SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Financial Assistance Policy

Last Revised
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FINANCIAL ASSISTANCE PROGRAMS POLICY OVERVIEW

Policy Statement

SMMC is required by law to provide discounts and waivers to financially qualified patients. Financial assistance screening is offered to all uninsured patients and to those with an account balance due, including deductibles, co-payments and co-insurance amounts.

The financial assistance policy applies to all services billed by SMMC. Patients will receive separate billing for services provided by contracted providers such as emergency room physicians and ambulance services. Those providers are also required by law to provide discounts and waivers to uninsured patients and to insured patients with high medical costs whose household income is at or below 400% of the Federal Poverty Level (FPL). The FPL is a measure of income used to determine eligibility for various assistance programs and benefits. Patients are notified in advance of receiving services when a separate billing will occur.

In addition to financial assistance programs, SMMC offers sliding fee discounts for income qualifying patients served through the Healthcare for the Homeless/Farmworker Health program. Information is available on our website at www.smchealth.org.

SMMC is committed to complying with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy. SMMC's financial assistance practices adhere to hospital billing and collection laws, fair billing and pricing policies as established by the California Hospital Fair Pricing Act, Health and Safety Code §127400 et al., and the Fair Debt and Collections Act, 15 U.S.C.1692.

FINANCIAL ASSISTANCE PROGRAMS CHARTS

Financial Assistance programs are not considered health insurance. All programs require you to provide proof of income and identity. Information provided during the application process will not be used for collection purposes.

Overview Chart

Applied in the Following Order	Description	General Qualifications
Discounted Health Care (DHC) Program	Eligible patients will have a 65% discount applied to balances due for services received at SMMC, clinics, and contracted pharmacies, as listed on the prescription card.	• Current household income is at or below 400% FPL. • Uninsured or possess third party coverage but qualifies as having high medical costs*. *High medical costs are defined as annual out-of-pocket expenses for medical care that exceed 10% of the patient's current family income or income in the prior 12 months (whichever is lower). Patients are required to provide proof of their out-of-pocket medical expenses.
Charity Care Program	Patients approved for Charity Care will have their SMMC balance(s) waived. All SMMC services are covered except for prescription benefits. SMMC screens patients for eligibility for county and state health coverage programs before Charity	Must have household income at or below 138% FPL.

	Care is considered.	
Financial Hardship Assistance (FHA) Program	FHA is for patients who have a financial hardship and cannot pay for the services received at the hospital or clinics. If approved, patients get a discount of 100% and will not be responsible for the balance due.	• Have submitted a complete application and required verifications. • In addition to proof of income and identity, FHA also requires proof of assets and hardship. Financial hardship includes (but is not limited to): • Death of family member (living in household or claimed on taxes) - within last 6 months • Loss of job or reduction of income • Illnesses or accidents • Loss of Housing - foreclosure, eviction, natural disaster, etc. • Financial Liability - bankruptcy, lien, lawsuits, etc.
Prompt-Pay Discount	Provides a 50% discount for payments received within 30-days of first bill date; for patients who do not qualify for other programs	• No income requirement • Required to pay deposit in advance of receiving non-emergency services

Self-Pay Extended Repayment Plan	Allows for payment of full charges over an established repayment period, not to exceed 24 months; for patients who do not qualify for other programs	• No income or residency requirement • Required to pay deposit in advance of receiving non-emergency services

NOTIFICATION AND POSTING OF FINANCIAL ASSISTANCE PROGRAMS

Individuals who receive medical services at the San Mateo Medical Center (SMMC) shall be provided an understandable written notice detailing their right to apply for various financial assistance programs and shall be provided with information regarding the application process. SMMC will make available a plain language written financial assistance policy detailing discount payments and charity care for financially qualified patients.

SMMC will clearly and conspicuously post information about its financial assistance programs in locations that are visible to the public, including, but not limited to all the following:

- The California Department of Health Care Access and Information (HCAI) website
- Emergency Department registration
- Clinic and Outpatient registration
- Patient Financial Services
- Business Services
- Admitting Department
- Long-Term Care registration
- Same Day Surgery Unit registration
- SMMC website

This includes the distribution of pamphlets, letters, and public notices in visible locations where there is a high volume of patient registrations, the dissemination of information on the SMMC web site and inclusion of statements on patients' bills indicating the availability of financial assistance.

