Sutter Health and Affiliates Administrative Policies and Procedures Sutter West Bay Hospitals *dba* California Pacific Medical Center	
POLICY ON FINANCIAL ASSISTANCE FOR UNINSURED PATIENTS, INCLUDING CHARITY CARE	
Finance Policy: 14-294 Supersedes 14-285, 14-291,14-292, 14-293	Date: 10/1990 Revised Date: 1/1/2015 Next Review Date: 1/1/2016
Approved by: Warren Browner, M.D., CEO	

POLICY

It is Sutter Health's policy that all hospital affiliates shall provide Financial Assistance, consistent with this policy, in the form of free or discounted care to eligible:

(1) Low-income Uninsured Patients
(*Full Charity Care, Special Circumstances Charity Care);*
(2) Patients with high medical costs
(*Catastrophic Charity Care, High Medical Cost Charity Care*); and
(3) Uninsured Patients
(*Uninsured Patient Discount, Prompt Payment Discount*).

Further, Sutter Health's policy is to provide Uninsured Patients with information required by law regarding their estimated financial responsibility for services and the availability of Financial Assistance and discounts. *Any modification of this policy must be approved in writing by the Sutter Health Controller.*

PURPOSE

This policy is intended to:

(1) Define the forms of available Financial Assistance and the associated eligibility criteria; and
(2) Establish the processes that patients shall follow in applying for Financial Assistance and the process the hospital will follow in reviewing applications for Financial Assistance; and
(3) Provide a means of review in the event of a dispute over a Financial Assistance determination; and
(4) Provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance; and
(5) Establish the process that patients shall follow to request an estimate of their financial responsibility for services, and the process the hospital shall follow to provide patients with these estimates.

GENERAL INFORMATION

A. Interaction with Other Policies.
This policy is intended to be read with the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227).*

B. Scope of Policy.
This policy does not create an obligation for hospital affiliates to pay for charges of physicians or other medical providers including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc. not included in the hospital bill.

DEFINITIONS AND ELIGIBILITY

**** Financial Assistance is available to eligible patients who receive Covered Services and who follow applicable procedures (such as completing applications and providing required information).***

A. **Financial Assistance:** The term Financial Assistance refers to Full and Partial Charity Care, Special Circumstance Charity Care, Catastrophic Charity Care, High Medical Cost Charity Care, the Uninsured Patient Discount, and the Prompt Payment Discount. Guidelines for determining when the Financial Assistance policy applies to particular circumstances that arise during the ordinary course of business are set forth in Exhibit A.

1. **Full Charity Care:** Full Charity Care is a *complete* write-off of the hospital's undiscounted charges for Covered Services. Full Charity Care is available to patients:
    a. Whose Family Incomes are at or below 400% of the most recent Federal Poverty Income Guidelines (Exhibit B) (the 400% threshold represents the minimum required to be offered to low-income uninsured patients; hospital affiliates may adopt a higher income threshold); and
    b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability.

2. **Special Circumstances Charity Care:** Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance criteria set forth in section 1 or 2, above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of the hospital's undiscounted charges for Covered Services, with the approval of the affiliate hospital Chief Financial Officer, or designee. The hospital must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non-exhaustive list of some situations that may qualify for Special Circumstances Charity Care:
    a. Bankruptcy: Patients who are in bankruptcy or recently completed bankruptcy.
    b. Homeless Patients: Emergency room patients without a payment source if they do not have a job, mailing address, residence, or insurance.
    c. Deceased: Deceased patients without insurance, an estate or third party coverage.
    d. Medicare: Income-eligible Medicare patients may apply for Financial Assistance for denied stays, denied days of care, non-covered services and Medicare cost shares.
    e. Medi-Cal: Income-eligible Medi-Cal patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services, and services where shares of cost were not met due to financial hardship; SOC liability assistance in non reportable by SWBH to the state as Financial Assistance.
3. **Catastrophic Charity Care:** Catastrophic Charity Care is a partial write-off of an Uninsured Patient's financial responsibility for Covered Services that is applied when an Uninsured Patient's financial responsibility exceeds 15% of their Family Income. Patients eligible for Catastrophic Charity Care will receive a full write-off of their undiscounted charges for Covered Services that exceed 15% of their Family Income. *[Uninsured Patient's financial responsibility for undiscounted charges for Covered Services] – [Family Income * 15%] = Catastrophic Charity Care write-off.*

