SECTION: ADMINISTRATIVE

SUBSECTION: OPERATIONS

SUBJECT: PATIENT CHARITY CARE POLICY AND PROCEDURE

APPROVED BY: _____

ARMC Chief Executive Officer

PURPOSE AND EFFECTIVE DATE

The purpose of this policy is to define the eligibility criteria for Charity Care and the process used by Arrowhead Regional Medical Center to determine if a patient is eligible. The effective date for this policy is January 1, 2025.

POLICY

Arrowhead Regional Medical Center (ARMC) is committed to providing quality healthcare to the community and helping people who are uninsured, underinsured, ineligible for government programs or the California Health Benefit Exchange, and are unable to pay for medically necessary care based on their individual financial situation. ARMC strives to ensure that people who need health care services are not prevented from getting care due to their financial status. Patients who seek to obtain Charity Care from ARMC are expected to comply with this policy.

Emergency Physicians, (as defined in Health and Safety Code Section 127450), who provide emergency medical services in a hospital that provides emergency care are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% FPL. This statement shall not be construed to impose any additional responsibilities upon the hospital.

It is the policy of ARMC to provide patients with understandable written information regarding its Charity Care program and to provide Financial Assistance to eligible patients for medically necessary services.
The Charity Care program provides free medically necessary services to people who meet the hospital's eligibility criteria for Charity Care as set forth in this policy. Charity Care may also include unpaid coinsurance, deductibles, share of cost, and unpaid balances for healthcare services if the patient meets the hospital's eligibility criteria.

Patients will not be refused care or services due to inability to pay. Patients will not be asked to prepay for services or to pay a deposit to schedule an appointment for health care services at ARMC, unless otherwise required by law or contract (such as where it is determined that a copayment is required, by law or contract, to be paid in advance).

TYPE OF SERVICES COVERED

The Charity Care program under this policy covers all Eligible Services, including medically necessary hospital services, professional services provided by providers contracted with ARMC, educational services, and diagnostic services provided at all ARMC-operated facilities, including the hospital and its clinics. **PROCEDURES**

I. **ELIGIBILITY**

A. A patient is eligible for Charity Care if the patient follows this policy and meets both of the following requirements:

1. The patient is Uninsured, Underinsured, or is a Patient with High Medical Costs (each a "Qualified Patient"); and

2. The patient has a Family income that does not exceed 400% of the Federal Poverty Level (FPL).

B. Monetary assets are not considered in determining eligibility for Charity Care.

C. The determination of the patient's Family income is made in accordance with the Federal Poverty Level (FPL) in effect at the time of eligibility determination.

D. The granting of Charity Care does not take into consideration the patient's age, gender, race, social or immigrant status, sexual orientation or religious affiliation or any other legally protected status.

E. If the patient is eligible for Charity Care, the patient will be eligible for Charity Care for one year from the date of approval. Additional applications for subsequent medical visits will not be required during the one-year eligibility period.

F. Limitations on Charity Care for Medicare and Medi-Cal/Medicaid Patients:

1. Patients who meet the FPL requirement and have Medicare as primary coverage may qualify for Charity Care, but the amount qualifying for Charity Care is limited to the patient's copayments, coinsurance, deductible, and share of cost amounts unreimbursed by any other payer including Medi-Cal/Medicaid, and which is not reimbursed by Medicare as a bad debt.

2. Patients who meet the FPL requirement and have restricted or limited scope Med-Cal/Medicaid coverage may qualify for Charity Care, but the amount qualifying for Charity Care is limited to charges for Share of Cost responsibility and medically necessary services that are denied by Medi-Cal/Medicaid.

3. Patients who meet the FPL requirement and have full Med-Cal/Medicaid coverage may qualify for Charity Care, but the amount qualifying for Charity Care is limited to charges for any Share of Cost responsibility under Medi-Cal/Medicaid.

II. DETERMINATION OF ELIGIBILITY

A. ARMC will determine a patient's eligibility for Charity Care by assessing the patient's individual situation. Except as set forth in Section III of this policy, the patient or his/her guarantor is expected to provide all necessary documentation to allow ARMC to determine the patient's eligibility. Such documents include:

1. Application for Financial Assistance (Application) (Attachment A)

2. Copy of picture identification

3. Proof of Family income – Based on Recent Paystubs or Income Tax Returns

4. Statement of Support providing an explanation if living with no income

B. Proof of Family income is limited to recent pay stubs or income tax returns. No other documents showing Family income are required, but ARMC will accept and consider other documents if offered by the patient.