All notices and postings of financial assistance programs will be made available in English and languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code.

APPLICATION PROCESS FOR OBTAINING FINANCIAL ASSISTANCE

1. Financial assistance information will be provided at the time of service, during discharge, or within 72 hours post hospital or clinic visit. Uninsured patients will be given a written notice about the availability of financial assistance and the qualifying criteria, along with an application for financial assistance as soon as practical. The notice and application will be provided to patients at the time of service if the patient is conscious and able to receive written notice. If the patient is not able to receive it at the time of service, the notice and application will be provided during the discharge process. If the patient is not admitted, the written notice and application will be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital will mail the notice and application to the patient within 72 hours of providing service.
2. If a patient applies or has a pending application for one health coverage program, they can still be found eligible for a financial assistance program.
3. The Health Coverage Unit (HCU) will determine eligibility for financial assistance programs at any time in which the patient has requested assistance and provided the required documentation. We

encourage patients to apply as soon after their visit as possible. If the patient's circumstances change, they can request their eligibility be re-evaluated.

4. HCU staff will aid in the primary language of the patient or patient's guarantor. When staff do not speak the patient's preferred language, they will make use of the contracted interpreter services language line to ensure good communication.
5. HCU will make reasonable efforts to determine whether a patient is eligible for financial assistance based on prior eligibility for financial assistance or the use of third-party data to identify financially eligible patients, or through notification and processing of applications as specified in 16 C.F.R. 1-501(r)-6(c)(2) and (3). When eligibility is determined based on prior eligibility, it will be documented by a note in EPIC; a new application and verifications will not be required.
6. Applicants can apply:
    a. In person at one of the HCU application sites
    b. By calling **650-616-2002**
    c. By filling out and submitting a SMMC Financial Assistance Program (FAP) application
7. The FAP application is:
    a. Available online
    b. Provided during registration
    c. Included with a billing statement
8. Application accessibility:
    a. All applications will be made available in English and languages other than English.
        i. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code.
    b. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available.
    c. The Patient Experience Department assists with accessibility needs and translation requests.
9. Applicants may fill out the FAP application:
    a. With HCU staff assistance
    b. On their own and submit it via:
        i. Mail: Health Coverage Unit, 801 Gateway Boulevard, Ste. 100, South San Francisco, CA 94080.
        ii. E-mail: info-hcu@smcgov.org
10. Applications and the required documents must be complete to be processed.
    a. Proof of income and identity are required for all programs. Additional documents will be required for certain programs.
    b. Acceptable proof of income includes: a recent employment paystub, government check stub or letter (unemployment or disability), or federal tax forms from last year (photocopies only – originals will not be returned). **This information will not be used for collection purposes.**
    c. If the application and accompanying documents are incomplete, HCU will send the patient a letter advising what is missing.
    d. If all required verifications have not been submitted within 45 days of the application request, the patient will receive a denial letter.
    e. The information provided will determine for which program the patient qualifies.
11. An eligibility notice will be mailed to the patient. It will include the basis for the eligibility determination, information about how to appeal a denial or discontinuance, and the patient's right to reapply.

12. If a patient provides fraudulent information on their application or verifications, they will be disqualified from financial assistance. Patients may then be billed retroactively for all services previously covered or discounted. Providing false information to get benefits is a reportable offense.

Assets

None of the financial assistance programs covered by this policy has an asset limit. However, the Financial Hardship Assistance program does consider assets when determining if an applicant has an inability to pay.

Household Size

An applicant's household size is an important factor for determining eligibility for the SMMC's financial assistance programs. Income eligibility is based on the Federal Poverty Level (FPL), and the number of people in the household.

