Daughters of Charity Health System

DCHS POLICIES AND PROCEDURES

SECTION 06: FINANCIAL INTEGRITY AND UNIFORM REPORTING

POLICY/PROCEDURE #:	**06.03.04**
TITLE:	**CHARITY CARE AND DISCOUNTED PAYMENT POLICY** **(Formerly titled FINANCIAL DISCOUNT POLICY)**
BOARD APPROVAL DATE:	**July 28, 2005**
EFFECTIVE DATE:	**July 28, 2005**
REVISION DATE(s):	**April 27, 2007** **February 22, 2008** **October 23, 2009** **September 30, 2011** **June 21, 2013** **January 1, 2015**
APPROVED:	 **Robert Issai, President/CEO**
Reference to System Policy:	**06.03.08 Financial Assistance Policy**
Reference to CBS Policy:	N/A

I. POLICY

Pursuant to this Charity Care and Discounted Payment Policy (the "Policy"), Daughters of Charity Health System ("DCHS"), through its Local Health Ministries ("LHMs"), will provide Charity Care or Discounted Payment to eligible low income, uninsured and underinsured patients who meet certain eligibility requirements, as set forth herein. This Policy is adopted both in accordance with the Daughters of Charity mission and with requirements set forth in California Health & Safety Code §§ 127400 *et seq*.

II. POLICY PURPOSE AND PRINCIPLES

The purpose of this Policy is to ensure that DCHS, in keeping with the mission and values of the Daughters of Charity and its founders, St. Vincent de Paul, St. Louise de Marillac and St. Elizabeth Ann Seton, provides health care services and equal access to

its diagnostic and therapeutic treatments, regardless of the financial status of the patient and in a manner that respects the dignity of patients and their families.

It is the policy of DCHS to advance and strengthen the healing mission of the Catholic Church by providing comprehensive, excellent health care that is compassionate and attentive to the whole person—body, mind and spirit. In furtherance of these principles, LHMs will provide hospital services without delay or limitation and without regard to the patient's ability to pay or pending eligibility and/or financial discount determinations.

III. DEFINITIONS

A. "**Charity Care**" means Medically Necessary Services provided at no cost to a Financially Qualified Patient whose income is at or below 200 percent of the Federal Poverty Level.

B. "**Discounted Payment**"means that an LHM shall limit the expected payment for Medically Necessary Services to a discounted rate for Financially Qualified Patients whose income is between 201 and 350 percent, inclusive, of the Federal Poverty Level.

C. "**Essential Living Expenses**"means expenses for any 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.

D. "**Federal Poverty Level**" is defined in the chart set forth on Attachment A, based on the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services. The DCHS Patient Financial Services ("PFS") Department will update Attachment A annually upon publication of updated poverty guidelines in the Federal Register.

E. "**Financially Qualified Patient**" means a patient who is both of the following:

1. A patient who is a Self-Pay Patient, as defined in Section III.J, *or* a Patient with High Medical Costs, as defined in Section III.H; and
2. A patient whose family income does not exceed 350 percent of the Federal Poverty Level.

F. "**Income**" includes, but is not limited to, wages, salaries, Social Security payments, public assistance, unemployment and workers' compensation, veterans' benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets and one-time insurance or compensation payments.

G. "**Medically Necessary Service**"means a service or treatment provided or billed by the LHM that is necessary to treat or diagnose a patient and could adversely affect the patient's condition, illness or injury if it were omitted, and the service or treatment is not considered an elective or cosmetic surgery service or treatment.

H. "**Patient with High Medical Costs**" means a patient who meets *all* of the following requirements:

1. A patient with third party coverage (*i.e.*, not a Self-Pay Patient);
2. A patient whose family income does not exceed 350 percent of the Federal Poverty Level; and
3. A patient whose annual out-of-pocket costs incurred by the individual at the LHM exceed 10 percent of the patient's family income in the prior 12 months; *or* whose annual out-of-pocket medical expenses exceed 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.

