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Owner	Amanda Escobedo: Training Coord-Revenue Cycle
Area	Patient Financial Services/Patient Access Services
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References	Charity Care, Patient Financial Svcs / Patient Access Svcs, Policy & Procedure

Financial Assistance for Uninsured or Low-Income Patients, 15602.99

I. PURPOSE:

The purpose of this policy ("Financial Assistance Policy") is to provide patients with information on the Financial Assistance (Charity Care) available at Sharp HealthCare hospital facilities and to outline the process for determining eligibility for Financial Assistance.

II. POLICY:

It is the policy of Sharp HealthCare to provide patients, regardless of ability to pay, with understandable written information regarding Financial Assistance and to provide income-based Financial Assistance (Charity Care) to qualified patients for emergent and medically necessary services. Sharp HealthCare provides, without discrimination, examination, medical screening and care for emergency medical conditions [(within the meaning of section 1816 of the SSN Act) (42.U.S.C.1395DD)] to individuals regardless of their eligibility under the policy on financial assistance for Sharp HealthCare Hospitals

(Charity Care),within the capabilities and capacity of the facility. Sharp HealthCare will not engage in any actions that discourage individuals from seeking treatment for emergency medical conditions.

III. SCOPE:

This policy applies to Sharp HealthCare Hospitals. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a hospital's bill. This policy does not create an obligation for the hospital to pay for such physicians' or other medical providers' services. In California, an emergency physician who provides emergency services in a hospital must comply with FPL requirements according to California Health and Safety Code section 127450. Attachment A is a list of providers, other than the hospitals themselves, delivering emergency or other medically necessary care in the hospitals.

IV. DEFINITIONS:

A. **Financial Assistance or Charity Care:** Means free care or full assistance (i.e., 100% discount) to qualifying patients that relieves the patient and their guarantor of their entire financial obligation to pay for medical services. Charity Care does not reduce the amount, if any, that a third-party may be required to pay for eligible services provided to the patient. Means to provide full charity care and high medical cost charity care (as outlined in section V.A.1 Eligibility).

B. **Discounted Payment or Discount Payment:** Means any charge for care that is reduced but not free.

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

D. **Financial Assistance**: Means to provide full and partial charity care and high medical cost charity care (as outlined in section V.A.1 Eligibility).

E. **Hospital or Sharp HealthCare Hospitals**: Means (a) all licensed hospital facilities operated by Sharp HealthCare and (b) all hospitals in which Sharp HealthCare and/or an Affiliated Entity has a direct or indirect voting control or equity interest of greater than fifty percent (50%) and all substantially-related entities (as such term is defined at 26 C.F.R. section 1.501(r)-1(b)(28), to the extent such hospitals and substantially-related entities described in this clause (b) provide emergency services.

F. **Hospital Services**: Means all services that a hospital is licensed to provide, including emergency and other medically necessary care.(excluding Complex/Specialized Services).

G. **Flat Rate/Package/Complex/Specialized/Elective Services:** Means services that Sharp HealthCare determines are complex and specialized (e.g., transplants, experimental and investigational services) as well as certain services which are non-covered services under health plan coverage agreements (e.g., elective procedures).

H. **Primary Language of Hospital's Service Area**: Means a language used by the lesser of 1,000 people or 5% of the community served by the Hospital or the population likely to be affected or encountered by the Hospital based upon the most recent Community Health Needs

Assessment performed by Hospital or any other reasonable method.

I. **Uninsured Patient**: Means 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, and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission.

J. **Insured Patient**: Means a patient who has a third-party source of payment for all or a portion of their medical expenses.

K. **Patient Responsibility**: Means 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. For purposes of determine whether a patient has “high medical costs,” “out-of-pocket” costs and expenses means “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.”

L. **Presumptive Charity**: Means that hospital recognizes that a portion of the uninsured patient population may not engage in the traditional financial assistance application process. If the financial assistance application is not submitted by the patient, Sharp HealthCare may choose to provide charity care in lieu of sending the patient responsibly to collections.

M. **Medical Debt**: Means a debt owed by a consumer to a person whose primary business is providing “medical services, products, or devices,” or to that person’s agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid.