Household size ONLY includes:

Applicants 18 years of age and older: their spouse or domestic partner and their dependent children under 21 years of age

Applicants under 18 years of age: their parent or caretaker relatives and all the parent or caretaker relatives' children under 21 years of age

Identity

Applicants must provide proof of identity when applying for a health coverage program. The applicant may provide any one document from the lists below. Even if the document has expired, it is still an acceptable verification.

Proof of Identity

Acceptable identification documents in order of priority:

- California driver's license or California DMV identification card
- U.S. passport or other U.S. federal government identification
- Other state driver's license or DMV identification card
- Photo in SMMC's eClinicalWorks (eCW)
- Foreign government identification document (consular ID card, passport, national ID card, or national voter card).

If documents listed above are not available, other acceptable documents, in order of priority include:

- Birth certificate
- Social Security card
- Medicare card
- Medi-Cal card
- Health Plan of San Mateo card
- Bank card with photo ID
- Two signed affidavits attesting to the identification of the patient photo identification from both parties who signed them.

Income

The SMMC financial assistance programs follow federal and state guidelines when determining countable income, non-countable income, and allowable deductions. Refer to this job aid provided by Centers for Medicare & Medicaid Services (CMS) for more detailed information than the information below.

Income Counted

Income is defined as total or gross cash receipts, wages, salaries and bonuses, before taxes and from all sources. It includes self-employment income, tips and gratuities, regular payments from Social Security, Unemployment Compensation, strike benefits, training stipends, alimony, military family allotments or other regular support from an absent family member or someone not living in the household, pensions, insurance or annuity payments, dividend income, capital gains/losses, interest, tax refunds, rents, royalties, estates, and trusts.

The following Social Security income will be counted: Retirement, Survivor's, Disability Income (RSDI), Federal Retirement, and Federal Disability.

Income Not Counted

The following Social Security income will not be counted: Supplemental Security Income (SSI) and State Supplemental Payment (SSP).

Other income that will not be counted include child support received, workers compensation, gifts and inheritances, child tax credit payments, military allowances, veteran's benefits and portion of scholarships, awards, fellowships used for education purposes, state disability insurance (SDI) and public assistance payments.

Deductions

Income may be offset with the following deductions: education expenses; business expenses of reservists, performing artists and fee-basis government officials; health savings account contributions; moving expenses; deductible part of self-employment tax; self-employed, simple and qualified deduction; self-employed health insurance deduction; penalty on early withdrawal of savings; alimony paid; IRA deduction; student loan interest; tuition and fees; and domestic production activities.

Proof of Income

Income verification documentation for SMMC's financial assistance programs must be dated within the last 90 days, except for tax returns, award letters or other proof of irregular income which can exceed the 90 days. The applicant must provide proof of all forms of income for each household member.

- Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.

- Earnings – pay stubs; employer's wage record; state and/or federal income tax return; EDD records; employee W-2 form; farm business records; an employer statement, preferably on the employer's letterhead, or name of company stated on letter, including name of person

employed, signature of employer, date of letter, pay frequency and gross amount.

- Affidavit - Person receiving income can write an affidavit if there is no alternative manner to document income. This letter should include: claimant's name and signature; date of letter; how much employee is paid; date, frequency and source of payment; declarations that (1) the information provided is true and correct (2) there is no other form of income documentation available, and (3) the employee understands the county/state may verify the information provided

- Self-Employment – recent tax returns/business records; receipts for goods and services; last year's federal income tax return including Schedule C; last three months net profit and loss statement; beneficiary's statement when expenses cannot be verified; signed statement from business associates; statement from institutions where checks are deposited/cashed.

- Unearned Income – Social Security Administration (SSA) award letter, official correspondence from SSA, bank statement showing SSA deposit; alimony; government and private pension checks; insurance/annuities checks, correspondence; bank statements verifying interest income; rents; dividends; royalties; estates and trusts; military or other regular support from an absent family member or someone not living in the household.

- Other proof of income – other third-party documents verifying income of applicant can be provided

APPEALS PROCESS

How to Appeal

Patients can dispute eligibility decisions at any time. Patients can get help with any issues related to their ability to pay for medical services.

Submit appeals to the Health Coverage Unit (HCU) by mail, phone or email.