C. Information obtained from income tax returns and paystubs provided by the patient for determination of eligibility for Charity Care will not be used for collection activities by ARMC.

D. When the patient is unable to provide recent pay stubs or income tax returns, the following procedures shall be followed and considered in determining the patient's Family income:

1. Written Attestation: The patient can sign a statement attesting to the accuracy of the income information provided.

2. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempts should be made to document the patient's yearly income before taking a verbal attestation, but the Hospital financial counselor may not request any documents from the patient relating to income except recent pay stubs or income tax returns.

E. Timing:

1. A patient's eligibility for Charity Care may be determined at any time information on the patient's eligibility becomes available.

2. There is no time limit for a patient to apply for Charity Care.

F. ARMC's staff shall assist patients applying for Charity Care determine if they qualify for and, if so, apply for alternative sources of assistance, including Medi-Cal, the California Health Benefit Exchange or other state or county-funded health coverage programs.

G. Any patient who applies, or has a pending application, for another health coverage program may, at the same time, submit an Application for Financial Assistance.

H. Any patient who expresses the inability to pay a bill for medical care shall be evaluated for Financial Assistance under the Charity Care and Discount Payment policies.

III. PRESUMPTIVE ELIGIBILITY FOR CHARITY CARE

A. There may be instances where a patient may appear eligible for Charity Care, but the patient does not submit an Application or provide recent pay stubs or income tax returns. In certain circumstances, there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to determine that a patient is eligible for Charity Care. In the event a patient does not submit an Application or documentation of Family income, ARMC may presumptively determine that a patient is eligible for Charity Care as set forth in this Section of the policy. Presumptive eligibility may be determined on the basis of a patient's life circumstances that may include:

1. Homelessness or received care from a homeless clinic

2. Behavioral health patients in altered mental status where the patient cannot appropriately communicate, lacks perception, and psychomotor skills, or with cognitive impairments.

3. Patients are deceased without an estate or third-party coverage

IV. FINANCIAL ASSISTANCE APPLICATION AVAILABILITY

A. Patients who desire to apply for Charity Care may obtain an Application upon request, as follows:

1. Call Customer Service: 1-877-818-0672.

2. Email Customer Service: patientaccounts@armc.sbcounty.gov

3. Obtain an Application from the Patient Accounts Cashier Office located inside the ARMC hospital 1st floor-across from the outpatient pharmacy.

4. Download the Application from the ARMC website: https://www.arrowheadregional.org/patients-visitors/help-paying-your-bill/

V. APPLICATION REVIEW PROCESS

A. Application Review Process

1. Financial Counselors (FC) will review the submitted Application and documentation.

2. If a patient submits an incomplete Application, FC notifies applicant to provide the missing information and will provide reasonable opportunity to do so.

3. If a patient submits a completed Application, the FC reviews the health care visit documentation.

4. If the FC identifies the visit as a possible claim where the patient might be seeking compensation for injuries or damages resulting from an accident or harm caused by someone else, the following procedures will be followed:

   a. FC provides the account information to the County Revenue Recovery Division (RRD) to further evaluate the possibility of a recovery claim submitted by the patient due to the injury.

   b. The FC sends a letter to the patient to contact the RRD to provide documentation for RRD to determine whether there is the possibility of a recovery claim against a third-party.

   c. The Application will be on hold pending clearance process by RRD for any possible recovery claims submitted by patient for the injury.

   d. The FC, RRD, and patient will continue to communicate until and if injury recover claim is necessary.

5. If the FC determines that the visit is not a possible injury recovery claim or if the patient will not pursue a recovery claim for their injury, the following procedures will be followed:

   a. FC will review the Application, pay stubs, income tax returns, and any other documents submitted by the patient to determine the patient's eligibility for Charity Care as follows:

      1) FC will determine if the patient is Qualified Patient; and

      2) FC will determine if the patient's Family income is 400%, or less, of the FPL.

   b. If the FC determines that the patient is Qualified Patient, but the patient's Family income exceeds 400% FPL, FC will assess whether the patient qualifies for the Discount Payment program under Policy No. 110.29.

c. If the FC determines that the patient is eligible for Charity Care, the following procedures will be followed:

1) ARMC will provide the patient with the Eligibility Determination for Financial Assistance Letter. (Attachment B)

2) The FC updates the financial case in Epic with the Application determination, either approved or denied, and effective date.

3) Epic will automatically adjust the patient account balance.

VI. PATIENT ELIGIBILITY DISPUTE PROCESS

A. A patient may file an appeal for re-evaluation. All appeals are to be submitted in writing to the attention of the Patient Accounts Department, Administrative Manager, 400 N Pepper Ave., Colton, CA 92324. The patient shall be notified in writing of the outcome of their appeal within thirty (30) days.