1. Medical Service, Product, or Device. Does not include cosmetic surgery, but does include, without limitation, all of the following:
    a. Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers.
    b. Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon.
    c. Initial or subsequent prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.
    d. A mastectomy.

V. PROCEDURES:

A. **Eligibility**

1. **Eligibility Criteria**: During the application process set forth in sections B and C below, Sharp Hospitals shall apply the following eligibility criteria for Financial Assistance:

FINANCIAL ASSISTANCE CATEGORY *NO APPLICATION REQUIRED*	PATIENT ELIGIBILITY CATEGORY
PRESUMPTIVE	Special circumstances under which the patient

FINANCIAL ASSISTANCE CATEGORY *NO APPLICATION REQUIRED*	PATIENT ELIGIBILITY CATEGORY
	may be deemed eligible for Charity Care without submission of a financial assistance application: • Patient is expired and without a known living spouse, third-party insurance coverage or identifiable estate. • Patient is homeless, is not currently enrolled in Medicare, Medi- Cal or any government sponsored program, and is without third-party insurance. • Patient is treated in the Emergency Department but the Hospital is unable to issue a billing statement.
MEDI-CAL	Patients eligible for qualified programs such as Medi-Cal and other government sponsored low-income assistance programs. Such patients are eligible for Charity Care when payment for services is not made by the programs. Specifically included as eligible are charges related to the following: • Denied inpatient stays • Non-covered services • Treatment Authorization Request (TAR) denials • Denials due to restricted coverage
PANDEMIC/CRISIS	An Access to HealthCare Crisis may be related to any emergent situations whereby State/Federal regulations are modified to meet the immediate healthcare need of the hospitals community during the Access to HealthCare Crisis. During this time Sharp may: • "Flex" its patient financial assistance policy to meet the needs of the community in crisis • "Flex" its discount policy to meet the

FINANCIAL ASSISTANCE CATEGORY *NO APPLICATION REQUIRED*	PATIENT ELIGIBILITY CATEGORY
	needs of the community in crisis

FINANCIAL ASSISTANCE CATEGORY *APPLICATION REQUIRED*	PATIENT ELIGIBILITY CATEGORY
FULL CHARITY CARE WITH APPLICATION PROCESS	Patient is an Uninsured Patient with a Family Income (as defined below) at or below 400% of the most recent FPL.
HIGH MEDICAL COST REDUCED CHARITY CARE (for Insured Patients) WITH APPLICATION PROCESS	• Patients who are covered by insurance but exhaust their benefits either before or during their stay at the hospital, and have a family income at or below 400% of the federal poverty level. • Patients who are covered by insurance but have (i) family income at or below 400% of the federal poverty level; and (ii) medical expenses for themselves or their family (incurred at the hospital affiliate or paid to other providers in the past 12 months) that exceed 10% of the patient's family income.

a. **Calculating Family Income**: To determine a patient's eligibility for Financial Assistance, the Hospital shall first calculate the patient's Family Income, as follows:

    i. **Patient Family**: The Patient Family shall be determined as follows:

    - **Adult Patients**:For patients over 18 years of age, the patient family includes their spouse, domestic partner, dependent children less than 21 years of age, whether living at home or not, and dependent children of any age if those children are disabled.
    - **Minor Patients**: For patients (1) under 18 years of age or (2) who are 18 to 20 years of age and are dependent children, the patient family includes their parents, caretaker relatives, other children less than 21 years of age of the parent(s) or caretaker relatives, and

dependent children of the patient's parents or caretaker relatives if those other children are disabled.

ii. **Proof of Family Income**: Family Income is annual earnings of all members of the Patient Family from the prior 2 months and r prior tax year as shown by the recent pay stubs, and income tax returns, less payments made for alimony and child support. Income included in this calculation is every form of income, e.g., salaries and wages, retirement income, and investment gains. Annual income may be determined by annualizing year-to-date family income.

