VIBRA HOSPITAL OF NORTHERN CALIFORNIA

Effective January 1, 2025

Vibra Hospital of Northern California
Notice of Charity Care and Discounted Services

Vibra Hospital of Northern California has a financial assistance program for low income, uninsured individuals who may not be able to pay their healthcare bills. This program provides for full or partial discounts based on the following criteria and definitions:

Definition of Charity Care for Self- Pay Patients: A self-pay patient is eligible for charity care (free care) based upon meeting the income eligibility criteria established by the Hospital. Financial eligibility criteria is derived from the most recently published US Department of Health and Human Services Annual Update of the HHS Poverty Guidelines, also referred to as the Federal Poverty Level (FPL). The income eligibility criterion for free care is defined as an income that is at or below 100% of the FPL.

Definition of Discount Payment Plan for Insured Patients: An insured patient is eligible for a discount plan based on meeting the income eligibility criteria and has high medical costs. The income eligibility criterion is defined as an income that is at or below 400% of the FPL. High medical cost is if the annual out of pocket medical expenses are greater than 10% of their household income.

If you think you or a family member may qualify and would like to learn more about our financial assistance programs, please contact our Business Office at (866) 554-1928.

VIBRA HEALTHCARE **BUSINESS OFFICE POLICY**	**Policies** **Title:** Financial Assistance **Created** 1/2007 **Revised** 1/2025 **Distribution:** Billing Offices Hospitals Corporate Finance

POLICY

Vibra hospital shall provide financial assistance to patients who either do not have health insurance or are underinsured, and may not be able to pay in full for their care based on their income, and needs. Uninsured or underinsured patients will be treated fairly and with respect during and after their treatment. Patients with high medical costs may also be eligible for a discounted rate if they meet the eligibility requirements. The hospital will provide financial counseling to all patents requiring financial assistance. This will include help in understanding and applying for local, state and federal healthcare programs such as Medicaid. All patients requiring financial assistance will be offered discounted pricing for the services provided at rates comparable to Medicare. All patients will be offered reasonable payments plans and, subject to their acceptance of the offer, will be billed at discounted rates. Whenever possible, this will occur before the services are provided or patients leave the hospital, as part of the financial counseling process. The hospital will not pursue legal action for non-payment of bills against any patient who is unemployed and without other significant income or assets.

PURPOSE

The purpose of this policy is to define the eligibility criteria for Charity Care services and to provide administrative and accounting guidelines for the identification, classification and reporting of patient accounts as Charity Care.

Self-Pay Patients: A self-pay patient means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance as determined and documented by the hospital. Self-pay patients may include Charity Care patients.

Charity Care for Self-Pay Patients: A self-pay patient is eligible for Charity Care (free care) or a discount payment plan based upon meeting the eligibility criteria established by the hospital. Financial eligibility criteria is derived from the most recently published US Department of Health and Human Services Annual Update of the HHS Poverty Guidelines, also referred to as the Federal Poverty Level (FPL).

Discount Payment Plan for Patients with High Medical Costs: An insured, uninsured and patients with high medical cost are eligible for a discount plan based on meeting the income eligibility criteria and has high medical costs. The income eligibility criterion is determined by discount payment eligbility.. High medical costs are defined as out-of-pocket medical expenses in the prior twelve (12) months that exceed 10% of the family's income..

Patient's Family: (1) For persons 18 years of age or older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

PROCEDURE

Eligibility Criteria:

1. **Charity Care and Discount Payment Plans Application** (See Attachment A)
   a. A low income self-pay patient or a low income insured patient with high medical costs who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for financial assistance.
   b. The Financial Assistance Application (Attachment A) will be used to document each patient's overall financial situation.
      i. Recent pay stubs or income tax return for the purpose of determining eligiblity.
      ii. Income consistent with the application of the federal poverty level for discounted payment and monetary assets are taken into consideration however, monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans.
      iii. For charity care, the patient will need to apply for Medicaid eligibility and must be turned down for reasons other than not following through with the application process. This does not apply to discounted payment.
   c. The hospital and patient shall negotiate the terms of the payment plan and take into consideration the patient's family income and essential living expenses.
   d. Once a determination has been made, a notification form will be sent to each applicant advising them of the facility's decision and the reason for the denial if denied.
   e. If the hospital and patient cannot agree on the payment plan, the hospital shall create a reasonable payment plan, where monthly payments are not more than 10% of the patient's monthly family income, excluding deductions for essential living expenses.
   f. A patient may request an appeal of a denial of eligibility. These requests are directed to the CFO of the hospital. The CFO will review the information submitted and/or request

additional allowable documents to be submitted by the patient. A written decision regarding the appeal is provided by the CFO to the patient within 72 hours of the receipt of the request.

