergency Physician who provides emergency medical services in a hospital is required to provide discounts to Uninsured Patients or Patients with high medical costs who are at or below 400% of the FPL.

## IV. PROCEDURE

A. Eligibility

1. Eligibility Criteria: During the application process, CMC shall apply the following eligibility criteria for Financial Assistance:

| **Financial Assistance Category** | **Patient Eligibility Criteria** | **Available Discount** |
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| Full Charity Care | a. Patient is an Uninsured Patient; and<br>b. Patient has a family income at or below 400% of the FPL; or<br>c. Patient can provide proof of eligibility and current enrollment in a form acceptable to CMC in one of the following government programs: Medicare Savings Program, CalWORKS, CalFresh (Food Stamps), SSI/SSP, or WIC. | Complete write-off of CMC's undiscounted charges for Covered Services. |
| Discount Payment | a. Patient is an Uninsured Patient; and<br>b. Patient has a family income between 401% and 450% of the FPL. | Discount or partial write-off of CMC's undiscounted charges for Covered Services. For Inpatient Services: CMC shall limit the expected payments to the Medicare inpatient Diagnosis-Related Group (DRG) for the Covered Service(s) provided (or the highest rate CMC would expect in good faith to be paid by a government program in which CMC participates), or for services where there is no established Medicare DRG, an appropriated discounted amount, provided the services are not already |

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| | | discounted. For Outpatient Services, CMC shall limit expected payments to the Medicare fee schedule, or where there is no Medicare fee schedule rate, CMC's undiscounted charges multiplied by CMC's Medicare to cost charge ratio for outpatient services. |
| High Medical Costs Charity Care (Insured Patients) | a. Patient is an Insured Patient.<br>b. Patient's family income is at or below 400% of the FPL.<br>c. Out of pocket expenses for Patient or their Family (incurred at CMC or other providers in the past 12 months) exceeds the lesser of 10% of the Patient's current family income or Patient's family income in the last 12 months. Out of pocket expenses include any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing. | Complete write-off of the Patient Responsibility Amount for Covered Services. |
| Bankruptcy | a. Patient is an Uninsured Patient; and<br>b. Patient is currently in bankruptcy or completed bankruptcy within the last three (3) months of their last date of service at CMC. | Full write-off of CMC's undiscounted charges for Covered Services. |
| Uninsured Discount | a. Patient is an Uninsured Patient; and<br>b. Patient has not previously negotiated a fee with CMC for the services that are the subject of the current | 35% write-off of CMC's undiscounted charges for Covered Services. |

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| | charges; and<br>c. Patient does not have medical insurance provided by an insurer outside of the United States; and<br>d. Patient does not qualify for other types of Charity Care outlined in this policy; or<br>e. Patient has not returned an Application for Financial Assistance for other types of Charity Care outlined in this policy. | |

B. Calculating Patient's family income: To determine a Patient's eligibility for Financial Assistance, CMC shall first calculate the Patient's family income, as follows:
   1. Patient's family income is the annual earnings of the members of the Patient's Family, as defined in Section II.R. above, from the prior twelve (12) months or prior tax year as shown by the recent pay stubs or income tax returns, less payments made for alimony and child support. Monetary assets will not be considered when determining family income. Annual income may be determined by annualizing year-to-date family income.
      i. Calculating family income for Deceased Patients: Deceased Patients with no surviving spouse, may be deemed to have no income for purposes of calculation of Patient's family income. Documentation of income is not required for deceased Patients; however, documentation of estate assets may be required. The surviving spouse of a deceased Patient may apply for Financial Assistance.
      ii. For purposes of calculating the Patient's current family income to determine High Medical Costs, as defined in Section II. K. above, certain situations may be based on three (3) months to determine the Patient's current family income.
   2. Calculating Patient's family income as a Percentage of FPL: After determining a Patient's family income, CMC shall calculate the Patient's family income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the FPL for a family of three is $20,000, and a Patient's family income is $60,000, CMC shall calculate the Patient's family income to be 300% of the FPL. This calculation shall be used to determine whether a Patient meets the criteria for Financial Assistance.
   3. Calculating family income to determine presumptive eligibility for Financial Assistance: If an Uninsured Patient does not request or return a completed Application for Financial Assistance, at no less than 150 days after providing the Patient with a post-discharge billing statement, CMC may screen the Patient for Presumptive Eligibility for Financial Assistance using demographic software of an external service provider. If the demographic software indicates the Patient likely qualifies for Full Charity Care, CMC will provide the Patient with a complete write-off of CMC's undiscounted charges for Covered Services.

4. Proof of family income: Patients shall only be required to provide recent pay stubs or tax returns as proof of income (except in the case of enrollment in government programs, as outlined in this policy).