iii. **Type of Income:**

Type of Income	Documentation
Employment Income	Copy of individual tax return (1040) for current tax year
	Copy of last 2 months of the most recent pay stubs
Self-Employment	Copy of individual tax return (1040) for current tax year
	Copy of business profit and loss statement for current year
	Copy of three most recent bank statements, checking and/or savings
Social Security/ Retirement	Copy of individual tax return (1040) for current tax year
	Copy of Award Letter from Social Security stating monthly payment
	Copy of monthly payment notification from Social Security Administration
Disability	Copy of individual tax return (1040) for current tax year
	Copy of Award Letter from State stating disability payment
	Copy of monthly notification from disability
Unemployment	Copy of individual tax return (1040) for current tax year
	Copy of letter stating monthly award amount

iv. **Calculating Family Income for Expired Patients**: Expired patients, with no surviving spouse may be deemed to have no income for purposes of calculation of Family Income.

Documentation of income is not required for expired patients. However, documentation of estate assets may be required from the surviving spouse.

b. **Calculating Family Income as a Percentage of FPL**: After determining family income, hospital shall calculate the family income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the federal poverty level for a family of three is $20,000, and a patient's family income is $60,000, the hospital shall calculate the patient's family income to be 300% of the FPL. Hospitals shall use this calculation during the application process to determine whether a patient meets the income criteria for financial assistance.

c. **Special Circumstance: Benefits Exhausted During Inpatient Stay**: When an Insured Patient's third-party coverage pays only a portion of the expected reimbursement for the patient's stay because the patient exhausted their benefits during the stay, the hospital should collect from the patient the balance of the expected reimbursement that would have been due from the third-party coverage if the benefits were not exhausted. A hospital shall not pursue from the patient any amount in excess of the amount that would have been due from the third-party coverage if the benefits were not exhausted, plus the patient's share of cost.

d. **Financial Assistance Exclusions/Disqualification**: The following are circumstances in which Financial Assistance is not available under this Financial Assistance Policy:

    i. **Uninsured Patient seeks Flat Rate/Packages/Complex/ Specialized/Elective & Surrogacy Services**: Generally, uninsured patients who seek Flat Rate/Packages/Complex/Specialized or Elective services (e.g. transplants, experimental or investigational procedures) are not eligible for financial assistance. Elective services are excluded from coverage under health plan coverage agreements (e.g., cosmetic procedures) and are therefore not eligible for financial assistance. International patients may be considered on a case-by-case basis.

    ii. **Patient declines covered services**: An insured patient who elects to seek services that are not covered under the patient's benefit agreement (such as an HMO patient who seeks out-of-network services from Sharp HealthCare, or a patient refuses to transfer from a Sharp HealthCare hospital to an in-network facility) is not eligible for financial assistance.

    iii. **Payer pays patient directly**: If a patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the patient is not eligible for Financial Assistance for the services.

    iv. **Information falsification**: Hospitals may refuse to award

financial assistance to patients who falsify information regarding family income, household size or other information in their eligibility application.

v. **Third-Party Recoveries**: If the patient receives a financial settlement or judgment from a third-party payor that caused the patient's injury, the patient must use the settlement or judgment amount to satisfy any patient account balances to the extent required or permitted under applicable law. All third-party benefits/monies payable to the hospital under applicable law must be paid prior to being considered for financial assistance.

vi. **Professional (physician) Services**: Services of physicians such as anesthesiologists, radiologists, hospitalists, pathologists, etc. are not covered under this policy. 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.

e. No Consideration of Assets: Hospitals can not consider a patient's monetary assets when determining that patient's eligibility for discount payment or charity care.

i. Exception for Health Savings Accounts and Extended Payment Plans: As a narrow exception to the general prohibition against considering monetary assets, hospitals may consider HSAs when negotiating the terms of an extended payment plan to allow a patient to pay the discounted price over time.

ii. Note regarding Waiver or Reduction of Medi-Cal and Medicare Cost-Sharing Amounts: Hospitals may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of their charity care or discount payment program. In doing so, a hospital may consider some of the patient's monetary assets to the extent required for the hospital to be reimbursed under the Medicare program for Medicare bad debt without seeking to collect cost-sharing amounts from the patient as required by federal law. (See law for details on which assets may be considered.)

iii. Other Forms of Income Documentation:

- Hospitals may accept other forms of documentation of income but shall not require those other forms.
- If a patient does not submit an application or documentation of income, a hospital may presumptively determine that a patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on a prior eligibility determination.

iv. Cannot Require Discount Payment Patients to Apply for Health

Coverage: Hospitals cannot require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment.