I. "**Patient's Family**" means the following:

1. For persons 18 years of age and older:
   a. Spouse;
   b. Domestic partner, as defined in Section 297 of the California Family Code; and
   c. Dependent children under 21 years of age, whether living at home or not.
2. For persons under 18 years of age:
   a. Parent;
   b. Caretaker relative; and
   c. Other children under 21 years of age of the parent or caretaker relative.

J. "**Self-Pay Patient**" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medi-Cal, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance or other insurance, as determined and documented by the LHM.

K. "**Reasonable Payment Plan**" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for Essential Living Expenses.

IV. ELIGIBILITY

A. **Eligible Services.**

1. Charity Care and Discounted Payment Programs apply to all types of hospital services provided or billed by an LHM, subject to the terms of this Section. Services not provided or billed by the LHM are not covered by this Policy.
2. Non-Medically Necessary Services are not covered by this Policy unless the service or procedure has been ordered by a physician who is a member of the medical staff of an LHM.

3. Emergency physicians who provide emergency medical services in a hospital that provides emergency care are required by law to provide discounts to Self-Pay Patients and Patients with High Medical Costs who are at or below 350 percent of the Federal Poverty Level. Patients must contact the emergency physician's billing office for further information regarding financial assistance programs for emergency services.

B. **General Eligibility.**

1. Eligibility for the Charity Care Program or Discounted Payment Program will be determined on an individual basis and evaluated on an assessment of the patient's and/or family's need, financial resources, and all financial obligations including medical expenses.

2. Charity Care and Discounted Payment will be provided to Financially Qualified Patients without regard to race, religion, color, creed, age, gender, sexual orientation, national origin or immigration status.

3. Before a patient may be eligible for the Charity Care Program or the Discounted Payment Program, all available resources must first be applied, including, but not limited to, private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children's Services Program, or other state- or county-funded programs designed to provide health coverage.

4. Patients who are eligible for government sponsored programs may apply for the Charity Care Program or Discounted Payment Program for Medically Necessary Services not covered by government programs.

5. Patients who are currently eligible for Medicaid in a state other than California will qualify for a 100 percent financial discount under this Policy.

6. Determining eligibility for the Charity Care Program and Discounted Payment Program requires the full cooperation of patients and their families, who must provide and complete required documents and information on a timely basis. If a person requesting a determination of eligibility under this Policy fails to provide information that is reasonable and necessary for the LHM to determine eligibility, the LHM may consider that failure in making its determination.

7. Patients who are eligible for and/or receive financial assistance under the Charity Care or Discounted Payment Policy may not receive financial assistance pursuant to DCHS's Financial Assistance Policy (Policy No. 06.03.08). On the other hand, patients who are *not* eligible for Charity Care or a Discounted Payment under this Policy may apply for a financial assistance pursuant to the DCHS Financial Assistance Policy (Policy No. 06.03.08).

C. **Specific Eligibility.** Patients may apply for financial assistance under Section C.1 or Section C.2, as described below.

1. Discounted Payment Program. Both Self-Pay Patients and Patients with High Medical Costs are eligible to apply for the Discounted Payment Program.

   a. **Self-Pay Patients:** For Self-Pay Patients whose family income is between 201 percent and 350 percent, inclusive, of the Federal Poverty Level, each LHM shall limit the expected payment for services provided by the LHM to the amount of payment the LHM would expect in good faith to receive for providing services under Medicare, Medi-Cal, Healthy Families Program or another government-sponsored health program of health benefits in which the LHM participates (collectively, "**government-sponsored program rate**"), whichever is greater. If an LHM provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the LHM participates, then the LHM shall establish an appropriate Discounted Payment amount.

   b. **Patients with High Medical Costs:** For Patients with High Medical Costs whose documented income is between 201 percent and 350 percent, inclusive, of the Federal Poverty Level, each LHM shall limit the expected payment for services provided by the LHM to the amount of payment to the lesser of (i) the balance after any insurance payments are applied or (ii) the applicable government-sponsored program rate.

   After determining the applicable rate, the LHM will apply the sliding scale set forth on Attachment A.

   Patients seeking Discounted Payment must make reasonable efforts to provide the LHM with documentation of income (limited to recent pay stubs or income tax returns) and health benefits coverage. Patients with High Medical Costs also must provide documentation of medical expenses paid by such patients or their families in the prior 12 months.

2. Charity Care Program. LHMs will provide Charity Care (*i.e.*, care at no cost) to Financially Qualified Patients who are unable to pay, regardless of insurance status, provided that the patient's income is at or below 200 percent of the Federal Poverty Level.

   Patients seeking Charity Care must make reasonable efforts to provide the LHM with documentation of income, monetary assets (including all liquid and non-liquid assets owned, less liabilities and claims against such assets) and health benefits coverage.

   However, monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans. Also, the first $10,000 of the

patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first $10,000 be counted in determining eligibility. The LHM may, nonetheless, require waivers or releases from the patient or the patient's family authorizing the LHM to obtain verifying information from financial or commercial institutions, or other entities that hold or maintain the monetary assets.

V. APPLICATION PROCEDURES

A. Notice Requirements.

1. Posted Notice.Each LHM will post the availability of Charity Care and Discounted Care under this Policy, as set forth on Attachment B, at all locations with high patient volume, including admission and registration areas, emergency departments, outpatient settings and PFS offices.

2. Written Notice.Each LHM will provide patients with written notice containing information about availability of the Charity Care and Discounted Payment Programs, including information about eligibility, as well as contact information for a hospital employee or office from which the person may obtain additional information about this Policy. This written notice also will be provided to patients who receive emergency and/or outpatient care and who may be billed for that care, but were not admitted as an inpatient. The notice shall be available in English and other languages, as determined by each LHM's primary service area and in accordance with applicable federal and state law. Each LHM shall retain written acknowledgement of a patient's receipt of such notice.

3. Billing Statements. LHM billing statements communicate the availability of government sponsored programs and DCHS Charity Care and Discounted Payment Programs for eligible patients and for any patient who has not provided proof of coverage at the time of billing. Each LHM shall provide the following information with a patient's bill:

   a. A statement of charges for services provided by the LHM;

   b. A request that the patient inform the LHM if the patient has health insurance coverage, including Medicare, Healthy Families, Medi-Cal or other coverage;

   c. A statement indicating how patients may obtain applications for government sponsored coverage and that the LHM will provide these applications; and

   d. The name and telephone number of the LHM employee from whom, or office from which, a patient may obtain information about the LHM's financial assistance policies, and how to apply for assistance under those policies.

B. Identification of Financially Qualified Patients.

1. Financial counselors or Health Benefits Resource Center ("HBRC") staff at each LHM will make reasonable efforts to obtain from the patient or

his/her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the LHM to the patient.

2. Financial counselors and HBRC staff at each LHM will assist patients in understanding and applying for government sponsored programs and for Charity Care or Discounted Payment.

3. Each LHM will provide information about and applications for Medi-Cal, the Healthy Families Program, the California Health Benefit Exchange, and other state- or county-funded health coverage to uninsured patients in registration areas as well as in the PFS Department office. If the patient does not indicate coverage by a third-party payer or requests a discounted price, then each LHM will provide the patient with an application for applicable government programs. Such applications will be made available prior to discharge (if the patient has been admitted) or to patients receiving emergency or outpatient care.

4. If a patient applies, or has a pending application, for another health coverage program at the same time s/he applies for Charity Care or Discount Payment under this Policy, neither application shall preclude eligibility for the other program.

C. **Application Process.**

1. A Financial Discount Application, set forth on Attachment C, is provided to patients to begin assessment of a patient's qualifications for the Charity Care or Discounted Payment under this Policy. Patients may be referred to the Charity Care or Discounted Payment Programs by the patient's physician, family members, community or religious groups, social services or hospital personnel.