g. A patient's employment status may be taken into consideration when evaluating Charity Care status as well as potential payments from pending litigation, and third party liens related to the incident of care.
h. Interest free extended payment plans are also offered by the hospital to assist patients with payment and are subject to negotiation with the patient.
i. A deposit may be required from self-pay patients prior to determination that a patient qualifies for Charity Care or discounted payment. The hospital will refund to the patient any amount collected from a financially qualified patient in excess of the amount due under the hospital's Charity Care or discounted payment policy.
j. If the hospital bills a patient who has not provided proof of third party coverage, the hospital shall provide the patient with a notice of the following:
    1. A statement of charges
    2. A request to inform the hospital of coverage
    3. Notice of eligibility requirements for Medicaid etc.
    4. Instructions on how to obtain applications for Medicaid, and other governmental programs; and will be given copies of above mentioned applications
    5. A copy of the Patient Financial Assessment Application (Attachment A), the Sliding Scale Discount chart (Attachment B), and the Review Process and Eligibility notice.

2. Charity Care and discount benefits
    a. If you are at 100% of the Federal Poverty Guideline and under the Charity care, we will write off the amount due.. Partial discount eligibility is determined per the Sliding Scale Discount (Attachment B) which is based on the most recent Federal Poverty Guidelines. However, the total payment to the hospital is based on the lesser of either the hospital's sliding scale discount or the amount the federal healthcare programs (Medicare/Medicaid) would pay for the services delivered by the hospital. The hospital is limited to collecting no more than the maximum allowable reimbursement from a federal plan for services received by a financially qualified patient. Current Federal Poverty Level Guidelines are as follows:

ANNUAL GUIDELINES

POVERTY GUIDELINE BASED ON SIZE OF FAMILY									
SIZE	**100%**	**150%**	**200%**						
1	15,060	22,590	**30,120**						
2	20,440	30,660	40,880						
3	25,820	38,730	**51,640**						
4	31,200	46,800	**62,400**						
5	36,580	54,870	**73,160**						
6	41,960	62,940	**94,680**						

b. Out-of-pocket payment to the hospital is discounted to the difference between the amount of payment available from the third party payor and the maximum rate allowable by a federal healthcare plan.

3. The hospital shall reimburse for any amount actually paid in excess of the amount due, including interest based upon rates set in Section 685.010 of the Code of Civil Procedures. The hospital is not required to reimburse amounts less than $5.00. The hospital shall reimburse any amount over $5.00 paid in excess of the amount due under the Hospital Fair Pricing Act including interest*Notice Prior to Commencing Collection Activities:*
Every initial statement of charges mailed to patients will include the following plain language summary of the patient's rights pursuant to AB 774, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices Act. *"State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00am or after 9:00pm. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. "*For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 877-FTC-HELP.
4. Collection Agency
    a. The hospital will have a written agreement in place for all outside agencies that requires the agency to abide by the hospital's standards for collection activities as defined in this policy. The hospital shall obtain a written agreement from each

collection agency that collects hospital receivables that it will adhere to the hospital's standards and scopes of practice.

b. If a patient is attempting to qualify for eligibility under the hospital's Charity Care or discount payment policy and is attempting, in good faith, to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to the collection agency.
c. If the patient fails to make all consecutive payments due during a 90-day period, the hospitals payment plan may be declared no longer operative. However, all reasonable attempts must be made to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the payment plan.
d. If a collection agency identifies a patient meeting the hospitals Charity Care eligibility criteria, their patient account may be considered Charity Care, even if it was originally classified as a bad debt. Collection agency patient accounts meeting Charity Care criteria will be returned to the hospital billing office and reviewed for Charity Care eligibility. The collection agency will not, within 180 days of initial billing, commence a civil action against a patient who lacks coverage or provides information that he or she may be a patient with high medical costs. The collection agency will not use wage garnishments or liens on all real properties to collect an unpaid hospital bill with respect to patients who are eligible under the hospitals Charity Care or discount payment policies.