- However, hospital can require a patient to apply for Medicare, Medi-Cal, or other coverage before screening for, or providing, charity care.
  When screening for discount payment, can require patient to participate in screening for Medi-Cal eligibility.
- No Application Deadlines: Hospitals cannot impose time limits for charity care or discount payment applications. Hospitals also cannot deny eligibility based on the timing of a patient's application. May need to pull accounts back from collections.

B. **Application Process**

1. Each hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance may fully or partially cover the charges for care rendered by the hospital to a patient. A patient who indicates at any time the financial inability to pay a bill for hospital services shall be evaluated for financial assistance. In order to qualify as an uninsured patient, the patient or the patient's guarantor must verify that he or she is not aware of any right to insurance that would cover or discount the bill.
2. Patients who wish to apply for financial assistance shall use the Sharp HealthCare standardized application form, the "Application for Financial Assistance".
3. Patients may request assistance with completing the application for financial assistance in person at the Sharp HealthCare Hospitals listed on Attachment G, or provided upon request and without charge or over the phone at (858) 499-2400, through the mail, or via the Sharp HealthCare website (www.Sharp.com/billing/financial-assistance.cfm) or download the mobile application, Sharp App.
4. Patients should mail Applications for financial assistance to:
   Sharp HealthCare
   Attn: Charity Care Application
   8695 Spectrum Center Blvd.
   San Diego, CA 92123
5. Patients should complete the application for financial assistance as soon as possible after receiving hospital services.
6. Upon Emergency department discharge it is usual and customary to provide a financial assistance application to all uninsured patients or patients who indicate at any time the financial inability to pay for hospital services.

C. **Financial Assistance Determination**

1. The hospital will consider each application for financial assistance and grant financial assistance when the patient meets the eligibility criteria set forth in Section A.

a. Patients also may apply for governmental program assistance., The hospital may assist patients in determining if they are eligible for any governmental or other assistance or if a patient is eligible to enroll with plans in the California Health Benefit Exchange (i.e., Covered California).

b. 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 pend the patient's eligibility for financial assistance until a determination of other coverage is made.

2. Once a Charity Care or High Medical Cost Charity Care determination has been made, a "Determination Letter" will be sent to each applicant advising them of the hospital's decision (Attachment D).

3. Patients are presumed to be eligible for financial assistance for a period of one year -days after the hospital issues the Notification Form to the patient. After one year , patients must re-apply for financial assistance.

4. If the financial assistance determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest on the amount of the overpayment from the Date of the patient's payment at the statutory rate (10% per annum) pursuant to California Health and Safety Code section 127440, provided that Hospitals are not required to refund a credit balance that is, together with interest, less than five dollars ($5).

D. **Disputes**

1. A patient may seek review of l any decision by the hospital to deny financial assistance by notifying the hospital, or his or her designee, of the basis of the dispute and the desired relief within thirty (30) days of the patient receiving notice of the circumstances giving rise to the dispute. Patients may submit the dispute orally or in writing. Hospital, or designee, shall review the patient's dispute as soon as possible and inform the patient of any decision in writing. Disputes are also accepted via telephone at (858) 499-2400.

2. Help paying your bill: 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.

3. Hospital Billing 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 HospitalBillCompliant.hcai.gov for more information and to file a complaint.

E. **AVAILABILITY OF FINANCIAL ASSISTANCE INFORMATION**

1. **Languages**:

   This policy shall be available in the Primary Language(s) of Hospital's Service Area. In addition, all notices/communications provided in this section shall be available in the Primary Language(s) of Hospital's Service Area during regular business hours

(Mon – Fri, 8am to 4:30pm) and in a manner consistent with all applicable federal and state laws and regulations.

2. **Information Provided to Patients During the Provision of Hospital Services**:
    a. **Preadmission or Registration**: During regular business hours at preadmission (Mon-Fri, 8am to 4:30pm) or registration (or as soon thereafter as practicable) Hospitals shall make available to patients a copy of a Plain Language Summary (Attachment E) of the policy that also contains information regarding their right to request an estimate of their financial responsibility for services. In the event the patient discharges without receiving a copy of a Plain Language Summary (Attachment E) the notice shall be mailed, if an address was provided, within 72 hours.
    b. **Emergency Services:** In the case of emergency service, hospital shall attempt to provide all self-pay patients a financial assistance package upon stabilization of the patient's emergency medical condition or discharge.
    c. **Application provided at discharge**: At the time of discharge, hospital shall provide all patients with a financial assistance package and application for Medi-Cal/Medicaid and California Children's Services or any other potentially applicable government program.
    d. **Financial Assistance Counselors**: Patients who may be uninsured patients shall be assigned Financial Assistance Counselors who shall attempt to visit with the patients in person at the Hospital. Financial Assistance Counselors shall give such patients assistance with securing government funding. If the patient does not qualify for any government programs, a Financial Assistance Counselor may assist with information regarding the financial assistance process and hospital personnel who can provide additional information about this policy and assist with the application process.

3. **Information Provided to Patients at Other Times**:
    a. **Contact Information**: Patients may call (858) 499-2400 or contact the hospital department listed on Attachment G to obtain additional information about financial assistance and assistance with the application process.
    b. **Billing Statements**: Hospitals shall bill patients in accordance with the Sharp HealthCare Billing, Collections and Bad Debt Review Policy 15801.99. Billing statements to patients shall include a Patient Information Notice (Attachment F), a conspicuous written notice that notifies and informs recipients about the availability of financial assistance under the hospital's policy that includes a telephone number of the hospital office or department for patients to call with questions about the policy and application process, and the website address where patients can obtain additional information about financial assistance, including copies of the Financial Assistance Policy, a Plain Language Summary of Financial Assistance Policy, and the application for financial

assistance (Attachment B).

c. **Upon Request**: Hospitals 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. **Public posting**: Hospitals shall post copies of the policy, the application for financial assistance, and the Plain Language Summary of the financial assistance policy in a prominent location in the emergency room, admissions area, and any other location in the hospital where there is a high volume of patient traffic, including, but not limited to, the waiting rooms, billing offices, and Hospital outpatient service settings. These public notices shall include information about the right to request an estimate of financial responsibility for Hospital Services.

b. **Website**: The financial assistance policy, application for financial assistance and Plain Language Summary shall be available in a prominent place on the Sharp HealthCare website (www.sharp.com/billing/financial-assistance.cfm or Sharpapp). 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.

c. **Mail**: Patients may request that a copy of the financial assistance policy, application and Plain Language Summary be sent by mail, at no cost to the patient.

d. **Advertisements/Press Releases**: As necessary, and at least on an annual basis, Sharp HealthCare will place an advertisement regarding the availability of financial assistance at hospitals in the communities served by Sharp HealthCare. Sharp HealthCare will issue a Press Release containing this information, or use other means that Sharp HealthCare concludes will widely publicize the availability of this Financial Assistance Policy to affected patients in our communities.

e. **Community Awareness**: Sharp HealthCare will work with affiliated organizations, physicians, community clinics and other health care providers to notify members of the community (especially those who are most likely to require Financial Assistance) about the availability of Financial Assistance.

F. **Miscellaneous**

1. **Recordkeeping**:

Records relating to financial assistance must be readily accessible. Each hospital shall maintain information regarding the number of uninsured patients who have received services from the hospital, the number of financial assistance applications 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, as well as a copy of the application for financial assistance and supporting documents scanned and filed according to the patient's visits related to the application.

2. **Payment Plans**:

   Patients may be eligible for a payment plan. Payment plans shall be offered and negotiated per the Sharp HealthCare Hospital Billing, Collections and Bad Debt review Policy #15801 and/ Discounts 15603.99.

   a. **Billing and Collections**:

      Hospitals 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 hospital or by any collection agency engaged by hospital. The actions the hospitals may take in the event of nonpayment are described in the hospitals' separate Billing, Collections and Bad Debt Review Policy. General collection activities may include issuing patient statements, automated phone calls, and referrals of statements to the patient or guarantor. Hospital or collection agencies will not engage in any extraordinary collection actions (as defined by the Policy on Billing, Collections and Bad Debt 15801). Copies of the Policy may be obtained free of charge within the hospital patient registration, patient financial services offices and may be obtained without charge on the www.Sharp.com/patient/billing/financial-assistance.cfm website/ Sharpapp or by calling (858) 499-2400 or within the Hospital Patient Registration, Patient Financial Services offices and the Emergency Department (locations in Attachment G).

   b. **Debt Collection**:

      - No Consideration of Patient Assets for Debt Recovery Determinations: In determining the amount of a debt it may seek to recover from patients who are eligible under its charity care or discount payment policy, a hospital may only consider income and not monetary assets.
      - No liens On Any Real Property For Collections: Wage garnishments and liens on any real property owned by the patient cannot be used as a means of collecting unpaid hospital bills by (i) the hospital, (ii) assignees that are affiliates or subsidiaries of the hospital, (iii) collection agencies, (iv) debt buyers, and (v) other assignees that are not subsidiaries or affiliates of the hospital.

3. **Submission to HCAI (formerly OSHPD)**:

   Sharp HealthCare Hospitals will submit Financial Assistance policies to the

California Department of Health Care Access and Information (HCA. Policies can be located on the OSHPD website located here: https://hcai.ca.gov/

4. **Amounts Generally Billed**:

   In accordance with Internal Revenue Code Section 1.501(r), Sharp HealthCare adopts Medicare methodology for amounts generally billed. Following a determination that a patient is eligible for financial assistance, the patient may not be charged more than this amount for emergency or medically necessary care after all reimbursements from third-party payers, if any, have been applied.

5. **Charges for non-covered services**:

   Charges for non-covered services provided to patients eligible for Medi-Cal or other indigent care programs (including charges for days exceeding a length of stay limit) can be included, if the patient meets the hospital Charity Care criteria.

6. **Post Bad Debt Charity Determination**:

   Until such time that hospital has exhausted all means of collections, services may be reviewed and considered for charity.

7. **Two Types of Permissible Reimbursements from Patient or Guarantor**:
   - A hospital may require a patient or guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for that hospital's services.
   - If a patient receives a legal settlement, judgment, or award under a liable third-party action that includes payment for health care services or medical care related to the injury, a hospital may require the patient or guarantor to reimburse the hospital for the related health care services rendered up to the amount reasonably awarded for that purpose.

8. **5-Year Record Retention for Money Owed to the Hospital**:

   A hospital must maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for 5 years, including, but not limited to, all of the following: (a) documents related to litigation filed by the hospital, (b) a contract and significant related records by which a hospital assigns or sells medical debt to a third party, (c) a list, updated at least annually, of every person, including the person's name and contact information, that is either: (i) a debt collector to whom the hospital sold or assigned medical debt or (ii) retained by the hospital to pursue litigation for debts owed by patients on behalf of the hospital.

9. **Contracts With Assignees and Debt Buyers Must Require 5-Year Record Retention**:

   Any contract entered into by a hospital related to the assignment or sale of medical debt must require the assignee or buyer (and any subsequent assignee or buyer) to maintain records related to litigation for five years.

10. **Changed Relevant Lookback Date for Policy's Application to The Time the Patient Was First Billed**:

A hospital must not deny a patient financial assistance that would be available under the hospital's policy published on HCAI's website at the time the patient was first billed by the hospital.

11. **Generally**:
    - Medical Debt Must Be Excluded from Consumer Credit Reports: No consumer credit reporting agency shall make any consumer credit report containing medical debt.
    - Hospitals Cannot Provide Information Regarding Medical Debt to Consumer Credit Reporting Agencies:Hospitals must not furnish information regarding a medical debt to a consumer credit reporting agency.
    - 180-Day Grace Period: Hospitals cannot commence civil action against a patient for nonpayment of medical debt before 180 days after initial billing.
12. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

VI. REFERENCES:

A. Internal Revenue Code Section 501(r)
B. 26 Code of Federal Regulations 1.501(r)-1.501(r)-7
C. California Health and Safety Code sections 127400 – 127446
D. Social Security Act (42 U.S.C. 1395dd)
E. NSA AB 1020
F. CAHSC 1250
G. AB 2297
H. SB 1061

VII. ORIGINATOR:

Patient Financial Services

VIII. LEGAL REFERENCES:

Emergency Medical Treatment and Active Labor Act (EMTALA), 64 Fed Reg 18434 (April 7, 2000), AB 774 (January 1, 2007) AB 774 (January 1, 2014), Health& Safety Code 127400(g-i),127446, AB 1503(January 1, 2024)& SB 1276 (January 1, 2015), 501 (r) 2016, AB 537 (January 1, 2022), 45 Code of Federal Regulations Part 149 NSA (January 1, 2022), AB 1020 (January 1, 2024), CAHSC 1250 [96051.1 - 96051.37 (f of title 22 of the CCR)]

IX. ACCREDITATION:

None

X. CROSS REFERENCES:

A. Policy 35033 Transfer: Emergency Treatment and Transfer (COBRA-EMTALA)

B. Policy 15603.99 Discounts

C. Policy 15800.99 Payment Plans- Establishing Budget Plans

D. Policy 15801 Billing, Collections and Bad Debt Review

XI. APPROVALS:

A. PFS Policy and Procedure Committee - 12/94; 2/95; 5/98; 12/03; 03/04; 10/04; 11/05; 02/06; 03/06; 01/07; 07/07; 08/07; 04/08; 06/08; 02/11; 12/12; 03/13; 02/14; 04/14; 12/14; 03/15; 09/16; 01/17; 04/18; 8/2020; 03/2021; 03/2024; 04/2024; 12/2024

B. System Policy & Procedure Steering Committee – 04/04/96

C. Legal Affairs Department - 12/03; 03/04; 03/13; 08/16

D. Sharp Finance Department – 06/16

XII. REPLACES:

PFS Dept. P&P originally dated 12/94

XIII. HISTORY:

System #15602.99; Originally Dated 3/96;
Reviewed/Revised: 03/99; 06/01; 12/03; 12/24 -- Revised & Removed CCD's: 03/04; 10/04 -- Updated Attachment: 11/05; 02/06; 01/07; 07/07; 08/07; 05/08; 06/08; 12/24 -- Updated Attachments: 02/11; 07/12 -- Updated Attachments: 03/13; 02/14; 12/24 -- Updated Attachments: 04/14; 12/14; 03/15; 03/16; 06/16; 09/16; 12/24 -- 501 (R) Updates: 01/17 -- Financial Assistance Application Updated: 4/18 (FPL Chart); 07/19 (FPL Chart); 12/24 (removed FPL chart); 01/2025 (revisions to the applicant form submitted by SBO leadership) -- Financial Assistance Calculator Updated with New Federal Poverty Level: 2/19; 07/19; 12/24 -- Provider/Physician Emergency Room Contact: 07/19, 12/24

A. Attachments

Attachments

A: Provider/Physician Emergency Room Contacts

B. 2025 Sharp HealthCare Financial Assistance Application

C: Financial Assistance Calculations Worksheet

D: Charity Letters – Denied, Full

E: Important Billing Information for Patients Financial Assistance Plain Language Summary

F: Patient Informational Notice

G: Sharp HealthCare Hospitals Physical and Website Addresses and Community Assistance Locations

H: Hospital Financial Assistance Notification

Approval Signatures

Step Description	Approver	Date
Administrator	Tamara Westgate: Prgm Mgr-Policies and Procedures	01/2025
	Amanda Escobedo: Training Coord-Revenue Cycle	01/2025

Applicability

Chula Vista, Coronado, Grossmont, Mary Birch, McDonald Center, Memorial, Mesa Vista, Sharp HealthCare