B. Additionally, any patient who is denied Charity Care or wishes to dispute any other issue relating to eligibility for Charity Care may seek review from the ARMC Administrative Manager of the Patient Accounts Department by calling (909) 777-0771.

C. If the patient was previously approved under the Discount Payment policy but then becomes eligible to receive Charity Care due to a successful appeal, ARMC is authorized to go back to adjust previous balances otherwise approved under the Discount Payment policy due to the successful appeal by the patient.

VII. DISCOUNT PAYMENT PROGRAM

Any individual that is determined to not be eligible for Charity Care shall be considered for eligibility for ARMC's Discount Payment Program under Policy No. 110.29.

VIII. THIRD-PARTY PAYMENTS

ARMC may require a patient or guarantor to pay ARMC the following amounts even if a patient is eligible for Charity Care:

A. The entire amount of any reimbursement received by the patient or guarantor from a third-party payor for the services that the patient received at ARMC.

B. Any amount received by the patient or guarantor through a legal settlement, judgment, or award under a liable thirty-party action that includes payment for health care services or medical care related to the injury for which the patient seeks Charity Care.

COMMUNICATION OF THE CHARITY CARE PROGRAM

A. ARMC shall provide patients with a written notice ("Notice") that contains information about availability of ARMC's Charity Care and Discount Payment policies (collectively, "Policies"), including information about eligibility, and contact information for who can be contacted to obtain further information about the policies. The notice shall comply with and include all of the elements required under Health & Safety Code Section 127410.

B. The Notice of the Policies shall be provided to patients as follows:

1. At the time of service if the patient is conscious and able to receive the Notice at that time.
2. If the patient is not able to receive the Notice at the time of service, the Notice shall be provided during the discharge process.

3. If the patient is not admitted, the Notice shall be provided when the patient leaves the facility.
4. If the patient leaves the facility without receiving the Notice, ARMC shall mail the Notice to the patient within 72 hours of providing services.

C. Notice of the Policies shall also clearly and visibly be posted in locations that are visible to the public, including, but not limited to, all of the following:

1. Emergency Department
2. Billing Office / Cashier Window
3. Family Health Centers- Outpatient Clinics
4. Hospital Website: https://www.arrowheadregional.org/patients-visitors/help-paying-your-bill/

OVERPAYMENTS

A. ARMC shall reimburse a patient any amount actually paid by the patient in excess of the amounts due under the Hospital Fair Pricing Act, including interest, and this Charity Care policy. Interest shall accrue at the rate set forth in Code of Civil Procedure Section 685.010 beginning on the date payment by the patient is received by ARMC. Such a refund shall be made within 30 days. However, ARMC is not required to reimburse the patient or pay interest if the amount due is less than $5.00, or if it has been five years or more since the patient's last payment to ARMC or RRD.

B. Payment from any third-party source shall not constitute overpayment unless such payment is more than billed charges.

EDUCATION AND TRAINING

The following ARMC staff shall receive training regarding ARMC's Charity Care and Discount Payment policies:

A. Registration/Admitting (including Financial Interviewers)
B. Patient Advocate
C. Billing/Patient Accounts Department

REGULATORY REQUIREMENTS

In implementing this policy, ARMC shall comply with all applicable federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

REFERENCES: **California Health & Safety Code Sections 127400-127446**
AB 1503. Statutes of 2010, Ch. 445 Section 127450
AB 2297. Statutes of 2024 Ch 511
SB 1061 Statutes of 2024 Chapter 520
SB 1276. Statutes. 2014, Ch. 758

DEFINITIONS:

Charity Care. Free health care services are provided without expectation of payment to people who meet the hospital's eligibility for Charity Care under this policy. Charity Care may include unpaid coinsurance, deductibles, share of cost, and unpaid balances for healthcare services if the patient meets the hospital's eligibility criteria. Charity Care does not include bad debt defined as uncollectible charges that the hospital recorded as revenue but wrote off due to a patient's failure to pay.

Discount Payment Policy: Refers to the ARMC Patient Discount Payment Policy and Procedure No. 110.29.

Eligible Services. All emergency medical care or non-emergency, medically necessary professional and hospital care services delivered within ARMC-operated facilities, including its clinics. Eligible Services may also include medically necessary care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted. Eligible Services also include services provided to patients as part of any federal, state or local managed indigent care program.

Family. Family includes the following:

A. For persons 18 years of age and older, spouse, domestic partner, dependent children under 21 years of age, or any age if disabled, whether living at home or not.

