Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
DISTRICT OPERATIONS

ISSUE DATE: 09/96

SUBJECT: Charity Care, Uncompensated Care, Community Service

REVISION DATE: 08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15, 06/17, 02/22, 03/22

POLICY NUMBER: 8610-285

Department Approval:	**05/22**
Administrative Policies and Procedures Committee Approval:	**08/22**
Finance, Operations and Planning Committee Approval:	**08/22**
Board of Directors Approval:	**08/22**

A. PURPOSE:

1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations.
2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et. seq. hereinafter referred to as the California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law.

B. POLICY:

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual, orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.
4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by or for the patient, will be confidential and the dignity of the patient will be maintained during this process.
5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage garnishments or a lien on the patient's primary residence if the patient or the patient's legal representative are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.
6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

7. All collection agencies working on behalf of the Hospital shall comply with the California Fair Pricing Law.
8. Without the completion of an application for financial assistance, the Hospital, at its discretion, may approve financial assistance outside the scope of this policy. Discretionary full or partial charity write-offs include, but are not limited to, a history of non-payment on the patient account balance, where referral to an outside collection agency would not result in a payment on the patient account, the social situation of the patient, and patients/guarantors who cannot be located

C. DEFINITIONS AND ELIGIBILITY:

1. Charity – Financial assistance to qualifying insured and uninsured patients, in whole or in part, to relieve them of their financial obligation for health care services. For individuals who meet the Hospital's charity criteria, charity care results from the Hospital's mission to provide free health care services. Charity care is measured based on revenue forgone, at full established rates. Charity care does not include contractual write-offs, courtesy discounts, prompt pay discounts, employee discounts, or friends and family discounts.
2. Charity care does not include bad debt resulting from a patient's unwillingness to pay or from a failure to meet the definitions in this financial assistance policy.
3. Definitions of Charity include:
    a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost. All charges are eligible for consideration under the Hospital's definition of High Medical Cost.
    b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
    c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
    d. Special Circumstance Charity Care **–** Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
    e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
        i. Bankruptcy,
        ii. Patient without a residential address (homeless), or reasonable efforts are made to locate and contact the patient, and such attempts have been unsuccessful,
        iii. Deceased patients without an estate,
        iv. MediCal/Medicaid denials – patients who are eligible for MediCal/Medicaid are also presumed to qualify for full charity care. This definition includes patient's whose MediCal/Medicaid coverage is limited or restricted, TAR denials, medical necessity denials, billing denials (i.e. untimely filing)
        v. Charges for days exceeding a length-of-stay limit for patients enrolled in MediCal/Medicaid or other state or county indigent care programs,
        vi. Non-covered services for MediCal/Medicaid eligible patients,
        vii. The patient has coverage from an entity that does not have a contractual relationship with the provider; this would include Medicaid out of state patients, or situations where the insurance carrier is not under contract with the Hospital and denies the claim.
    f. Patient Obligations for deductible and coinsurance amounts, non-covered services, or services provided to a patient where the patient's benefits are exhausted, where the insured patient qualifies for full or partial charity care are included in the definition of charity care.
4. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
5. High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or reached a lifetime limit, non-covered relating to services not medically necessary) High medical costs means:
    a. Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceeds 10 percent of the patient's family income in the prior 12 months.
    b. Annual out-of-pocket medical expenses by the patient that exceeds 10 percent 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.

c. Annual family income that does not exceed 400 % of the annual poverty level.

6. Patient's Family and Determination of Family Income – For persons 18 years of age and older: Spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.
7. Reasonable payment formula - monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
   a. "Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
8. Self-pay discount discounts are provided to uninsured patients or to insured patients where the payer does not cover the services provided, or where the insured patient has exhausted their benefits. The discount provided to uninsured is 40% of total charges. This excludes self-pay discounts for OB services, which are based upon the type of delivery and the length of stay

D. PROCEDURES:

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels:

Income Level	Discount Amount
Up to 400% of FPL	100% Discount
401% to 500% FPL	75% Discount
Over 500% of FPL	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

   a. All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Patient Financial Assessment Form (PFAF). If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre-arranged with the Hospital financial counselor. Charity determinations over $25,000 require the approval of the Chief Financial Officer or his/her designee.
2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a PFAF should be completed.
   a. Family Members – Patient will be required to provide the number of family members in their household.
   b. Income Calculation – Patient will be required to provide their household's yearly gross income. Adult patient's yearly income on the PFAF means the sum of the total yearly

gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the PFAF means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.

c. Income verification – Patients will be required to verify the income set forth in the PFAF. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.

d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:

i. Expired patients: Expired patients may be deemed to have no income.

ii. Written Attestation: Patient can sign the PFAF attesting to the accuracy of the income information provided.

iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.

3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patients will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.
4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient who is eligible for partial charity to pay over an extended period of time. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" formula to determine the payment plan.
5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or County-funded health coverage program.
6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.
7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt that the external agency will adhere to the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. NOTICE:

1. Timeframe - There is no rigid limit on the time when the charity determination will be made. In some cases, a patient eligible for charity care may not be identified prior to the initiation of external collection action. The Hospital's collection agencies shall be made aware of this procedure so that the agencies know to refer back to the Hospital patient accounts that may be eligible for charity care.
2. Once a full or partial charity determination has been made, a written notification will be sent to the applicant advising them of the Hospital's decision.

F. COMMUNICATION:

1. Information provided to patient – During registration, or as soon thereafter as practicable and before discharge, the Hospital shall provide:

a. All uninsured patients with written information regarding the Hospital's charity care

policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.

b. At the request of the patient, the Charity application will be provided.

c. Patient statements to patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or County- funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications. Further, this information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, to the extent possible, these communications will be in the primary language of the patient.

d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physicians. The statement will include contact information for the emergency room physician who treated the patient.

2. Postings and Other Notices – Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

G. FORMS/RELATED DOCUMENTS:

1. Patient Financial Assessment Form - Sample

H. REFERENCE:

1. California Health and Safety Code, Section 127400, et. Seq
2. ACA provisions, IRC §501(r)

Tri-City Medical Center

Financial Assistance Application Program

Financial Assistance (Charity Care) is available to you if you don't have the resources to pay your hospital expenses and don't qualify for any government programs. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability after their insurance has paid will be screened for charity care. If you need assistance in completing the form please (760) 940-5912.

Instructions for Completing the Application for Financial Assistance:

Financial Assistance Qualifications: All application funding sources must be complied with and determined prior such as Medi-Cal and other state or county programs. Your financial assistance application may be pended if you have applied for another health coverage program at the same time until the outcome for that application has been determined.

- Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **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.
- 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.

Proof of Income Required: Along with your application, please attach the following information or an explanation as to why this information is not available. Missing documentation may delay the process of your application and could result in a denial for financial assistance.

- Current employer's three (3) months of pay stubs or other statements of income for all family members
- All current bank statement(s) for all family members
- Previous year's tax return
- Monthly household expenses not included on the application

Once completed, the application and supporting documents can be submitted to any registration team member, cashier, or patient financial services team.

Financial Assistance Notification Process: Once the eligibility process is complete you will receive a financial assistance notification letter in the mail. The form will indicate if you are eligible for full or partial Financial Assistance. You may receive a notification that you are ineligible for financial assistance or that more information is needed to make a determination.

Sincerely,
Tri-City Medical Center - Financial Assistance Team

Tri-City Medical Center

Financial Assistance Application Form

Application Date: _____

Patient Information

Patient Name (Last, First)	Date of Birth:
Street Address	Phone Number:
City, State, Zip Code	Medical Record or Account Number

Spouse or Parent/Guardian (if patient is less than 18 years old) Information

Name (Last, First)	Date of Birth:
Street Address (if not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Other Parent Information (if patient is less than 18 years old)

Name (Last, First)	Date of Birth:
Street Address (if not same as patient)	Phone Number:
City, State, Zip Code	Relationship to Patient:

Additional Questions (Please circle Yes or No)

Was the patient a resident of California at the time of service?	Yes	No
Did the patient have medical insurance at the time of service?	Yes	No
Was the patient an active Medicaid recipient at the time of service?	Yes	No
**If you answered *yes* to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.		

Family Household/Dependents (List the number of family members who live in your home)

Name	Relationship to Patient	Age

Tri-City Medical Center

Monthly Gross Income (List ALL adult Income from family members in the household)

Monthly Gross (Before Taxes) Income Sources	Patient	Family Members
Employment/Self Employment	$	$
Social Security	$	$
Disability	$	$
Unemployment	$	$
Pension, Retirement, Annuity	$	$
Alimony/Child Support	$	$
Other	$	$
Total Combined Monthly Income: $		
If you do not have monthly income, please attach a written statement explaining how you or the patient are taking care of your monthly expenses including who provides food, shelter, transportation, etc. and how long you have been without income.		

Monthly Assets and Expenses

Monthly Expenses		Monthly Assets	
Rent/Mortgage	$	Checking Account Balance	$
Utilities	$	Saving Account Balance	$
Car Payments	$	Business Ownership	$
Medical Expenses	$	Stocks and Bonds	$
Insurance Premiums (life, home, car, medical)	$	Real Estate (excluding primary residence)	$
Medical Expenses	$	Other	$
Clothing, Groceries, Household Goods	$		
Other Debt/Expenses (child support, loans, other)	$		

My signature below certified that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Name Applicant's Signature Date

Please send your completed application and required documents to:

Tri-City Medical Center
Patient Accounting
4002 Vista Way
Oceanside, CA 92056