Mail: HCU Appeals Coordinator, 801 Gateway Blvd., Ste. 100, South San Francisco, CA 94080
Phone: 1-650-616-2002
E-Mail: info-hcu@smcgov.org.

Appeals must include:

- Identifying information (name and date of birth, or medical record number)
- A statement about what is being appealed. Include supporting documentation.

HCU will reply in writing with the appeal decision within 30 days from the date the complete appeal request was received. If the appeal is denied, the decision letter will include the rationale for the denial, a description of the Step 2 appeal process, and a Step 2 appeal form.

If the patient does not agree with the appeal decision, they can submit a second appeal. The second appeal will be reviewed by the SMMC Eligibility and Financial Review Committee.

Notice of the right to appeal will be included in SMMC billing statements.

Step-One (1) Appeal Review Process

The Step 1 appeal will be reviewed by an individual appointed by SMMC Revenue Cycle Leadership. The appointee will determine if a system, user or process error was made and will make an appeal determination.

Step-Two (2) Appeal Review Process

Step 2 Review Process

The Eligibility and Financial Review Committee (EFRC) will consist of three individuals: the County Health Chief or his/her appointee (someone other than the Step 1 original appointee), the San Mateo Medical Center Chief Financial Officer or his/her appointee and a public member to be chosen by the County Manager and County Health Chief. The applicant has the right to appear before the EFRC, to present testimony including the sworn testimony of witnesses, and to bring an attorney. An electronic record of the proceedings will be obtained at the applicant's request.

Step 2 Appeal Decision Criteria

The EFRC will consider all documentation and circumstances supporting the applicant's claim of eligibility or claim of inability to pay. The EFRC will enlist additional expertise, as needed, to consider the appeal request.

The EFRC will reply in writing with the appeal decision within 30 days of the date the complete Step 2 appeal request was received. If the appeal is denied, the decision letter will include the rationale for the denial.

CHARITY CARE

Charity care is free care for patients who cannot pay their balance due to SMMC. It includes services received at the hospital, clinics and/or emergency department. It does not include prescription or emergency providers. If approved for Charity Care, the patient's balance will be waived. Patients must requalify for Charity Care for future visits.

How to Qualify

Patients are eligible for the Charity Care Program if their current household income is not more than 138% FPL.

DISCOUNTED HEALTH CARE PROGRAM

The Discounted Health Care (DHC) program gives a 65% discount on balances due to patients who meet the criteria. DHC applies to services billed by SMMC's hospital, clinics, and pharmacies listed on the prescription card.

An individual approved for the DHC program will receive a discount to all open balances due. Approved applicants will receive discounted health for a full calendar year before needing to reapply.

Health Coverage Unit (HCU) staff review all application materials to determine eligibility for County and State health coverage programs. HCU will submit an application to any program for which the patient qualifies and wishes to apply.

How to Qualify

The DHC program offers a discount to SMMC patients who:
1. Have a current household income at or below 400% FPL AND
2. Are uninsured or have insurance but qualify as having high medical costs.*

* High medical costs are defined as annual out-of-pocket expenses for medical care that is more than 10% of the patient's current family income OR income in the prior 12 months (whichever is lower).

FINANCIAL HARDSHIP ASSISTANCE (FHA) PROGRAM

Financial Hardship Assistance (FHA) is for patients who have a financial hardship and cannot pay for the services received at the hospital or clinics. If approved, patients get a discount of 100% and will not be responsible for the balance due.

Financial hardship includes (but is not limited to):

- Death of family member (living in household or claimed on taxes) - within last 6 months
- Loss of job or reduction of income
- Illnesses or accidents
- Loss of Housing - foreclosure, eviction, natural disaster, etc.
- Financial Liability - bankruptcy, lien, lawsuits, etc.

How to Qualify

To qualify for the FHA Program, patients must:

- Have a financial hardship
- Have a balance due at SMMC

In addition to providing proof of income and identity, patients applying for FHA must also submit proof of household assets and financial hardship.

Application and Review Process

- The FHA program requires proof of household income, household assets, proof of identification, and proof of financial hardship. Click on the links for additional details.
- The decision to grant or deny a waiver will be made by the Revenue Cycle Appointee.
- When FHA is approved, a waiver will be applied to charges for the specific date(s) of service for which financial assistance was requested.

BILLING AND COLLECTION

SMMC's Patient Financial Services (PFS) department bills for services received at the hospital and clinics. SMMC may use contracted billing vendors who will follow this policy, as authorized by PFS. If SMMC refers outstanding balances to collections, we will not refer patient accounts to a consumer credit reporting agency or place liens on real property.

All billing and collections activities are compliant with applicable laws, including without limitation California Health and Safety Code §127400 et al., Assembly Bill No's. 774 (AB774), 1020 (AB1020), 532 (AB532), Senate Bill 1276 (SB1276) and the Fair Debt and Collections Act.

Self-Pay Patients

A self-pay patient is an individual who pays for their medical services out-of-pocket, with or without health insurance.

Prior to determining whether a patient is self-pay, SMMC will confirm valid health coverage or insurance information.

Uninsured patients will receive a Good Faith Estimate (GFE) prior to a scheduled non-emergency visit, during registration, or within 72 hours post admit and upon request. The GFE is only an estimate and provides the expected cost for services. Your actual costs may be up to $400 more. Self-pay patients may be required to pay a deposit before receiving services. The deposit is $150 for any outpatient services and $550 for any inpatient stay or surgery. If the patient is eligible for a health coverage program or becomes active on an insurance plan, the patient's deposit will be refunded.

Insured patients or their guarantors may be responsible for a balance amount due after the insurance payment is received.

Group health plans and health insurance coverages are out-of-network for SMMC services. Out-of-network plans usually do not cover the entire cost, leaving the patient with higher costs than if they had been seen by an in-network provider. Billing patients at this higher rate for out of network services is considered "balance billing". An unexpected balance bill is called a surprise bill and is prohibited by state law. SMMC does not balance bill patients and will waive these fees as applicable. Billing patients for deductible, co-payment and co-insurance amounts is not considered "balance billing" and is allowed.

SMMC follows all applicable laws which require patients with high-cost medical bills, including deductibles and co-insurance amounts, are given an opportunity to apply for financial assistance, discounts, and payment plans.

1. Patients with a balance due will receive the following:
    a. A billing statement within 10 business days of the date of service or after the insurance payment is received.
    b. A request for health insurance coverage information
    c. A statement that if the patient does not have health insurance coverage, he/she may be eligible for Medicare, Medi-Cal, Covered California, California Children's

Services program, other state- or county-funded health coverage or charity care

d. A statement indicating how a patient may apply for a financial assistance program and that the hospital will provide the application
e. A statement that if the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care, then the hospital shall provide an application for financial assistance programs to the patient
    i. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.
f. Information about the SMMC's Financial Assistance Programs, including a statement that if a patient lacks or has inadequate health insurance, and meets certain income requirements, the patient may qualify for the Charity Care, DHC or FHA program.
g. The contact information for HCU which assists with financial assistance program enrollments
h. A statement that if a patient is pending eligibility for one health coverage program, they can still be found eligible for a financial assistance program.
i. The Health Consumer Alliance (HCA) offers free in-person and phone assistance at (888) 804-3536 to help people who are struggling to get or maintain health coverage, resolve problems with their health plans and hospital bills, and provide information about Covered California and Medi-Cal presumptive eligibility. The internet address for Health Consumer Alliance is https://healthconsumer.org. Patients may also contact Legal Aid for assistance at (650) 558-0915 or visit https://www.legalaidsmc.org.
j. The internet address for the hospital's list of shoppable services

2. When new coverage is identified, or a patient becomes eligible for a financial assistance program, the patient's amount due will be updated to reflect these changes. A new statement will be sent.

Prompt Pay Discount

SMMC gives a 50% discount to balances due from patients when payment is received within 30 days of the first bill date. This includes Medi-Cal Share of Cost when the Share of Cost exceeds total charges. It does not apply to DHC discounted charges. , . The patient is responsible for the full balance amount if paid after 30 days.