B. For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parent's or caretaker's relatives' other dependent children under 21 years of age, or any age if disabled.

Federal Poverty Level (FPL): The FPL is defined by the poverty guidelines updated periodically in the Federal Register by the HHS under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Financial Assistance: A full or partial reduction in charges for emergencies or medically necessary services for patients who have qualified for either Charity Care or the Payment Discount program.

High Medical Costs: Means any of the following:

A. Annual Out-Of-Pocket Costs incurred by the patient at ARMC that exceed the lesser of 10% of the patient's current Family income or Family income in the prior 12 months. 10% of the patient's current family income or family income in the prior 12 months, whichever is less.

B. Annual Out-of-Pocket Costs that exceed 10% of the patient's Family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's Family in the prior 12 months.

Medically Necessary Services: As defined by the California Welfare & Institutions Code 14059.5, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Out-Of-Pocket Costs: Means any expense for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays, co-insurance, deductible, or Medi-Cal Share of Costs.

Recent Pay Stubs or Income Tax Return: Recent tax returns are tax returns which document income for the year in which the patient was first billed or 12 months prior to when the patient was first billed. Recent paystubs are paystubs within a 6-month period before or after the patient is first billed by the hospital, or in the case of preservice, when the application is submitted.

Share of Cost(s): Refers to the share of medical costs that is the patient's responsibility under the Medi-Cal/Medicaid program.

Underinsured: Refers to a patient who has insurance or third-party coverage, including Medi-Cal and Medicare, but has Out-Of-Pocket Costs (e.g. self-pay balances associated with high deductible/out of pocket or limited benefit plans) that exceed the patient's claimed ability to pay. This also refers to a patient with active insurance with ineligible periods.

Uninsured: A patient who has no insurance or third-party coverage to assist with meeting the patient's payment obligations for medical services.

ATTACHMENTS: Attachment A: Application for Financial Assistance
B: Eligibility Determination Letter sample

APPROVAL DATE: 12/13/2024 — Kim Hirotsu, Revenue Cycle Manager
Applicable Administrator, Hospital or Medical Committee

12/13/2024 — Patient Safety and Quality Committee
Applicable Administrator, Hospital or Medical Committee

_____ — Board of Supervisors
Approved by the Governing Body

REPLACES: Administrative Policy No. 110.28 Issue 10

EFFECTIVE: 08/24/2006, 01/01/2025

REVISED: **10/30/2006, 02/05/2007, 10/12/2007, 08/13/2010, 01/03/2012, 01/16/2013, 01/02/2014, 01/01/2015, 08/20/2015, 07/01/2016, 12/13/24**

REVIEWED: 01/01/2019

RETIRED: 09/28/2020

ATTACHMENT A

QUESTIONS?
(909) 777-0740
(909) 777-0763

ARROWHEAD REGIONAL MEDICAL CENTER
APPLICATION FOR FINANCIAL ASSISTANCE

400 N. PEPPER AVE
COLTON CA 92324
ATTN: PATIENT ACCOUNTS DEPARTMENT

e-mail: patientaccounts@armc.sbcounty.gov
Phone: 1-877-818-0672
Fax: (909) 777-0815

This application is for you to apply for Arrowhead Regional Medical Center's Financial Assistance Programs, which include the (1) Charity Care Program and (2) Discount Payment Program. The criteria for eligibility for these programs can be found in Arrowhead Regional Medical Center's Charity Care and Patient Discount Payment policies.

Select the program you are applying for:

☐ Charity Care Program (free care)
☐ Discount Payment Program (reduced charges)

To make your application complete, the following documentation must be included:

- Copy of picture identification
- Proof of Family income (recent paystubs or income tax returns only)
- Statement of support if there is no income

Failure to submit all required documentation with the application will result in an incomplete application. The application process takes approximately 30 days from the date the application is received.
Patients that apply only for the Discount Payment Program may receive less financial assistance than what may be available under the Charity Care Program.

This application is for Arrowhead Regional Medical Center (ARMC) charges, including professional services provided by providers contracted with ARMC only and does not apply to Professional Fees charges, which are billed separately by your provider, such as Physicians, Anesthesiologist, Radiology, Laboratory, etc. These charges will be your responsibility.

Arrowhead Regional Medical Center maintains a list of non-covered providers. You can access the list online at https://www.arrowheadregional.org/patients-visitors/help-paying-your-bill/ or you may request a copy by calling ARMC -- Patient Accounts department 1-877-818-0672.