C. Financial Assistance Exceptions: The following are circumstances in which Financial Assistance may not be available under this policy:
   1. Medi-Cal Patients with Share of Cost: Medi-Cal Patients are eligible for Financial Assistance for the purpose of reducing the amount of Share of Cost owed. Community Medical Centers shall seek to collect these amounts from patients.
   2. 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 may not be eligible for Financial Assistance unless Insured Patient shows good cause for the failure at any point through and including participation in an Extraordinary Collection Action.
   3. Payer Pays Patient Directly: If a Patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the Patient may not be eligible for Financial Assistance for the amounts paid by that payer.
   4. Information Falsification: Community Medical Centers may refuse to award Financial Assistance to patients who falsify information regarding income, household size, or other information in their eligibility application.
   5. Third Party Recoveries: If the Patient receives a financial settlement or judgment from a third-party Tortfeasor that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any Patient account balances and may not be eligible for Financial Assistance.
   6. Professional (Physician) Services: Services of physicians such as anesthesiologists, radiologists, hospitalists, pathologists, etc. are not covered under this policy, though medical debt to such providers will be included in calculating High Medical Costs. Many physicians have charity care policies that allow patients to apply for free or discounted care. Patients should obtain information about a physician's charity care policy directly from their physician.

D. Application Process
   1. Community Medical Centers shall provide the Plain Language Summary of the Financial Assistance Policy and the Application for Financial Assistance when it provides the good faith estimate prior to services.
   2. Community Medical Centers shall make all reasonable efforts to obtain from the Patient or his/her representative, information about whether private or public health insurance may fully or partially cover the charges for care rendered by CMC to Patient. If CMC bills a Patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, CMC shall provide the Patient with a Notice of Rights.
   3. A Patient who indicates at any time, through and including referral for Extraordinary Collections Action, that they are financially unable to pay a bill for hospital services shall

promptly be given the opportunity to have their eligibility for Financial Assistance evaluated by CMC's Patient Financial Services Department. Community Medical Centers shall attempt to contact the Patient by mail and by telephone to attempt to determine if patient's household income is less than 400% of the FPL. If the Patient indicates his/her household income is less than 400% of the FPL, CMC shall notify Patient of availability and potential eligibility for financial assistance and promptly provide an application.

4. To qualify as an Uninsured Patient, the Patient or the Patient's guarantor must verify that he/she is not aware of any right to insurance or government program benefits that would cover or discount the bill.
5. All Patients will be encouraged to investigate their potential eligibility for government program assistance if they have not already done so. Community Medical Centers or its authorized representatives will provide an application for the Medi-Cal program or other government funded programs if the Patient indicates they do not have coverage by a third-party payer or requests Financial Assistance. Community Medical Centers will also attempt to assist Patients in determining whether they are eligible to enroll with plans in the California Health Benefit Exchange (i.e., Covered California). However, application in any of these programs is not required to apply for or receive financial assistance.
6. Patients are required to make every reasonable effort to provide CMC with documentation of income and health benefits coverage. Patients who are insured but fail to provide CMC with necessary insurance and/or income information may be denied Financial Assistance.
7. Patients who wish to apply for Financial Assistance shall use the CMC standardized application form "Application for Financial Assistance".
8. Patients may request assistance with completing the Application for Financial Assistance in person at the Admitting Department of any CMC Licensed Hospital Facilities or over the phone by contacting Patient Financial Services at (559) 459-3939.
9. Copies of the Application for Financial Assistance may also be found by visiting the Admitting Department of any CMC hospital, through the mail, or via the CMC website, (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill).
10. Patients should complete the Application for Financial Assistance as soon as possible after receiving treatment at CMC. Applications received at any time will be considered for acceptance.
11. Patients should mail Applications for Financial Assistance to: Community Medical Centers, Patient Financial Services Department, P.O. Box 1232, Fresno, CA 93715, Attn: Financial Assistance Application.

E. Financial Assistance Determination

1. Community Medical Centers will consider each application for Financial Assistance and grant Financial Assistance when the Patient meets the eligibility criteria set forth in this policy.
2. Information concerning income obtained as part of the eligibility process shall be maintained separately from the files used to collect the debt and shall not be used for

collections activities either by CMC or by any collection agency engaged by CMC, unless independently obtained by CMC or the collection agency.