If an uninsured patient applies for coverage and is denied, their account will change from pending application status to self-pay status. After being changed to self-pay status, the Prompt Pay discount will apply if the patient pays 50% of the balance due within 30 days of the revised statementdate.

Extended Payment Policy

SMMC provides an extended, reasonable payment plan to self-pay patients who do not choose the Prompt-Pay discount. The extended payment plan is used when the patient is unable to make a full payment within the normal billing cycle timeframe. The extended amount of time granted is based on the total amount to be repaid and the patient's current financial status.

The extended payment plan can be applied to all or a portion of charges billed to the patient. Extended payment plans are interest-free and will be made available to all patients based on their ability to pay. SMMC and the patient will negotiate the terms of the payment plan. The plan will take into consideration the patient's family income and essential living expenses. If SMMC and the patient cannot agree on a payment plan, SMMC will use the following definitions to create a payment plan.

Reasonable payment plan means monthly payments that are not more than 10 percent of a patient's family income for one month, excluding deductions for essential living expenses.

Essential living expenses means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Patients defaulting on an extended payment plan may be referred to SMMC's contracted collection agency for follow-up.

Collection Practices

SMMC is a safety net hospital whose mission requires that healthcare be provided for individuals regardless of their insurance status or ability to pay. The mission of SMMC is to focus and emphasize a devotion to providing the best possible healthcare for those who may be experiencing adverse circumstances. These circumstances mostly revolve around problems with financial payments, insurance plans, or health conditions. SMMC will make every effort to work with patients, guarantors, and insurance plans to resolve outstanding balances before referring an account to a collection agency. SMMC will make every reasonable effort to obtain valid insurance information from the patient to ensure proper billing.

SMMC will not refer matters to collection when payment plans are in negotiation or established. However, patients who have committed to an established payment plan and default on the agreement may be sent to collections.

SMMC will not refer patients to collections who are actively pursuing financial assistance or pending an eligibility determination for a governmental program. Additionally, SMMC will retract any collection account upon notice of verified insurance information.

1. SMMC will send three (3) or more statements to patients and will allow a minimal of 180-day billing cycle prior to assigning an unpaid balance amount to a collection agency.
    a. Prior to forwarding a bill for collections or selling the bill to another entity, SMMC will provide patients with a written notice called a goodbye final letter that includes the following information:
        i. The date(s) of service of the bill that is being assigned to collections or sold;
        ii. The name of the entity to which the bill is being assigned or sold;
        iii. A statement informing the patient how to obtain an itemized hospital bill from the hospital;
        iv. The name and plan type of the health coverage for the patient on record

with the hospital at the time of services or a statement that the hospital does not have that information;

v. An application for the hospital's charity care and financial assistance;
vi. The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

Overpayment Process

SMMC will reimburse patients any amount paid that is more than the amount due, including interest. Interest owed by the hospital to the patient will accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, SMMC is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). SMMC will refund the patient within 30 days once the overpayment has been identified.

SMMC will only send patient accounts to a collection agency when the collection agency agrees to adhere to all state and federal laws pertaining to fair collection of debt, as well as those pertaining to charity and discount care. That includes the SMMC Financial Assistance Policy, the California Hospital Fair Pricing Act, the Rosenthal Fair Debt Collection Practices Act, the federal Fair Debt Collection Practices Act, and the tax regulations at 26 C.F.R. §§ 1.501(r)-1, *et seq*.

SMMC Policy Review & Approval Grid	
Origination Date:	Last Review Date: 2025-09
Reviewed and approved by:	Date:
Manager, Patient Access	9/25
Manager, Patient Financial Services	9/25
Manager, HCU	9/25
Revenue Cycle Governance Council	9/25
Chief Financial Officer	9/25, FINAL
Date & Submission By: 2025-9, Kathy Van Kirk-Supervisor HCU	
NOTE(s): This waiver or reduction of fees policy has been approved by the Healthcare for the Homeless/Farmworker Health Co-Applicant Board. The County Board of Supervisors sets the discount rate for the DHC program.	