5. *Time Requirements for Determination:*
   Eligibility is determined within one (1) week after all requested documentation is provided to the Billing Office by the applicant.
6. *Definition of Income:*
   Annual family earnings and cash benefits from all sources before taxes, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates.
7. *Application of Policy:*
   This policy does not create an obligation to pay for any charges or services not included in the bill at the time of service. This policy does not apply to services provided within the hospital by physicians or other Medicaid providers.
8. *Public Notice and Posting:*
   Public notice of the availability of assistance through this policy will be visible in locations where there is a high volume of inpatient or outpatient admitting/registration, such as

admitting, registration, billing offices and outpatient services settings. Posted notices shall be in the primary language of the service area and in a manner consistent with all applicable federal and state laws and regulations. Posted notices shall contain a statement indicating that the hospital has a financial assistance policy for low-income uninsured patients who may not be able to pay their bill and that this policy provides for full or partial Charity Care write-off. A contact phone number is included for the patient to call to obtain more information about the policy and how to apply for assistance in the posted notice.

9. *Written Notice to Patients:*
   Patients will be provided written information about the availability of the hospitals discount payment and Charity Care policy, including information about eligibility and contact information to obtain further information regarding the policy. This notice will be included in the admission paperwork for both the hospital and outpatient admissions.

VIBRA HEALTHCARE BUSINESS OFFICE POLICY	**Policies** **Title:** Financial Assistance **Created** 1/2007 **Revised** 1/2025 **Distribution:** Billing Offices Hospitals Corporate Finance

VIBRA HEALTHCARE

PATIENT FINANCIAL ASSESSMENT STATEMENT

Note: If you are applying for a discounted payment, you are only required doucmention is recent paycheck stubs or income tax. For those applying for discounted payment, you may receive less financial assistance than what may be available under the charity care program.

RESPONSIBLE PARTY NAME:	LAST	FIRST	MIDDLE
PATIENT NAME IF OTHER THAN RESPONSIBLE PARTY			HOSPITAL ACCOUNT # (S):
SPOUSE			NUMBER OF DEPENDENTS
STREET ADDRESS			HOME PHONE ( )
CITY, STATE & ZIP			WORK PHONE ( )
OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)		
SOCIAL SECURITY #	ADDRESS		
YEARS AT EMPLOYER	SALARY _____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY OTHER INCOME:_____ SOURCE_____		

SPOUSE

OCCUPATION	EMPLOYER (IF SELF EMPLOYED, DESCRIPTION)		
SOCIAL SECURITY #	ADDRESS		
PHONE ( )	YEARS AT EMPLOYER	SALARY _____ ☐HOURLY ☐BIWEEKLY ☐ MONTHLY	
OTHER INCOME	SOURCE		

ASSETS		**LIABILITIES/ MONTHLY TOTALS**	
CASH ON HAND	$_____	MORTGAGE/RENT PAYMENT	$_____
CHECKING ACCOUNT*	$_____	INSURANCE PREMIUMS:	
SAVINGS ACCOUNT*	$_____	☐AUTO, ☐MEDICAL, ☐ HOME	$_____
CREDIT UNION ACCOUNT*	$_____	OTHER: _____	
		UTILITIES: ☐ GAS, ☐ ELECT., ☐ WATER, ☐ PHONE	$_____
		AUTO PAYMENTS	$_____
		FOOD	$_____

TRUST ACCOUNTS	$_____	OTHER LIABILITIES:	
OTHER SOURCES (STOCK, BONDS)	$_____	DESCRIPTION	PAYMENT BALANCE
*BANK BRANCH (S) & ACCOUNT NUMBERS:			

I HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER LAW.