4. **High Medical Cost Charity Care (for Insured Patients):** High Medical Cost Charity Care for Insured Patients ("High Medical Cost Charity Care") is a full write-off of the patient's responsible amount for Covered Services. High Medical Cost Charity Care is not available for patients receiving services that are already discounted (e.g., package discounts for cosmetic services). The patient's Family Income is less than 400% of the Family Federal Poverty Income guidelines;

5. **Uninsured Patient Discount:** The Uninsured Patient Discount is a write-off of a portion of the hospital's undiscounted charges for Covered Services taken at the time an Uninsured Patient is billed for the hospital services rendered. The Uninsured Patient Discount does not apply to patients who qualify for charity care or receive services that are already discounted (i.e., package discounts for cosmetic services). The Uninsured Patient Discount may differ for inpatient and outpatient services and should be no greater than the hospital affiliate's current average commercial fee-for-service discounts with managed care payers; each hospital affiliate's minimum inpatient and outpatient discount is set forth in Exhibit C. Patients who are responsible for a hospital bill not covered or discounted by any type of insurance or governmental program, or whose benefits under insurance have been exhausted prior to admission are eligible for an Uninsured Discount if the patient or the patient's guarantor verifies that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill. Insurance in this case includes but is not limited to any HMO, PPO, indemnity coverage, or consumer-directed health plan.

6. **Prompt Payment Discount:** The Prompt Payment Discount is an additional partial write-off of the hospital's bill available to Uninsured Patients who pay promptly as described below. The Prompt Payment Discount is available only to patients receiving the Uninsured Patient Discount, as set forth in section 6, above and does not apply to insured patients' co-pays, deductibles, or cost shares. All affiliate hospitals must adopt the Post-Discharge Prompt Payment Discount as defined below. The Pre-Discharge Prompt Payment Discount is optional.
    a. Post-Discharge Prompt Payment Discount: The Post-Discharge Prompt Payment Discount is a partial write-off of at least 10% of the amount owed by the patient that is applied after all other discounts are applied if the patient submits payment within 30 calendar days of the date the hospital affiliate mails the final bills and/or itemized statement;

B. **Other Definitions**:

1. **Covered Services:**
    a. Covered Services for **Full Charity Care** or **Catastrophic Charity Care** are all services that are required to be covered by a Knox-Keene licensed Health Care Service Plan, except that services requiring prior administrative approval as defined below are not Covered Services.

    b. Covered Services for **Partial Charity Care** and **High Medical Cost Charity Care**, are all services provided by the hospital, except that services requiring prior administrative approval, as defined below, are not Covered Services.

    c. Covered Services for the **Uninsured Patient Discount** and the **Prompt Payment Discount** are all services provided by the hospital to Uninsured Patients.

    d. Services Requiring Prior Administrative Approval: Due to their unique nature, certain non-emergency services require administrative approval prior to admission and the provision of service. Generally, patients who seek complex, specialized, or high-cost services (e.g. experimental procedures, transplants) must receive administrative approval prior to the provision of services. Patients seeking to receive such services are **not** eligible for Full Charity Care, Partial Charity Care, Catastrophic Charity Care, or High Medical Cost Charity Care unless hospital administration makes an exception. Affiliate hospitals shall develop a process for patients to seek prior administrative approval for services that require such approval. If a patient receives a service that requires prior administrative approval without obtaining prior approval, the patient shall receive Partial Charity Care or High Medical Cost Charity Care if they are eligible under this policy, or if they are not eligible, they shall receive an Uninsured Patient Discount and a Prompt Payment Discount if payment is submitted promptly in accordance with this policy.

2. **Uninsured Patient:** An Uninsured Patient is a patient who has no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability, or whose benefits under insurance have been exhausted prior to the admission. Guidelines for determining when the Financial Assistance policy applies to Uninsured Patients under particular circumstances that arise during the ordinary course of business are set forth in Exhibit A.
3. **Primary Language of Affiliate's Service Area:** A language is a primary language of the affiliate's service area if 5% or more of the affiliate's local population speaks the language.

4. **Family Income:** Family Income is annual family earnings from the prior 12 months or prior tax year as shown by recent pay stubs or income tax returns, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates. For patients over 18 years of age, the patient's family includes their spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For patients under 18 years of age, the patient's family includes their parents, caretaker relatives, and other children under 21 years of age of the parents or caretaker relatives.

PROCEDURES

A. **Applying for Financial Assistance:**
1. An Uninsured Patient who indicates the financial inability to pay a bill for Covered Service shall be evaluated for Financial Assistance. In order to qualify as an Uninsured Patient, the patient or the patient's guarantor must verify that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill.
2. The Sutter Health standardized application form, "Statement of Financial Condition", **Exhibit** D, will be used to document each patient's overall financial situation. This application shall be available in the primary language(s) of the affiliate service area.
3. A sample of the "Charity Care Calculation Worksheet" (**Exhibit** E) is provided to aid hospital affiliates in determining the amount and type of charity care for which the patient may be eligible.
4. If an Uninsured Patient does not complete the application form within 30 days of delivery, the hospital will notify the patient that the application has not been received and will provide the patient an additional 30 days to complete the application. Failure to complete and return the application within 60 days may result in the Uninsured Patient being denied Financial Assistance.

B. **Financial Assistance Determination and Notice:**
1. **Determination:**
   a. The affiliate hospital will consider each applicant's Financial Assistance Application and grant Financial Assistance where the patient meets eligibility requirements and has received (or will receive) Covered Service(s).
   b. An affiliate may make Financial Assistance approval contingent upon a patient applying for governmental program assistance, which may be prudent if the particular patient requires ongoing services.
   c. In determining whether each individual qualifies for Financial Assistance, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, the Healthy Families Program, Victims of Crime, California Children Services, or through the California Health Benefit Exchange.
   d. The affiliate should assist the individual in determining if they are eligible for any governmental or other assistance, including the California Health Benefit Exchange.
   e. Where administrative approval is required, the hospital will consider the request for service in a timely fashion and provide a response to the request in writing**.**

f. If the patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

2. **Notice:**

a. While it is desirable to determine the amount of Financial Assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent while in other cases further investigation is required to determine eligibility. In some cases, a patient eligible for Financial Assistance may not have been identified prior to initiating external collection action. Each hospital affiliate's collection agency shall be made aware of this policy so that the agency knows to refer back to the hospital patient accounts that may be eligible for Charity Care.

b. Once a Full or Partial Charity Care, Catastrophic Charity Care, or High Medical Cost Charity Care determination has been made a "Notification Form" (**Exhibit** G) will be sent to each applicant advising them of the hospital affiliate's decision.

c. If the charity care determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest on the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health and Safety Code section 127440.

C. **Dispute Resolution:**

In the event of a dispute over the application of this policy, a patient may seek review from the hospital by notifying the affiliate's Chief Financial Officer (CFO), or designee, of the basis of any dispute and the desired relief. Written communication should be submitted within thirty (30) days of the patient's their notice of the circumstances giving rise to the dispute. The CFO or designee shall review the concerns and inform the patient of any decision in writing.

D. **Administrative and Accounting Guidelines:** To allow the affiliate to track and monitor the amount and type of charity care and discounts being granted, each affiliate will account for Financial Assistance as provided in **Exhibit** F.

E. **Recordkeeping:**

Records relating to Financial Assistance must be readily accessible. Affiliates must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied and the reasons for denial. In addition, notes relating to Financial Assistance application and approval or denial should be entered on the patient's account.

F. **Third-Party Liens:**

Sutter Health hospital affiliates may lien the tort recoveries of Uninsured Patients in a manner consistent with the *Management of Patient Accounts Receivable, Collection Practices, Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227).* Hospital affiliates may not lien tort recoveries for amounts actually paid by patients or for any amount other than the discounted amount owed by the Uninsured Patient.

G. **Billing for Uninsured Patients:** For special rules related to billing for Uninsured Patients, see the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227).*

H. **No Misrepresentation:** Hospital affiliates or their agents shall not misrepresent this policy to patients or patients' guarantors' in any way.

I. **Submission to OSHPD:**

Under the direction of the Sutter Health Office of the General Council, affiliates shall forward copies of their Financial Assistance policy to the Sutter Health Office of the General Council for posting to the Office of Statewide Health Planning and Development ("OSHPD"). Submission of the policy shall be done by the Office of the General Council consistent with and in the manner prescribed by OSHPD, which shall be at least biennially on January 1 or when a significant change is made. If no significant change has been made by the hospital since the information was previously provided, notifying the office of the lack of change shall meet the requirements of this section.

COMMUNICATION OF FINANCIAL ASSISTANCE AVAILABILITY

A. **Information Provided to Patients:**

1. Preadmission or Registration: During preadmission or registration (or as soon thereafter as practicable) hospital affiliates shall provide:

   a. **All patients** with information regarding the availability of Financial Assistance and their right to request an estimate of their financial responsibility for services (Important Billing Information for Uninsured Patients), **Exhibit** H;
   b. **Patients who the hospital identifies may be uninsured** with a Financial Assistance application substantially similar to the Sutter Health standardized Financial Assistance application, "Statement of Financial Condition", **Exhibit** D.

2. Emergency Services. In the case of emergency services, hospital affiliates shall provide the above information as soon as practicable after stabilization of the patient's emergency medical condition or upon discharge.

3. All other times: Upon request, hospital affiliates shall provide patients with information about their right to request an estimate of their financial responsibility for services, the Sutter Health standardized Financial Assistance application form, "Statement of Financial Condition", **Exhibit** D, and/or the Important Billing Information for Uninsured Patients, **Exhibit** H.

B. **Postings and Other Notices:**

Information about Financial Assistance shall also be provided as follows:

1. By posting notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, including but not limited to the emergency department, billing offices, admitting office, and other hospital outpatient service settings.

2. By posting information about Financial Assistance on the Sutter Health website and each hospital affiliate website, if any.

3. By including information about Financial Assistance in bills that are sent to Uninsured Patients. A sample that contains the required information is set forth in **Exhibit** I**.**

4. By including language on bills sent to uninsured patients as specifically set forth in the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227).*

C. **Applications Provided at Discharge:**

If not previously provided, hospital affiliates shall provide Uninsured Patients with applications for Medi-Cal, Healthy Families, California Children's Services or any other potentially applicable government program at the time of discharge.

D. **Languages:**

All notices/communications provided in this section shall be available in the Primary Language(s) of the affiliate's service area and in a manner consistent with all applicable federal and state laws and regulations.

E. **Notification to Uninsured Patients of Estimated Financial Responsibility:**

By law, Uninsured Patients are entitled to receive an estimate of their financial responsibility for hospital services. Except in the case of emergency services, hospital affiliates shall notify patients who the hospital identifies may be Uninsured Patients that they may obtain an estimate of their financial responsibility for hospital services, and provide estimates to those patients upon request. Estimates shall be written, and be provided during normal business hours. Estimates shall provide the patient with an estimate of the amount the hospital affiliate will require the patient to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to the patient by the hospital, based upon the average length of stay and services provided for the patient's diagnosis. A sample estimate form is found in **Exhibit** J.

Exhibit A

Guidelines for Application of Full and Partial Charity Care, Uninsured Patient Discount, and Prompt Payment Discount

The following guidelines are intended for use in specific situations that arise in the ordinary course of business.

(1) Co-pays, deductibles and cost shares per direction from insurers, government programs, or other third party payers	These amounts should be collected from the patient. These amounts are not subject to Full or Partial Charity Care, the Uninsured Patient Discount or the Prompt Payment Discount, except: Patients with Medicare cost share obligations are eligible to apply for Full or Partial Charity Care. Except in the case of high medical cost Patients with Medi-Cal share of cost obligations are not entitled to Full or Partial Charity Care.
(2) Insurance coverage not available due to patient's election to seek services not covered under insurance contract (e.g. patient seeks out-of-network services; patient refuses to transfer to an in-network facility)	These amounts should be collected from the patient. Patient is not eligible for Full or Partial Charity Care. The Uninsured Patient Discount applies. If the non- covered services are priced as a package discount (e.g. fertility, cosmetic) then the package price applies in lieu of the Uninsured Patient Discount. The Prompt Payment Discount applies.
(3) Indemnity Insurance company refuses to pay claiming patient has failed to cooperate by providing needed information.	Patient may be billed. Full and Partial Charity Care and other discounts do not apply.
(4) Services and items that are never covered benefits under the patient's benefit policy (e.g. services that are not medically necessary).	These amounts should be collected from the patient. Patient is not eligible for Full or Partial Charity Care. The Uninsured Patient Discount applies. If the non-covered services are priced as a package discount (e.g. fertility, cosmetic) then the package price applies in lieu of the Uninsured Patient Discount. The Prompt Payment Discount applies.
(5) Services provided to ineligible members.	If coverage is denied, these amounts should be collected from the patient, unless the patient's health plan is responsible for the services under the terms of the contract. Patient may be eligible for Full or Partial Charity Care. If the patient is not eligible for Full or Partial Charity Care, the Uninsured Patient Discount and Prompt Payment Discount apply.
(6) Indemnity Insurance Company or Medicare Supplement Plan pays member directly.	Patient may be billed. Full and Partial Charity Care and other discounts do not apply.

Exhibit A

(7) Indemnity insurance Company, PRO or non-contracted third party payer underpays claiming charges are unreasonable or unsupported	Continue to pursue amounts due from insurance and do not initiate collections for these amounts against patient without Office of the General Counsel approval. Pursue collection of patient liability amounts as set forth herein.
(8) Charges not covered by insurance because patient exceeded benefit cap <u>prior to admission.</u>	These amounts should be collected from the patient. Patient may be eligible for Full or Partial Charity Care. If the patient is not eligible for Full or Partial Charity Care, the Uninsured Patient Discount and Prompt Pay Discounts apply.
(9) Charges not covered by insurance because patient exceeded benefit cap <u>during patient's stay.</u>	When a payer pays only a portion of the expected reimbursement for a patient's stay due to exhaustion of the patient's benefits during the stay, affiliates should collect from the patient the balance of the expected reimbursement under the payer contract. Affiliates shall not pursue from the patient any amount in excess of the payer's contractual rate under the payer contract. Patients who exceed their benefit cap may apply for Full or Partial Charity Care for the services that are in excess of the benefit cap, and may receive a Prompt Payment Discount. The Uninsured Patient Discount does not apply to these services.
(10) Charity care determination creates a credit balance	If the charity care determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest on the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health and Safety Code section 127440.

Exhibit B

Eligibility Guide

Eligibility for the programs described in this policy are based on the most recent Federal Poverty Income Guidelines. The most current guidelines can be accessed at aspe.hhs.gov/poverty. Guidelines are published annually in January in the Federal Register and also available by contacting California Pacific Medical Center.

Exhibit C

Sutter Health Affiliate	Inpatient	Outpatient
California Pacific Medical Center	40%	20%
Novato Community Hospital	40%	20%
St. Luke's Hospital	40%	20%
Sutter Lakeside Hospital	20%	20%
Sutter Medical Center of Santa Rosa	40%	20%

Exhibit D

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE _____
ACCOUNT# _____ SNN _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
Contact Person & Telephone: _____
If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (before deductions)		
Add:	Income from Operating Business (if Self-Employed)	_____	_____
Add:	Other Income:		
	Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
Subtract:	Alimony, Support Payments Paid	_____	_____
Equals:	Current Monthly Income	_____	_____
	Total Current Monthly Income (add Patient + Spouse)	_____	_____
	Income from above	_____	_____

FAMILY SIZE

Total Family Members _____
(add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?	☒	☒
Do you have other Insurance that may apply (such as an auto policy)?	☒	☒
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	☒	☒

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financing discount, I understand that I may be required to provide proof of the information I am providing.

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

_____ _____
(Signature of Spouse) (Date)

Exhibit E

CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____
Affiliate: _____

Special Considerations/Circumstances: _____
_____
_____
_____

	Yes	No
Does Patient have Health Insurance?	☒	☒
Is Patient Eligible for Medicare?	☒	☒
Is Patient Eligible for Medi-Cal?	☒	☒
Is Patient Eligible for Other Government Programs (i.e. Crime Victims, etc.)?	☒	☒

If the patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.

Does Patient have other insurance (i.e. auto medpay)?	☒	☒
Was Patient inured by a third party?	☒	☒
Is Patient Self-Pay??	☒	☒

Charity/Financial Assistance Calculation:
Total Combined Current Monthly Income (From Statement of Financial Condition) $_____

Family Size (From Statement of Financial Condition) _____

Qualification for Charity Care/Financial Assistance (circle one): Full Partial

(Identify using eligibility guide) Catastrophic No Eligibility

Partial Charity Write-off Calculation (complete this section only if patient qualifies for partial charity care):

A. Total Charges $_____

B. Medicare DRG rate for IP and Medicare Fee Schedule for OP $_____

C. Patient Liability (Line A *times* Line B) $_____

D. Discount Amount (Line A *minus* line C) $_____

Exhibit E

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o*):*

A. Patient Liability (total charges unless another discount has been applied)	$_____
B. Annual Income	$_____
C. Patient Liability as Percent of Annual Income	_____%
D. Is line A divided by Line B greater than .30 (30%)?	Yes No
E. If no, patient is not eligible for this type of write-off	_____$0_____
F. If Yes, multiply Line B by 30% to identity the patient liability amount.	$_____
G. If Yes, Subtract line F from Line A to identify the write-off amount.	$ _____
Total Amount of Recommended Charity Write-off(s)	**$_____**

Worksheet Completed by: _____ Phone: _____

Approved by: _____

Exhibit F

Account balance matrix for Charity Care and AB774		
40800	0000	OTHER I/P - CHARITY - FULL
40800	0001	OTHER I/P - CHARITY - PARTIAL
40800	0002	OTHER I/P - CHARITY - CATASTROPIC
44800	0000	OTHER O/P - CHARITY - FULL
44800	0001	OTHER O/P - CHARITY - PARTIAL
44800	0002	OTHER O/P – CHARITY – CASTASTROPIC
40000	0000	I/P DEDUCT – SELF PAY DISCOUNT
44000	0000	O/P DEDUCT – SELF PAY DISCOUNT

Scenario #	Scenario	Step 1	Step 2	Step 3
Charity Care Scenarios **NOTE: If patient does not qualify for charity care per Policy 14-294, refer to appropriate "Discount" scenario section.**				
CC - 1	Indentified as Charity Care	Write-off to Charity Care adjustments that post to applicable GL accounts 40800 -xxxx or 44800-xxxx		
CC - 2	Identified as Charity Care and account has been written off and is in collections	Reinstate account	Reverse bad debt write-off code	Write-off to Charity Care adjustments that post to applicable GL accounts 40800 -xxxx or 44800-xxxx
Uninsured Patient Discount Scenarios **NOTE: If patient qualifies for charity care, refer to appropriate Charity Care scenario**				
Discount - 1	Qualified for uninsured discount	Write-off to self pay discount adjustments that post to applicable GL accounts 40000-0000 or 44000-0000		
Discount - 2	Qualified for uninsured discount and account has been written off and is in collections	Reinstate account	Reserve bad debt write-off code	Write-off to self pay discount adjustments that post to applicable GL accounts 40000-0000 or 44000-0000
Self-pay account with a prompt pay discount				
PP - 1	Qualified for Prompt pay discount	Write off to Prompt Pay adjustments that post to applicable GL accounts. Other – Admin Discount 40991-0000 or 44991-0000		

Exhibit G

NOTIFICATION FORM
SUTTER HEALTH
ELIGIBILITY DETERMINATION FOR CHARITY CARE

Suffer Health has conducted an eligibility determination for charity care for:

_____	_____	_____
PATIENTS NAME	ACCOUNT NUMBER	DATE(S) OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on_____.
This determination was completed on _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for charity care has been approved for services rendered on_____.
After applying the charity care reduction, the amount owed is $_____.

Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____
_____
_____

Your request for charity care has been denied because:

REASON: _____
_____
_____
_____
_____

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided incomplete or inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold the you and/or third parties responsible for the hospital's charges.

If an application has been submitted for another health coverage program at the same time that you submit an application for charity care or discount payment program, neither application shall preclude eligibility for the other program.

If you have any questions on this determination, please contact:

_____
Financial Counseling
855-398-1633

Exhibit H

Important Billing Information for Uninsured Patients at CPMC

Thank you for choosing California Pacific Medical Center ("CPMC"). This handout is designed to help our uninsured patients understand our billing process, payment options, and services available. Uninsured patients are patients who have no health insurance or third-party payer source to assist with the payment of their hospital bill. This information applies only to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc. that may bill you separately for their services.

Uninsured Patient Discount: CPMC offers a **40% discount** off of hospital inpatient charges and a **20% discount** off of outpatient charges at time of billing. An itemized bill reflecting your discount will be mailed to the address obtained at time of registration five to seven days after the service/ discharge date. Please review your bill and contact us if you have any questions.

Additionally, "an emergency physician, as defined in Section 127450 of the Health and Safety Code, 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 350% of the federal poverty level." You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement.

Payment Options: CPMC has many options to assist you with payment of your hospital bill.

Prompt-pay Discount: CPMC offers a prompt-pay discount option to our uninsured patients. If your account is paid in full within 30 days of your bill date you will receive an additional 20% discount off of the balance due.

Payment Plans: Patient account balances are due upon receipt. Patients may elect to make payment arrangements for their hospital bill. A Financial Agreement must be signed before the Patient Financial Services office can accept payment arrangements that allow patients to pay their hospital bills over time. These arrangements are interest-free for low income uninsured patients and certain income-eligible patients with high medical costs. The payment plan should be agreed upon by the Hospital and the patient and if the Hospital and the patient cannot agree on a payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 of the Health and Safety Code to create a reasonable payment plan.

Medi-Cal & Government Program Eligibility: You may be eligible for a government-sponsored health benefit program. CPMC has staff available to assist you with applying for government assistance like Medi-Cal, Healthy Families, and California Children's Services to pay your hospital bill. This facility also contracts with organizations that may assist you further, if needed.

Healthy Families: You may obtain information about Healthy Families (California's low-cost, comprehensive medical, dental and vision care insurance program) by contacting the hospital's Patient Financial Services office.

California Health Benefit Exchange: You may be eligible for health care coverage under Covered California. Contact the hospital Financial Counseling Services for more detail and assistance to see if you quality for health care coverage through Covered California.

Pending applications: If an application has been submitted for another health coverage program at the same time that you submit an application for charity care or discount payment program, neither application shall preclude eligibility for the other program.

Financial Assistance (Charity Care): Uninsured patients who have an inability to pay their bill may be eligible for charity assistance. The eligibility for charity is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for charity.

Copies of this hospital's Uninsured Patient Discount Policy, Prompt Pay Discount Policy, Charity Care Policy, as well as government program applications are available at our Patient Registration or Patient Financial Services offices. We can also send you copies if you contact our **Patient Financial Services office at 415-600-7280**.

Notice of Availability of Financial Estimates: You may request a written estimate of your financial responsibility for hospital services. Requests for estimates must be made during business hours. The estimate will provide you with an estimate of the amount the hospital will require the patient to pay for health care services, procedures, and supplies that are reasonably expected to be provided by the hospital. Estimates are based on the average length of stay and services provided for the patient's diagnosis. They are not promises to provide services at fixed costs. A patient's financial responsibility may be more or less than the estimate based on the services the patient actually receives.

The hospital can provide estimates of the amount of hospital services only. There may be additional charges for services that will be provided by physicians during a patient's stay in the hospital, such as bills from personal physicians, and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. Patients will receive a separate bill for these services.

If you have any questions about written estimates, please contact Patient Access at 855-398-1637. If you have any questions, or if you would like to pay by telephone, please contact the Patient Financial Services at 855-398-1633.

Exhibit I

Notice of Rights

Thank you for selecting CPMC for your recent services. Enclosed please find a statement of the charges for your hospital visit. **Payment is due immediately.** Because you are uninsured, you have received an uninsured discount. You may be entitled to additional discounts if you meet certain financial qualifications, discussed below, or if you submit payment promptly.

Please be aware that this is the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital, such as bills from personal physicians, and any anesthesiologists, pathologists, radiologists, ambulance services, or other medical professionals who are not employees of the hospital. You may receive a separate bill for their services.

Summary of Your Rights: 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, or 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 (328-4357) or online at www.ftc.gov.

External collection agencies contracted to collect payments under this policy are required to comply with applicable payments plans as agreed upon by the hospital and the patient.

Prompt Payment Discount: You can receive an additional 20% discount off your bill if you submit payment within 30 days.

Health Insurance/Government Program Coverage: If you have health insurance coverage, Medicare, Medi-Cal, Healthy Families, California Children's Services, or any other source of payment for this bill, please contact Patient Financial Services at 415-600-7280. If appropriate, Patient Financial Services will bill those entities for your care.

If you do not have health insurance or coverage through a government program, you may be eligible for government program assistance. Patient Financial Services can provide you with application forms, and assist you with the application process.

California Health Benefit Exchange: You may be eligible for health care coverage under Covered California. Contact the hospital Business Services for more detail and assistance to see if you quality for health care coverage through Covered California.

Charity Care: If you are uninsured or it is a financial hardship to pay your hospital bill, this hospital has a charity care policy that may reduce or eliminate your financial responsibility to pay the bill. Eligibility for charity care is based on your income and family size. If you would like more information about charity care, or would like to apply for charity care, please contact the Patient Financial Services at 855-398-1633

Contact Information: Patient Financial Services is available to answer questions you may have about your hospital bill, or would like to apply for charity care or government program assistance. The telephone number is 855-398-1633. Our telephone hours are 7:00 A.M. to 5:00 P.M., Monday through Friday.

Exhibit J

ESTIMATE OF FINANCIAL RESPONSIBILITY FOR HOSPITAL SERVICES

IMPORTANT -- PLEASE READ BEFORE SIGNING. This estimate is the hospital's best effort to calculate your financial responsibility for hospital services. It is based on the average length of stay and level of service of other patients with your condition(s). Your financial responsibility may be more or less than this estimate based on the hospital services you actually receive.

This estimate is not a promise to provide services at a fixed cost. It is an estimate of the amount of services you will require based on the hospital's past experiences with patients with your diagnosis.

This estimate does not create a contract between you and the hospital. It is provided to you as required by California Health & Safety Code section 1339.585.

This estimate is not intended to result in the sale or lease of goods or services to you or anyone.

You should also be aware that there may be additional charges for services that will be provided by physicians during your stay in the hospital, such as bills from your personal physician, and any anesthesiologist, pathologist, radiologist, or other medical professionals who are not employees of the hospital. **You will receive a separate bill for their services.**

This hospital offers discounts to uninsured patients who submit payment for their services prior to being discharged by the hospital. You can receive further information regarding this discount from the business office.

This hospital offers free or discounted charity care to eligible low-income/uninsured patients. Your eligibility for charity care depends on your financial circumstances. You can receive information regarding charity care, and an application for charity care determination, from the business office.

This hospital also offers discounted care to eligible uninsured patients. Your eligibility for the uninsured discount depends upon your insurance status. You can receive further information regarding this discount from the Business Office.

THIS ESTIMATE IS BASED ON THE FOLLOWING INFORMATION:

Patient Name: _____ Account No: _____

Expected Admit Date: _____

Date of Estimate: _____ Estimate completed by: _____

Diagnosis _____

Average Length of Stay for Patients with this diagnosis: _____

Estimated charges for patients with this diagnosis:_____

Exhibit J

YOUR ESTIMATED FINANCIAL RESPONSIBILITY: $_____

[ ] Deposit of $ _____must be collected prior to admission.

[ ] Patient/Guarantor has been notified. []N/A. Notified by: _____

[ ] Charity care and uninsured patient discount information provided

[ ] Comments: _____

By my signature below, I signify that I have read and understand the information above concerning my estimated financial responsibility for hospital services.

_____ _____

Patient/Guarantor Signature Date

Hospital Use Only	
CPT Code Used	
ICD-9 Code Used	

Copies: Original to Patient Financial Services
Patient Policies