3. Community Medical Centers will not make Financial Assistance determinations based on information that CMC and any collection agencies acting on its behalf have reason to believe is unreliable, incorrect, or obtained from the Patient under duress or through the use of coercive practices.
4. If a Patient applies or has a pending application for another health coverage program at the same time that he or she applies for Financial Assistance, the application for coverage under another health coverage program shall not preclude the Patient's eligibility for Financial Assistance.
5. Financial Assistance Applications should be reviewed promptly. Community Medical Centers shall complete its determination of eligibility within 45 days of receipt of the application. A determination will be postponed while insurance or other sources of payment are still pending.
6. Once a Financial Assistance determination has been made, a notification will be sent to each applicant advising them of CMC's decision.
7. If a Patient is approved for Financial Assistance under this policy, CMC and any collection agencies acting on its behalf shall take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual, including but not limited to vacating any judgment, lifting any levy or lien on the Patient's property, and removing any adverse information reported to any consumer reporting agency from the individual's credit report that was reported prior to January 1, 2025, after which no reporting to consumer reporting agencies will be made.
8. If a Patient is approved for Financial Assistance under this policy, but after the initial application and approval process it is determined that Patient is ineligible due to a third-party payer, the charges shall be reinstated, and CMC shall pursue the third-party payer to obtain payment on the Patient's account. If it is later determined that the third-party payer is not responsible for payment of the Patient's charges, the Patient's eligibility shall be reinstated without requiring a new Application for Financial Assistance.
9. Once a determination is made that a Patient is eligible for Financial Assistance, the Patient is presumed eligible for Financial Assistance covering all outstanding bills for Covered Services as of the date CMC issues the Notification Form to the Patient, as well as Covered Services for a period of six (6) months following that date. After this six-month period has ended, Patients must re-apply for Financial Assistance.
10. If the Financial Assistance determination creates a credit balance in favor of the Patient, the refund of the credit balance shall be made within thirty (30) days from the date of the Patient's payment and must include interest on the amount of the overpayment from the date of the Patient's payment at the statutory rate (currently 10% per annum) pursuant to Health and Safety Code section 127440. Refunds under this section are not required if: (a) five years or more since the Patient's last payment to CMC or (b) the debt was sold prior to January 1, 2022.

11. If a Patient is determined eligible for Discount Payment, CMC will provide the Patient with a billing statement that indicates the amount the Patient owes and how that amount was determined.
12. 12. Reasonable Payment Plans: Financially Qualified Patients who do not qualify for Full Charity Care shall be eligible for a Reasonable Payment Plan. Community Medical Centers and the Patient shall negotiate the terms of the plan, taking into consideration the Patient's family income and essential living expenses. If CMC and the Patient cannot agree on the Reasonable Payment Plan, CMC shall use the formula described in Section II. T. of this policy to create a Reasonable Payment Plan. Payment plans shall be offered and negotiated per CMC's Billing and Collections Policy

F. Disputes
1. A Patient may seek review of any decision by CMC to deny Financial Assistance by notifying Patient Financial Services of the basis for the dispute and the desired relief within thirty (30) days of the Patient receiving the notice of the circumstances giving rise to the dispute. Patients may submit the dispute orally by calling Patient Financial Services at (559) 459-3939 or in writing by mailing the above information to Community Medical Centers, Patient Financial Services Department, P.O. Box. 1232, Fresno, CA 93715. A designated Patient Financial Services manager shall review the Patient's dispute as soon as possible and inform the Patient of any decision in writing.

G. Availability of Financial Assistance Information
1. Languages: This policy shall be available in the primary language(s) of CMC's Service Area. In addition, all notices and communications required by all federal and state laws and regulations regarding Financial Assistance shall be available and distributed in primary language(s) of CMC's Service Area and in a manner consistent with all applicable federal and state laws and regulations. When CMC has reason to know that a Patient's primary language is not English, all notices/communications provided the Patient and written correspondence to the Patient shall be in the language spoken by the Patient, provided it is one of the Primary Language(s) of CMC's Service Area. For purposes of these policies, a Primary Language of CMC's Service Area is a language used by the lesser of 1,000 people or 5% of the community served by CMC or the population likely to be affected or encountered by CMC. Community Medical Centers may determine the percentage or number of limited English proficiency individuals in CMC's community or likely to be affected or encountered by CMC using any reasonable methods.
2. Information Provided to Patients During the Provision of Hospital Services:
    a. Community Medical Centers or an authorized representative of CMC shall provide all Patients with a copy of a plain language summary of the Financial Assistance Policy which advises the Patient of the maximum gross monthly household income per family size to qualify for Financial Assistance as follows:
        i. At Registration: During registration (or as soon thereafter as practicable).