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

CITY _____STATE _____ ZIP CODE___

EMAIL ADDRESS _____

GUARANTOR#: _____ DATE OF BIRTH _____

MRN _____

FAMILY STATUS:

- If the patient is 18 years or older, please list the following: spouse, domestic partner, dependents under age 21, and/or dependents of any age if disabled.
- If the patient is under 18 years of age or for a dependent child 18 to 20 years of age, please list the parent, caretaker relatives, and parent's or caretaker's relatives' other dependent children under 21 years of age, or any age if disabled.

(If additional space is needed, please use page 5)

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employment: _____Position: _____

If self-employed, Name of Business:
_____

Spouse's Employment: _____ Position: _____

If self-employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Patient	Spouse
Monthly Gross Wages	_____	_____
Section A (Income-Unearned)		
Social Security Pension	_____	_____
Retirement or VA benefits	_____	_____
Unemployment	_____	_____
Alimony or Child Support Payments Received	_____	_____
Other (specify)	_____	_____
Total Income:	_____	_____

Please circle one:

Are you eligible for MEDICARE: YES__ NO__

Are you eligible for MEDI-CAL: YES__ NO__

PLEASE AGREE TO THE FOLLOWING INFORMATION

- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I understand that I may be required to provide proof of the information I am providing.
- I further agree that in consideration for receiving health care services as a result of an accident or injury, to reimburse the County from the proceeds of any litigation or settlement resulting from such an act.

_____ _____

(Signature of Patient or Guarantor) (Date) (Signature of Spouse) (Date)

Additional Space for comments:

Attachment B

ARROWHEAD REGIONAL MEDICAL CENTER
Eligibility Determination for Financial Assistance

Date:

FIRST, LAST NAME
MRN #M00
ADDRESS

APPROVED
☐ Charity Care
☐ Discount Payment

Effective Approval Date: Expiration date:

Arrowhead Regional Medical Center (ARMC) has approved your application for financial assistance based on one or more of the following criteria:

☐Based on current eligibility with IEHP or Medi-Cal.
☐Based on Family income.
☐Based on the completed application you submitted via fax, mail, in-person, or electronically.
☐Based on a phone interview conducted by ARMC's Financial Interviewer.

Charity approval reduces your balance to $0 and is active for 1 (one) year. You may reapply upon expiration or whenever your income or household circumstances change.

Discount Payment approval reduces your balance in accordance with current Medicare reimbursement rates and the discount is active for 1 (one) year. You may reapply upon expiration or whenever your income or household circumstances change.

Your next billing statement will include the discount rate and information on how to make your payment and set up a reasonable payment plan, if applicable.

If you receive a payment from a third-party, including through a legal settlement, judgment, or award through a court process for the services received at ARMC, ARMC may require you to pay that amount to ARMC.

The Financial Assistant Program (FAP) program only covers ARMC facility charges and charges for services provided by providers contracted with ARMC.

The (FAP) program does not cover professional fees that may be charged by individual service providers, including, but not limited to physicians, anesthesiologists, radiologists, pathologists and does not apply to the Professional Fees incurred, such as Physicians, Anesthesiologist, Radiology, Laboratory, etc. These charges are billed separately by your provider and will be your responsibility.

ARMC maintains a list of non-covered providers. You can access the list online at

https://www.arrowheadregional.org/patients-visitors/help-paying-your-bill/

or you may request a copy by calling the ARMC Patient Accounts Department at

1-877-818-0672 or via email: patientaccounts@armc.sbcounty.gov

If you do not agree with the outcome of your application, you may submit a written appeal within 30 days from the date of this letter addressed to:

PATIENT ACCOUNTS DEPARTMENT/ FAP
Attn: Administrative Manager
ARROWHEAD REGIONAL MEDICAL CENTER
400 N PEPPER AVE
COLTON, CA 92324

Hospital Bill Complaint Program

The Hospital Bill Complaint Program reviews hospital financial assistance policies and patient financial qualification decisions to ensure qualified patients have access to help pay their bills. If you believe you were wrongly denied financial assistance, you may file a complaint with the State of California's Hospital Bill Complaint Program. For more information and to file a complaint Visit:

HospitalBillComplaintProgram.hcai.ca.gov

More Help

There are organizations that will help you understand the billing and payment process.

You may call the Health Consumer Alliance at 888-804-3536 or visit https://healthconsumer.org/

Sincerely,

ARMC - Patient Accounts Department
Phone: 877-818-0672 Fax: 909-777-0815
Email: patientaccounts@armc.sbcounty.gov
Office hours: 8:30 AM to 4:30 PM Mon-Fri (closed on county holidays)