2. Eligibility for the Charity Care and Discounted Payment Programs requires the patient, the patient's guarantor or the patient's legal representative to provide accurate information and use reasonable efforts to provide all documentation necessary. If a person requesting a determination of eligibility under this Policy fails to provide the information that is reasonable and necessary for the LHM to determine eligibility, the LHM may consider that failure in making its determination.

3. Incomplete Financial Discount Applications will be denied due to insufficient information. The application will be returned to the patient with a cover letter requesting additional and/or missing information.

4. If the patient fails to complete an application or the application contains insufficient information and the patient does not comply with requests as noted in Sections V.C.2 and V.C.3, the LHM will utilize a risk assessment scoring software algorithm to determine presumptive eligibility. The software will be an industry-wide accepted product that has been validated by external audit.

5. LHM HBRC staff may provide presumptive Medi-Cal eligibility for financial assistance applicants. If LHM HBRC staff determine that there is no linkage to Medi-Cal, they may provide that determination in lieu of a Medi-Cal application denial.

6. Eligibility for Charity Care or Discounted Payment is valid by individual admission. Eligible patients will be requested to attest to absence of changes in financial status for subsequent admissions or to furnish updated information reflecting changes in financial status, as applicable.

7. Documents used for verification of a patient's financial resources and household income in the Financial Discount Application may include, but are not limited to:

    a. A copy of federal tax returns from the prior year, including schedules as applicable;

    b. Copies of current paystubs, Social Security, disability or unemployment checks or award letters;

    c. A copy of any Medi-Cal Decision/Denial Notice;

    d. Household income of the patient and, if the patient is 18 years or older, the patient's spouse or domestic partner, and any dependent children under age 21, whether living at home or not; if the patient is under age l8, consider income of the patient, the patient's parents, guardians or caretaker relatives, and other children under age 21, whether living at home or not.

8. Collection activities will be suspended during the eligibility determination process.

9. An LHM may adjust the eligibility criteria from time-to-time based on its financial resources and as necessary to meet the financial needs of its community with the prior written approval of the DCHS Chief Financial Officer ("CFO") and legal counsel.

10. LHMs keep all applications and supporting documentation confidential in accordance with the DCHS Policy/Procedure 11.0, Compliance with the Health Insurance Portability and Accountability Act of 1996.

11. Eligibility for Charity Care or Discounted Payment may be determined at any time by the LHM as information on the patient's eligibility becomes available.

D. **Notification of Charity Care or Discounted Payment Determination.**

1. The LHM's PFS Department will provide an eligibility determination to the patient or his/her representative within thirty (30) days after receipt of a completed Financial Assistance Application, including all required documentation.

2. A notification regarding the Charity Care or Discounted Payment determination will be mailed to the patient or his/her representative. This

notification will identify the amount due from the patient and the amount of payment discount, if any, applied to the patient's account.

3. A patient or his/her representative(s) may appeal a determination by providing additional information, such as income verification or an explanation of extenuating circumstances, to the PFS Director within thirty (30) days of notification of the LHM's determination. The LHM PFS Director will review and decide all appeals. The patient or his/her representative will be notified of the outcome.

E. **Amount of Charity Care or Discounted Payment.**

1. DCHS provides Charity Care for Medically Necessary Services at no cost to Financially Qualified Patients whose income is at or below 200 percent of the Federal Poverty Level.

2. DCHS provides Discounted Payment for Medically Necessary Services based on a sliding-fee, as set forth on Attachment A, to Financially Qualified Patients whose income is between 201 and 350 percent, inclusive, of the Federal Poverty Level.

3. An LHM may take into account unusual or exceptional patient circumstances and adjust the amount of financial discount under this Policy. These cases must follow the LHM's documentation guidelines and be approved by the DCHS Executive Vice President and the DCHS CFO.

F. **Payment Plans for Financially Qualified Patients.**

1. A patient who qualifies for Discounted Payment shall cooperate with the LHM in establishing an extended payment plan. If the LHM and the patient cannot agree on an extended payment plan, then the LHM shall create a Reasonable Payment Plan. Such payment plan shall be interest-free and negotiable.