ii. Emergency Services: In the case of emergency services, as soon as practicable after stabilization of the Patient's emergency medical condition or upon discharge.
iii. Outpatient Services: At the outpatient appointment before the procedure takes place.
iv. At Discharge: At the time of discharge, when CMC or an authorized representative of CMC shall also provide or offer to provide all Uninsured Patients applications for Medi-Cal, California Children's Services, or any other potentially applicable government program.
v. For notices provided pursuant to Section IV.G.2.A.2 and A.3, the plain language summary will be provided to patients who are conscious. If the Patient is unconscious or not able to receive the plain language summary, then the notice must be provided at discharge.
vi. For Patients not admitted to CMC, the plain language summary will be provided when the Patient is leaving the facility.
vii. If a Patient leaves CMC without receiving the plain language summary, CMC will mail the notice to the patient within seventy-two (72) hours of providing the services.

b. Community Medical Centers shall provide every Uninsured Patient with a written estimate of the amount CMC will require the person to pay, pursuant to California Health & Safety Code Section 1339. 585. The plain language summary of the Financial Assistance Policy and an Application for Financial Assistance will accompany the written estimate required by California Health & Safety Code Section 1339.585.

3. Information Provided to Patients at Other Times:
    a. Contact Information: Patients may contact CMC's Patient Financial Services Department by phone at (559) 459-3939 or in person at the locations listed on the Financial Assistance - Locations document, to obtain additional information about Financial Assistance and to receive assistance with the application process.
    b. Billing Statements: Community Medical Centers shall bill Patients in accordance with CMC's Billing and Collections Policy. Billing statements to patients shall include a Notice of Rights. A summary of the Patient's legal rights shall also be included on the Patient's final billing statement before engaging in Extraordinary Collection Actions.
    c. Upon Request: Community Medical Centers shall provide Patients with paper copies of the Financial Assistance Policy, the Application for Financial Assistance, and the plain language summary of the Financial Assistance Policy upon request and without charge.
4. Publicity of Financial Assistance Information
    a. Community Medical Centers shall widely publicize the Financial Assistance Policy in a manner that is reasonably calculated to reach, notify, and inform

those Patients in our communities who are most likely to require Financial Assistance, including at a minimum, the following ways:

i. Public Displays: Community Medical Centers shall clearly and conspicuously post public displays (or other measures reasonably calculated to attract Patients' attention) that notify and inform Patients about this policy in public locations at CMC including, at a minimum, the emergency department, billing office, admissions office, and outpatient settings, including observation units. These shall be posted in English, Spanish and Hmong.

ii. Website: The Financial Assistance Policy, Application for Financial Assistance, and plain language summary of the Financial Assistance Policy shall be available on the home page and main billing page, as well as other prominent places on CMC's website, (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill) Persons seeking information about Financial Assistance shall not be required to create an account or provide any personal information before receiving information about Financial Assistance.

iii. Mail: Patients may request a free copy of the Financial Assistance Policy, Application for Financial Assistance and plain language summary of the Financial Assistance Policy be sent by mail.

iv. Other Efforts: Community Medical Centers will provide a digital kit to relevant community organizations who will widely publicize the availability of this policy to affected Patients in the community.

H. Miscellaneous

1. Recordkeeping: Records relating to Financial Assistance must be readily accessible. Community Medical Centers must maintain information regarding the number of Uninsured Patients who have received services from CMC, the number of Applications for Financial Assistance completed, the number approved, the estimated dollar value of the benefits provided, the number of applications denied, and the reasons for denial. In addition, notes relating to a Patient's approval or denial for Financial Assistance should be entered into the Patient's account.
2. Billing and Collections: Community Medical Centers may employ reasonable collection efforts to obtain payment from patients. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by CMC, or by any collection agency engaged by CMC. General collection activities may include issuing Patient statements, phone calls, and referral of statements that have been sent to the Patient or guarantor. Affiliates and Revenue Cycle departments must maintain procedures to ensure that Patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the Patient. Neither CMC, nor any collection agency engaged by CMC, will engage in any Extraordinary Collection Actions, except as allowed by CMC's Billing and Collection Policy. Copies of CMC's Billing and Collection policy may be obtained free of charge

upon written request or obtained on CMC's website), (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill). Translations of the Financial Assistance Policy and the Billing and Collections Policy are available upon request.

3. Submission to California Department of Health Care Access and Information (HCAI): Community Medical Centers will submit this Financial Assistance Policy and the Billing and Collection Policy to HCAI (formerly the Office of Statewide Planning and Healthcare Development (OSHPD)) biennially and each time this policy or the Billing and Collection Policy are updated. Policies can be located on the HCAI website located here: https://hdc.hcai.ca.gov.

## V. AMOUNTS GENERALLY BILLED

In accordance with the Internal Revenue Code Section 1.501(r)(5), CMC adopts the prospective Medicare methods for amounts generally billed. Patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed.