Title/Description CHARITY CARE/PATIENT FINANCIAL ASSISTANCE				
Date Effective JAN/1.2007	Date Revised 12/1/2020		Applies to: Business Office	Approved By Kristen Templeton Director of Patient Accounting

POLICY OVERVIEW:

San Benito Health Care District is committed to providing financial assistance to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual financial situations. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Hazel Hawkins procedures for obtaining financial assistance.

ELIGIBILITY FOR PATIENT FINANCIAL ASSISTANCE/CHARITY CARE:

1. Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible or have limited serves for any government health care benefit program, no third-party insurance, and no compensable injury for purposes of workers compensation, automobile insurance or other insurance as determined and documented by the hospital., based upon a determination of financial need in accordance with the policy.

2. Eligibility for High Medical Cost Patients will be considered for those individuals who are not self pay, out-of-pocket medical expenses in prior 12 months (whether incurred in or out of the hospital) exceeds 10% of family income. A person with high medical costs will include all charges to patients covered by Third Party insurance, even if those charges include discounted rates as result of the third-party insurance coverage.

3. Eligibility for financial assistance will be considered for patients that have expired and do not have an estate.

4. Eligibility for financial assistance will be considered for patients that their guarantor has expired and do not have an estate.

5. Eligibility for financial assistance will be considered for patients that have Limited Services for Medi-Cal

6. Eligibility for financial assistance will be considered for patients that are going to College full time.

PATIENT FINANCIAL ASSISTANCE POLICY

POLICY OVERVIEW:

San Benito Health Care District is committed to providing financial assistance to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program, and are otherwise unable to pay for medically necessary care based on their individual financial situations. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Hazel Hawkins procedures for obtaining financial assistance.

ELIGIBILITY FOR PATIENT FINANCIAL ASSISTANCE:

1. Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible or have limited serves for any government health care benefit program, no third-party insurance, and no compensable injury for purposes of workers compensation, automobile insurance or other insurance as determined and documented by the hospital., based upon a determination of financial need in accordance with the policy.

2. Eligibility for High Medical Cost Patients will be considered for those individuals who are not self pay, out-of-pocket medical expenses in prior 12 months (whether incurred in or out of the hospital) exceeds 10% of family income. A person with high medical costs will include all charges to patients covered by Third Party insurance, even if those charges include discounted rates as result of the third-party insurance coverage.

3. Eligibility for financial assistance will be considered for patients that have expired and do not have an estate.

4. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age gender, race, socio-economic or immigrant status, or religious affiliation.

5. Clinic accounts will be assessed according the Sliding Fee Scale.

6. 30% of the Medi-Medi bad debts reported on the cost report related to services provided in the current year may be included as charity care.

DETERMINATION OF FINANCIAL NEED:

1. Financial need will be determined through an individual assessment of financial need, including an application process in which the patient or the patient's

7. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age gender, race, socio-economic or immigrant status, or religious affiliation.

8. Clinic accounts will be assessed according the Sliding Fee Scale.

9. 30% of the Medi-Medi bad debts reported on the cost report related to services provided in the current year may be included as charity care.

DETERMINATION OF FINANCIAL NEED:

1. Financial need will be determined through an individual assessment of financial need, including an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need. The following items will required to complete the application process:

    a.) A valid Medical denial an or Covered California Insurance denial on any application that is below the 300% Federal Poverty Limit (FPL).
    b.) A completed Financial Application.
    c.) Last 3 months of pay check stubs or income statements.
    d.) Last year's income tax return.
    e.) Statements on any monetary assets. (Monetary assets exclude retirement or deferred compensation plans and include only 50% of monetary assets over $10,000.00)
    f.) Application process must be completed within 150 days after the initial billing or application will be denied. Any application past the 150 days must be approved by the Director of Patient Accounting
2. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need or financial assistance shall be re-evaluated every 6 Months or at the discretion of the Director of Patient Accounting
3. A new valid Medi-Cal denial will be required for every Inpatient Admission unless the patient has insurance primary.
4. All Clinic visits will be process as Sliding-Fee scale.
5. All Elective Procedures will not be considered for Charity Care but will qualify for the Self-Pay Rate. Elective Procedures include Outpatient Surgeries, Therapy, Lab services, Radiology Services including Ultra Sound, MRI's, and CT's.
6. Application will note be needed for the following circumstances :
    a.) Patient or patient guarantor has expired
    b.) Patient is on Limited Services Medi-Cal (patient at this time has already completed the Medi-Cal application and meets the poverty guidelines.)

PATIENT FINANCIAL ASSISTANCE GUIDELINES:

guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need. The following items will required to complete the application process:

a.) A valid Medical denial an or Covered California Insurance denial on any application that is below the 300% Federal Poverty Limit (FPL).
b.) A completed Financial Application.
c.) Last 3 months of pay check stubs or income statements.
d.) Last year's income tax return.
e.) Statements on any monetary assets. (Monetary assets exclude retirement or deferred compensation plans and include only 50% of monetary assets over $10,000.00)
f.) Application process must be completed within 150 days after the initial billing or application will be denied.

2. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need or financial assistance shall be re-evaluated every 6 Months or at the discretion of the Business Office Manager.
3. A new valid Medi-Cal denial will be required for every Inpatient Admission.
4. All Clinic visits will be process as Sliding-Fee scale.
5. All Elective Procedures must be pre-approved by the Business Office Manager. Elective Procedures include Outpatient Surgeries, Therapy, Lab services, Radiology Services including Ultra Sound, MRI's, and CT's.

PATIENT FINANCIAL ASSISTANCE GUIDELINES:

1.) Patients with gross income below 300% of the poverty level will be eligible for 100% charity write off.
2.) Patients with gross income above 300% but not more then 400% of the poverty level will be eligible for services at rates that will not exceed what Medicare would pay for outpatient services and will not exceed what Medi-Cal would pay for inpatient services.
3.) Patients with gross income above 400% of the poverty level will be eligible for a prompt payment discount according to the discount policy.

NOTIFCATION PROCESS:

1.) Once the eligibility process is completed, the applicant will receive a notification by mail of approval or denial.
2.) The form will indicate whether the applicant is eligible for full or partial financial assistance.
3.) The form will indicate if more information is needed or the application is incomplete. If the application is incomplete, it will be noted what is needed and the applicant will have 15 days from the date of the letter to provide the needed information. If the information is not provided with in 15 days, the applicant will receive a final denial.

1.) Patients with gross income below 300% of the poverty level will be eligible for 100% charity write off.
2.) Patients with gross income above 300% but not more then 400% of the poverty level will be eligible for services at rates that will not exceed what Medicare would pay for outpatient services and will not exceed what Medi-Cal would pay for inpatient services.
3.) Patients with gross income above 400% of the poverty level will be eligible for a prompt payment discount according to the discount policy.

NOTIFCATION PROCESS:

1.) Once the eligibility process is completed, the applicant will receive a notification by mail of approval or denial.
2.) The form will indicate whether the applicant is eligible for full or partial financial assistance.
3.) The form will indicate if more information is needed or the application is incomplete. If the application is incomplete, it will be noted what is needed and the applicant will have 15 days from the date of the letter to provide the needed information. If the information is not provided with in 15 days, the applicant will receive a final denial.

COMMUNICATION OF THE FINANCIAL ASSISTANCE PROGRAM TO PATIENTS:

1.) Information about the Patient Financial Assistance Program will be available in designated areas of the hospital in various means, including posting notices in the Emergency and Admitting Departments, Business Office, and at other public places as the Hazel Hawkins Hospital may elect.
2.) Information about Patient Financial Assistance will be included in the patient's first bill of notice.

APPLEAL PROCESS:

1.) If the application is denied, the applicant has the right to appeal the denial within 30 days of the date the application was denied.
2.) The appeal must be in writing and must include why they are appealing the denial of the application.
3.) If additional documentation is required, it must be received within 15 days of the request.
4.) All appeals will be directed to the Director of Patient Accounting for review.
5.) Within 30 days the applicant will be given a final decision of the appeal.

COMMUNICATION OF THE FINANCIAL ASSISTANCE PROGRAM TO PATIENTS:

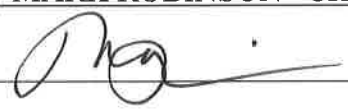
1.) Information about the Patient Financial Assistance Program will be available in designated areas of the hospital in various means, including posting notices in the Emergency and Admitting Departments, Business Office, and at other public places as the Hazel Hawkins Hospital may elect.
2.) Information about Patient Financial Assistance will be included in the patient's first bill of notice.

APPLEAL PROCESS:

1.) If the application is denied, the applicant has the right to appeal the denial within 30 days of the date the application was denied.
2.) The appeal must be in writing and must include why they are appealing the denial of the application.
3.) If additional documentation is required, it must be received within 15 days of the request.
4.) All appeals will be directed to the Business Office Manager for review.
5.) Within 30 days the applicant will be given a final decision of the appeal.

WRITTEN BY: KRISTEN TEMPLETON DIRECTOR OF PATIENT ACCOUNTING

APPROVED BY: MARK ROBINSON CHIEF FINANCIAL OFFICER

SIGNATURE: 

EFFECTIVE: JANUARY 1, 2007
REVIEWED: MARCH 30,2017

Title/Description Sliding Fee Scale				Filing Number CHC\#
Date Reviewed	Date Revised 1/1/2020	Date Effective 9/25/96	Applies to: Clinic Staff & Business Office Staff	Approved By: Kristen Templeton

STANDARD

The Sliding Fee Scale is for self-pay patients who request medical care at Hazel Hawkins Community Health Clinics and need financial assistance to pay their bill. To qualify for the Sliding Fee Scale program they must be ineligible for federal or state government assistance programs and/or insurance coverage through any third party payer. They must meet the Federal Poverty level laid out in the Slide Fee Scale Procedure below.

PROCEDURE:

The Sliding Fee Scale Guidelines are determined by the current year "Federal Poverty Income Guidelines" for size of household and income. (Example A)

An Assessment for Sliding Fee Scale Consideration Form will be completed on all patients that are self-pay who state that they would like to apply for the program on the Patient Questionnaire Form. (Example B)

Upon completion of the Assessment for Sliding Fee Scale Form by the patient, the Clinic Front Office clerk will:

- The Clinic Staff will verbally ask the patient for the number of members in their household
- The Clinic Staff will advise them that they have seven (7) calendar days to bring in the following required income documentation:

    1. Current month and last month's payroll stubs,
    2. Bank statements for the last 2 months,
    3. A copy of the last year's tax return or W2

- If the patient brings in one of the required income verification documentation they will be approved for the Sliding Fee Scale for one month. If they bring in two of the required income verification documentations they will be approved for the Sliding Fee Scale for 6 months.
- The Clinic Staff will advise the patient that if they are not able to bring the required documentation into the clinic within the seven (7) calendar days they will need to go to the Business Office located on the main hospital campus within thirty (30) calendar days with the required income documentation to qualify for the Sliding Fee Scale. Anything after thirty (30) calendar days will disqualify the patient for the Sliding Fee Scale and the patient will be charged full rate.

- Once the above information is received the Clinic Front Office staff or Business Office staff will compare the size of family and income to the Sliding Fee Scale Guidelines. Monthly or Yearly Income Guide will be used to determine the appropriate percentage level. The following is the amount the patient will pay for the clinic visit according to where they fall in the Federal Poverty Guidelines by the department of Health Care Services:

    1. Less than 100% of Federal Poverty Guideline patient will be discounted 100% of the clinic visit
    2. 100% to 149% of Federal Poverty Guideline patient will owe $10.00 per clinic visit
    3. 150% to 200% of Federal Poverty Guideline patient will owe $25.00 per clinic visit
    4. 201% to 250% of Federal Poverty Guideline patient will owe $50.00 per clinic visit
    5. Anything over the 250% of Federal Poverty Guideline patient will not qualify for the Sliding Fee Scale and will owe 100% of the visit.

- If the patient qualifies for the Sliding Fee Scale they will be asked to pay the full amount owed on the day that they qualify and/or at the time of the visit
- A copy of their charge sheet will be kept in a pending file for seven (7) calendar days.
- The Assessment for Sliding Fee scale Consideration Form will be scanned in the patient account.

ASSESSMENT FOR SLIDING FEE SCALE CONSIDERATION

All of the following questions MUST be answered

Number of family members that you provide sole support for _____ (must live in your home)

Total annual income _____

OR

Total monthly income _____

YOUR INCOME AMOUNT MUST BE SUPPORTED BY THE FOLLOWING:

1. Copies of payroll stubs for the current month and last month [ ]
2. Copies of your bank statements for the last 2 months [ ]
3. Copies of last year's tax return **OR** W2 Forms [ ]

Patient qualifies for: **[ ] One time visit only** **[ ] 3 months**

Date _____ **Percentage qualified at** _____ **%**

To qualify for the program all of the financial information must include the current month's income.

By signing I agree to bring in income verification and pay office visit within 7 calendar days.

Firmando esta forma entiendo que tengo que traer verficacion de ingresos y pagar por la consulta antes de 7 dias.

Signature / Firma: _____ **Date / Fecha:** _____

NOTE: IF YOU HAVE ANY TYPE OF HEALTH INSURANCE INCLUDING MEDI-CAL WITH A SHARE OF COST, YOU DO NOT QUALIFY FOR THE SLIDING FEE SCALE PROGRAM.

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

HAZEL HAWKINS MEMORIAL HOSPITAL
911 SUNSET DRIVE • HOLLISTER, CA 95023
"A PUBLIC AGENCY"
(831) 637-5711

ASSESSMENT FOR SLIDING FEE SCALE CONSIDERATION

ADMFEESCALE

Patient Sticker