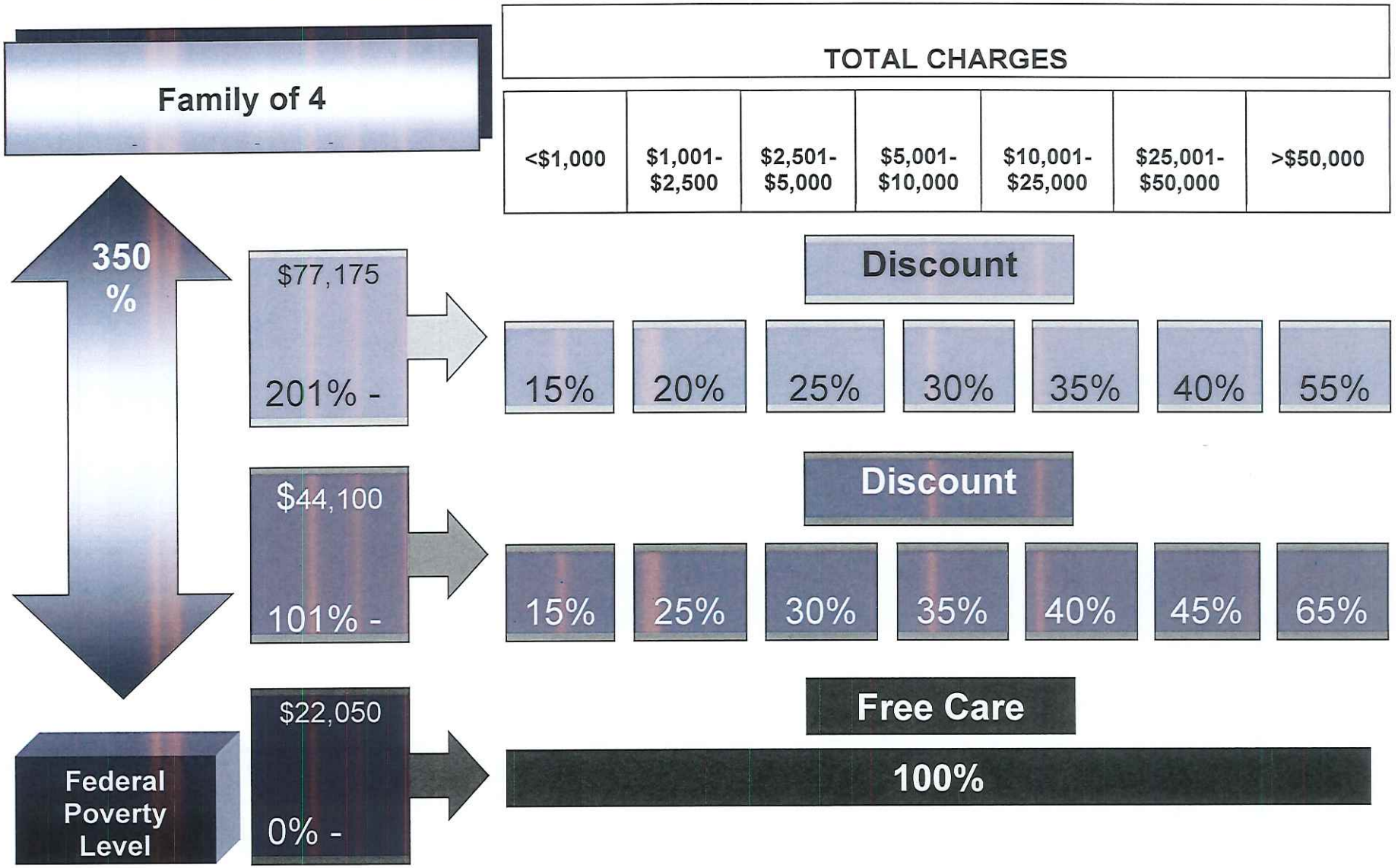
Signature

Date

ATTACHMENT B

Charity Care and Discount Policy

For the Uninsured & Patients with High Medical Costs



VIBRA HOSPITAL OF NORTHERN CALIFORNIA

Manual	Case Management LTAC
Title	Patient Discharge and Appeal Rights
Policy Number	CM 200.21
Effective Date	January 2011
Revise Date	January 1, 2025
Review Date	January 1, 2025
Scope:	Hospital-Wide
Reference	CMS §482.30

ATTENTION: If you need help in your language, please call [530-245-4235] or visit the Admissions Department. The office is open 8:00 am to 5:00pm Monday thru Friday and located at on the first floor directly after you end the main entrance of the hospital. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

POLICY:

Case Managers will ensure compliance with the Beneficiary Notices Initiative which defines both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.

PROCEDURE:

I. Case Managers will ensure the beneficiary is aware of his discharge rights with the presentation of the discharge copy of the Important Message from Medicare (IM), starting with the administration of the IM.

A. Admissions representative presents the admission copy of the IM to the patient and or representative.

B. The Case Manager will deliver an IM at the time of discharge, not more than 2 calendar days before discharge and not less than 4 hours before actual discharge for all Medicare beneficiaries.

C. For the purpose of this instruction, the term "discharge" does not include exhaustion of Part A days. When a beneficiary exhausts Part A, a follow-up copy of IM is not required.

D. The IM notice should be delivered to and initialed with date and time by the patient or patient's representative; this then becomes the follow up IM notice.

E. The case manager must document the timely delivery of the IM in the medical record.

F. The beneficiary (or representative) should sign or initial, date, and time the IM.

G. Either electronically or paper, the hospital must retain a signed copy of the IM.

II. When a patient disagrees with the date of discharge, the beneficiary or his representative must contact the Quality Improvement Organization (QIO) and request an appeal.

A. A timely beneficiary request for QIO review is no later than midnight the day of discharge. If timely request is made, the patient is not financially responsible for inpatient services (except coinsurance or deductible) furnished before noon of the calendar day following the day the beneficiary receives notification of the expedited determination from the QIO.

B. The QIO will direct the hospital to deliver to the beneficiary the Detailed Notice of Discharge (DND).

C. Non-covered Continued Stay notice informs the patient that the hospital believes Medicare may not continue to pay for their hospital stay beginning on a certain date and usually coincides with the Detailed Notice of Discharge and the QIO's agreement with the discharge.

III. Hospital Issued Notice of Non-coverage (HINN) is issued for continued stay denials. When a hospital determines that a beneficiary's continued stay may not be covered and the patient may be financially liable for continued stay, this notice must be given.

A. The non-covered notice may be used if a lower level of care (i.e., SNF bed) is available and the patient or family refuses to discharge and physician (or Physician Advisor) concurs with discharge plan. A plan for discharge should be written.

B. Fill in the date and indicate the reason Medicare is not expected to pay (either the service is not considered to be medically necessary or it could be furnished safely in another setting). The patient will be responsible for payment. The cost entered may be either the average daily rate or the estimated total cost.

C. When delivering the HINN letter, follow all delivery requirements and obtain signature of patient or patient's representative.

D. The Case Manager or designee must document the timely delivery of the HINN in the medical record or document the telephonic delivery of the HINN including representative's name, telephone number, date and time of call.

IV. Hospital Request Review (HRR) is issued when a hospital determines that a beneficiary no longer needs inpatient care, but is unable to obtain the agreement of the physician; the hospital may request a QIO review.

A. Hospitals must notify the beneficiary that the review has been requested.

B. The Case Manager will assure that the hospital supplies any and all information that the QIO needs to conduct its review. The case manager (or designee) must make the information available by phone or in writing, by the close of business on the first full day immediately following the day the hospital submits the request for review.

V. Quality Improvement Organization (QIO), at the request of the beneficiary, will make a determination and notify the beneficiary, the hospital, and the physician of its decision within 2 days of the hospital's request and receipt of any pertinent information submitted by the hospital.

A. At the request of the beneficiary, the hospital must furnish the beneficiary with a copy of, or access to, any documents it sends to the QIO including written records of any information provided by phone.

B. The QIO should have methods in place to accept request for review outside normal business hours and will issue decisions. The QIO's responsibilities for expedited review include all of the following:

1. Notify the hospital of patient's request for expedited review

2. Receive and examine the patient's records

3. Determine if the hospital delivered valid notice

4. Solicit views of patients and hospital

5. Make the determination based on whether the services are reasonable and medically necessary

6. The services meet professionally recognized standards of care

C. The results of the QIO review may be either QIO agrees with hospital and says the stay is not reasonable and customary or QIO disagrees with hospital and says the stay is reasonable and customary. If the QIO agrees with the hospital the beneficiary will be responsible for services on the date specified by the QIO. If the QIO disagrees with the hospital the

beneficiary will be refunded any amounts collected except applicable coinsurance, deductible and convenience items or services not covered by Medicare.

D. QIO will send the beneficiary a formal determination of medical necessity and appropriateness of the hospitalization. The QIO determination is binding on the beneficiary, physician and hospitals except in the following circumstance.

VI. Expedited Reconsideration by an Independent Review Entity (IRE) may be requested by a beneficiary who is dissatisfied with a QIO determination. Each QIO must be contacted for IRE contact information.

A. A beneficiary who chooses to exercise the right to an expedited reconsideration must submit a request to the appropriate IRE in writing or by telephone no later than noon of the calendar day following the initial notification (whether by telephone or in writing) of the QIO's determination.

The beneficiary, upon request of the QIO, should be available to discuss the case or supply information that the IRE may request. The beneficiary may, but is not required to, submit written evidence to be considered by the IRE.

B. When the beneficiary fails to make a timely request for an expedited reconsideration, he/she subsequently may request consideration under the standard claims appeal process.

C. On the day the IRE receives the request for an expedited reconsideration, the IRE must immediately notify the QIO that made the expedited determination and the provider of services of the request for the expedited reconsideration.

D. When an IRE notifies the QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the IRE needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the IRE notifies the QIO of the request for the reconsideration. At the beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the IRE.

E. The facility may, but is not required to, submit evidence to be considered by an IRE in making its decision. If a hospital fails to comply with IRE's request for additional information beyond that furnished by the QIO for purposes of the expedited determination, the IRE makes its reconsideration decision based on the information available.

F. When a beneficiary makes a timely request for an expedited determination, the hospital may not bill the beneficiary for any disputed services until the IRE makes its determination.

CMS Tools located at:
http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Charity Care/Discounted Payment

a.) Vibra hospital shall provide financial assistance to patients who either do not have health insurance or are underinsured, and may not be able to pay in full for their care based on their income,

b.) ***Charity Care for Self-Pay Patients:*** A self-pay patient is eligible for Charity Care (free care) or a discount payment plan based upon meeting the eligibility criteria established by the hospital. Financial eligibility criteria is derived from the most recently published US Department of Health and Human Services Annual Update of the HHS Poverty Guidelines, also referred to as the Federal Poverty Level (FPL).

c.) ***Discount Payment Plan for Patients with High Medical Costs:*** An insured, uninsured and patients with high medical cost are eligible for a discount plan based on meeting the income eligibility criteria and has high medical costs. The income eligibility criterion is determined by discount payment eligibility.. High medical costs are defined as out-of-pocket medical expenses in the prior twelve (12) months that exceed 10% of the family's income..

d.) Charity care and discount payment applications are available in the Admissions department or can be provided by the admissions liaison to bring to your bedside while in-house.

e.) The financial assistance policy is available from the Admissions department and can be provided by the admissions liaison to bring to your bedside while in-house. If you with wish to contact the Admissions department by phone, please call (530) 245-4235 to speak with our Admisisons Manager.

f.) **Helping Pay Your Bill** - California requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You or your family member may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance.

Shoppable Services

Below is a website that will take you to a list of the Vibra Hospital of Northern California's "shoppable services." The Centers for Medicare Services (CMS) has defined a "shoppable service" as a service package that can be scheduled by a health care consumer in advance. Shoppable services are typically those that are routinely provided in non-urgent situations that do not require immediate action or attention to the patient, thus allowing patients to price shop and schedule a service at a time that is convenient for them.

https://norcalrehab.com/about-us/price-transparency/

Covered California

Covered California is the state's health insurance marketplace that helps Californians find and enroll in affordable, high-quality health coverage from private insurance companies. It is the only place to get financial assistance (subsidies) to lower premium costs. You can apply online, by phone, or with a certified enroller to see if you qualify for financial aid or Medi-Cal. Below is the website to access potential coverage and additional information regarding Covered California.

https://www.coveredca.com/what-is-covered-california/

Hospital Bill Complaint Program

The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were

wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to **HospitalBillComplaintProgram.hcai.ca.gov** for more information and to file a complaint.

REVIEW/REVISION:

This policy will be reviewed annually, and updated as required by changes in operations, technology, and/or other laws, rules and regulations.

DEFINITIONS:

None

RELATED DOCUMENTS:

None