	Total Amount Owed and Months to Pay		
Total Amount Owed	$1 to $500	$501 to $3,000	$3,001+
Manager Approval	6 months	12 months	24 months
Director Approval	12 months	24 months	36 months

2. A patient who qualifies for a Discounted Payment must make good-faith efforts to honor the payment plan. Patients are responsible for communicating to the PFS Department any time an agreed upon payment plan may be broken.

3. An LHM may declare an extended payment plan (including a Reasonable Payment Plan) inoperative if the patient fails to make all consecutive payments during a 90-day period. Before declaring an extended payment plan inoperative, the LHM, collection agency or assignee shall make a reasonable attempt to contact the patient by telephone, give written notice

that the extended payment plan may become inoperative, and inform the patient that s/he may renegotiate the terms of the payment plan.

4. Any variation in or deviation from an agreed upon payment plan must be approved by the LHM's CFO.

VI. COLLECTION PRACTICES FOR FINANCIALLY QUALIFIED PATIENTS

A. Each LHM will maintain a written policy stating when and under whose authority patient debt is advanced for collection, and whether the collection activity is conducted by the LHM, an affiliate or a subsidiary of the LHM, or by an external collection agency.

B. Any written agreement between an LHM and an agency that collects such LHM's receivables shall require the affiliate, subsidiary or external collection agency of the LHM that collects the debt to comply with the LHM's definition and application of a Reasonable Payment Plan, as set forth in this Policy. Furthermore, collections agencies used by LHMs must follow fair debt and collection practices according to this Policy, and must further act in a manner that treats individuals with dignity, respect and compassion.

C. Prior to commencing collection activities, each LHM or its assignee shall provide the patient with written notice containing (1) a statement that nonprofit credit counseling services may be available in the area, and (2) a plain language summary of the patient's rights pursuant to California Health and Safety Code Section 127430(a), with the following summary being sufficient if it appears in substantially the following form:

> 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 8:00 a.m. or after 9:00 p.m. 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 1-877-FTC-HELP (382-4357) or online at www.ftc.gov.

Each LHM also will provide this notice to patients along with any document indicating that the commencement of collection activities may occur.

D. No LHM will pursue legal action for nonpayment of bills against any household where the primary wage earner(s) is unemployed or there are not significant income sources.

E. Financially Qualified Patients meeting an agreed upon monthly payment plan will not be assigned to a collection agency or reported to credit bureaus.

F. Each LHM expects its external collection agencies to receive approval from the DCHS PFS Department before pursuing any legal action against an individual who meets the requirements for a Financially Qualified Patient under this Policy.

G. Each LHM or its assignee that is an affiliate or subsidiary of the LHM will not, in dealing with patients eligible under any portion of this Policy, use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills of Financially Qualified Patients.

H. In dealing with patients eligible under any portion of this Policy, a collection agency or other assignee that is not a subsidiary or affiliate of an LHM shall not use a wage garnishment (except by court order) or notice or conduct a sale of the patient's primary residence as means of collecting unpaid hospital bills.

I. Neither Section VI.G nor Section VI.H of this Policy shall preclude an LHM, a collection agency or other assignee from pursuing reimbursement or any enforcement remedy or remedies from third-party liability settlements, tortfeasors or other legally responsible parties.

J. If a patient is attempting to qualify for eligibility under the Charity Care Program or Discounted Payment Program and is attempting in good faith to settle an outstanding bill with an LHM by negotiating an extended payment plan or by making regular partial payments of a reasonable amount, then the LHM shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this Policy.

K. Neither LHMs nor any LHM assignee or collection agency will report adverse information to a consumer credit reporting agency or commence civil action against a Financially Qualified Patient under the Discounted Payment Program for nonpayment of any patient debt at any time prior to 150 days after the initial billing. This period shall be extended if the patient has a pending appeal for coverage of the services until a final determination of the appeal is made.

L. No information collected by an LHM for the purpose of determining eligibility for Charity Care or Discounted Payment shall be used for collections activities. However, the LHM, collection agency or assignee may use information obtained independently of the eligibility process for the Charity Care Program or the Discounted Payment Program.

VII. REFERENCES

California Health & Safety Code §§ 127400–127446 (Hospital Fair Pricing Policies) and §§ 127450–127462 (Emergency Physician Fair Pricing Policies)

California Family Code § 297 (Definition: Domestic Partner)

U.S. Department of Health and Human Services, Poverty Guidelines, *available at* http://aspe.hhs.gov/poverty/

Internal Revenue Code § 501(c)(3) (Tax-Exempt Organizations)

VIII. CROSS REFERENCES

Policy No. 06.03.08, Financial Assistance Policy

IX. IMPLEMENTATION AND REVIEW

This Policy is to be implemented by DCHS President and CEO, LHM Presidents and CEOs.

This Policy is to be reviewed annually for compliance and relevance by DCHS President and CEO, LHM Presidents and CEOs, and DCHS Vice President Revenue Cycle Services.

ATTACHMENT A

FINANCIAL ASSISTANCE SLIDING SCALE

DISCOUNT AS PERCENTAGE OF APPLICABLE RATE (E.G., MEDICARE)

		FEDERAL POVERTY LEVEL AND ASSOCIATED DISCOUNT										
NO. IN FAMILY OR HOUSEHOLD	FEDERAL POVERTY LEVEL (FPL) *	200% of FPL = 100% Discount	215% of FPL = 90% Discount	230% of FLP = 80% Discount	245% of FPL = 70% Discount	260% of FPL = 60% Discount	275% of FPL = 50% Discount	290% of FPL = 40% Discount	305% of FPL = 30% Discount	320% of FPL = 20% Discount	335% of FPL = 10% Discount	351% of FPL = 0% Discount
1	$11,670	$23,340	$25,091	$26,841	$28,592	$30,342	$32,093	$33,843	$35,594	$37,344	$39,095	$40,962
2	$15,730	$31,460	$33,819	$36,179	$38,538	$40,898	$43,257	$45,617	$47,976	$50,336	$52,695	$55,212
3	$19,790	$39,580	$42,548	$45,517	$48,485	$51,454	$54,423	$57,391	$60,360	$63,328	$66,297	$69,463
4	$23,850	$47,700	$51,278	$54,855	$58,433	$62,010	$65,588	$69,165	$72,743	$76,320	$79,898	$83,714
5	$27,910	$55,820	$60,007	$64,193	$68,380	$72,566	$76,753	$80,939	$85,126	$89,312	$93,499	$97,964
6	$31,970	$63,940	$68,736	$73,531	$78,327	$83,122	$87,918	$92,713	$97,509	$102,304	$107,100	$112,215
7	$36,030	$72,060	$77,465	$82,869	$88,274	$93,678	$99,083	$104,487	$109,892	$115,296	$120,701	$126,465
8	$40,090	$80,180	$86,194	$92,207	$98,221	$104,234	$110,248	$116,261	$122,275	$128,288	$134,302	$140,716
For each additional person add:	$4,060	$8,120	$8,729	$9,338	$9,947	$10,556	$11,165	$11,774	$12,383	$12,992	$13,601	$14,250

* Based on the Department of Health and Human Services (HHS) Poverty Guidelines for the 48 Contiguous States and the District of Columbia, 79 Fed. Reg. 3593 (Jan. 22, 2014), *available at*http://aspe.hhs.gov/poverty/14poverty.cfm or http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf.

ATTACHMENT B

PATIENT NOTIFICATION

Charity Care and Discounted Payment Programs

Consistent with its mission, the Daughters of Charity Health System Local Health Ministries provide free or reduced cost medical services to persons who are unable to pay for their care.

Please discuss your individual needs with a Financial Counselor. Upon completion of a Financial Discount Application, along with the submission of all required documents, you may be eligible for financial discounts as defined by the Daughters of Charity Health System Charity Care and Discounted Payment Policy.

ST. VINCENT MEDICAL CENTER

ATTACHMENT C

FINANCIAL DISCOUNT APPLICATION

In order for this application to be considered for Financial Assistance, ALL of the following documents are required, if applicable

►Completed and signed Financial Assistance Application form

►A copy of most recentFederal Income Tax return with W-2's and Schedules

►A copy of current pay stubs (**13 weeks**)

►A copy of social security, disability, or unemployment checks or award letter

►A copy of a state AHCCS/Medi-Cal Decision/Denial Notice aka Notice of Action letter. You can obtain this by contacting the Medi-Cal office in the area in which you live. All potentially eligible patients must provide a valid "Notice of Action" from AHCCS/Medi-Cal stating completion of the application and the reason for acceptance or denial. Any Notice of Action stating a failure to provide information or failure to participate in the interview will not be accepted in consideration of this Application for Financial Assistance.

►**3 months** of current bank statements (checking and savings)

Please return your completed application with all requested forms to the following address within 10 days.

St. Vincent Medical Center
Attn: Financial Assistance Coordinator
2131 West Third Street
Los Angeles, CA 90057

Contact our billing office, Patient Financial Services, at 213-484-7111, if you have any questions.

Please be advised this in not a guarantee that financial assistance will be awarded; and payments should continue on a regular basis until a determination has been made. Your application and the information provided will be reviewed and verified and a decision will be provided to you in writing.

Thank you for your cooperation. We look forward to being of assistance to you to resolve your account.

Return by this Date:

Account Number:

Account Balance:

ST. VINCENT MEDICAL CENTER

Date:

Account:

Patient Name:

CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

LAST NAME (PATIENT)	FIRST	MIDDLE	SOCIAL SECURITY #	BIRTHDATE
RESIDENCE ADDRESS (FACILITY ADDRESS IF HOMELESS)			HOW LONG	PHONE
CITY	STATE	ZIP	MARITAL STATUS	

LAST NAME (GUARANTOR IF DIFFERENCE FROM ABOVE)		SOCIAL SECURITY #	BIRTHRATE
EMPLOYER OF GUARANTOR (NAME AND FULL ADDRESS			
	PHONE		MONTHLY GROSS PAY $
OTHER EMPLOYER (NAME AND FULL ADDRESS			
	PHONE		MONTHLY GROSS PAY $
IF UNEMPLOYED, NAME OF LAST EMPLOYER AND FULL ADDRESS			
			LAST EMPLOYMENT DATE

DEPENDENT FAMILY MEMBERS (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER)	BIRTHDATE	RELATIONSHIP	EMPLOYED BY	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

☐RENT HOME ☐ OWN HOME			*OTHER MONTHLY INCOME* $ *SPECIFY SOURCE*	
OWED TO OTHERS TO WHOM OWED	PRESENT BALANCE	MONTHLY PAYMENT	**ASSETS** BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE
RENT/MORTGAGE			CHECKING	
UTILITIES			SAVINGS OR CERTIFICATE	
FOOD			403(B) OR 401(K)	
AUTO LOAN			STOCKS & BONDS	
	PRESENT BALANCE	MONTHLY PAYMENT	ASSETS BANK NUMBER &ACCOUNT NUMBER	ACCOUNT BALANCE
CREDIT CARDS			IRA	
			AUTO (YEAR & MAKE)	
			AUTO (YEAR & MAKE)	
OTHER OBLIGATIONS (CHILD SUPPORT, ALIMONY, INSURANCE PAYMENTS)			RESIDENCE MARKET VALUE	
ADDITIONAL INFORMATION			INSURANCE CASH VALUE	
BILLS OWED TO OTHER MEDICAL PROVIDERS			OTHER ASSETS (DESCRIBE. E.G., SECOND HOME)	
COST OF PRESCRIPTION MEDICATION(S)				
TOTAL DEBTS			**TOTAL ASSETS**	

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND COMPLETE. YOU ARE HEREBY AUTHORIZED TO CHECK MY CREDIT HISTORY IN ORDER TO EVALUATE THIS APPLICATION FOR FINANCIAL ASSISTANCE CONSIDERATION.

SIGNATURE	DATE