



To Our Patients and Families:

Thank you for choosing Valley Presbyterian Hospital for your hospital services. Our hospital requests payments for services upon discharge from the hospital. An Admitting staff member will notify you of your estimated financial obligation, such as insurance co-payments or self pay responsibility. This will be addressed and collected during pre-registration; if scheduled, or during your hospital stay at Valley Presbyterian Hospital.

For patients who do not have insurance coverage, there are alternative funding and payment plan options offered by our hospital. Our Admitting staff will work with you to identify the best payment option based on government or hospital rules and regulations.

This packet is designed to provide you information regarding alternate funding and payment plans offered by our hospital. The following is an overview of the financial assistance programs provided by our hospital.

Medi-Cal and Government Programs

The Medical Eligibility Program is a hospital service provided to you at no cost. You may qualify for government programs which pay for all or part of your hospital expenses. Our Medi-Cal Eligibility Unit is available to assist you with the application process. For application assistance, please call **818-902-5125** or visit the Medi-Cal Eligibility Unit on the 5th floor tower of the hospital.

Charity Care Financial Assistance Program

A Financial Assistance Program is available to patients that do not have the means to pay for hospital expenses and do not qualify for any Medical Eligibility Programs. You may qualify if your gross household income falls at or below 350% of the federal poverty level or medical expenses exceed 10% of your annual household income. To be considered for the Financial Assistance Program, you will be required to provide information on your household finances through a confidential Financial Application. You must submit the required documentation within 10 days of receipt of the application. Documentation will be requested to verify your circumstances. Please reference the attached policy and application for additional information and requirements.

Uninsured Discount Rate

All Uninsured patients are eligible for discounts. The discount is similar to rates paid by Medicare and is offered to you under our Uninsured Discount Program.

In addition three maternity plans are available. *Normal Delivery: Up to a 2 day stay - \$3000; C- Section: Up to a 3 day stay - \$5000; C-Section: 4 day stay - \$ 6500 – Each additional day for a Normal Delivery or C-Section is \$2000/day; Additional OB Nursery days are \$600/day*

If during the admission, you choose to have a circumcision completed on your child; it is included in the maternity plan. If a decision is made to perform the procedure on an outpatient surgery basis, the cost will be calculated based upon the above referenced calculation for outpatient uninsured discounted rates.

Payment Plans

If you do not qualify for state assistance or any of our financial assistance programs, you may establish payment arrangements with our financial counselor. Payment arrangements may be made with no interest penalties. Defaulting on your payment plan disqualifies you from taking advantage of this option.

You may receive bills from other billing companies for physician charges, radiology, ambulance, etc. For additional assistance or questions regarding your hospital bill, please contact the Business Office at **818-902-2913**.

Non profit credit counseling service may be available in your area.

I hereby declare that I have been made aware of Valley Presbyterian Hospital's financial assistance programs. There were no other third party resources for coverage available to me at the time my services were rendered.

Date

Patient signature

Witness

VALLEY PRESBYTERIAN HOSPITAL Policy and Procedure		
SUBJECT: Charity Care		
POLICY OWNER: Finance	SUPERSEDES:	MANUAL: Finance

PURPOSE:

To provide free or discounted healthcare to patients treated at Valley Presbyterian Hospital (Hospital) that have an inability to pay for their care.

POLICY:

The determination for Charity Care generally should be made at admission or shortly thereafter. However, events after discharge could change the ability of the patient to pay. Therefore, retrospective determination may be necessary. Designation as Charity Care will only be considered after all payment sources have been exhausted. If a Charity Care patient is not awarded a grant of financial assistance up to full charges, the patient will be offered the ability to participate in the Uninsured Discount Program, based on criteria that would qualify a patient for reduced responsibility, i.e. no available resources for payment such as a third party resource or private health insurance.

Note: EMPLOYEES OF VALLEY PRESBYTERIAN HOSPITAL SHOULD NOT, AT ANY TIME, INDICATE OR SUGGEST TO THE PATIENT THAT HE/SHE WILL BE RELIEVED OF THE DEBT BY WAY OF A CHARITY CARE WRITE-OFF UNTIL THE DETERMINATION HAS BEEN MADE.

PROCEDURE:

I. DEFINITIONS:

Charity Care represents all the Hospital healthcare services that are provided to patients who are financially unable to satisfy their debts, resulting from a determination of a patient's inability to pay, not their willingness to pay. Hospital charges for patient accounts identified as Charity Care at the time of admission or service are not recognized by the facility as net revenue or net receivables. If patient accounts are identified as Charity Care subsequent to the facility recognizing the charges as revenue, an adjustment is required to appropriately classify the revenue and any Bad Debt previously recorded. Patient account transactions for Charity must be posted in the month the determination is made.

II. FACTORS TO BE CONSIDERED

- A. Factors to be considered in determining eligibility for Charity Care must include comparing the patient's gross income to the annually published Federal Poverty Guidelines (FPG), or equivalent thereof. This information may be obtained through verbal means from the patient/guarantor and documented by a MEP Patient Advocate, Financial Counselor, or other specifically designated Hospital Employee.
- B. Other factors may include, but are not limited to the following:
 1. Validate means of support if unemployed and no earned or unearned income have been provided on the application.
 2. Validate activity on accounts reported on credit bureau to determine how payments are being made if household expenses exceed income reported on Confidential Financial Statement.
 3. Liquid Assets validated (Stocks, Bonds, Certificates of Deposit, Money Market Accounts, Checking and Savings Balances)
 4. The previous exhaustion of all other available resources.

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- C. A Confidential Financial Application completed by the patient may not be required for patients who are deemed to be already eligible for other Federal, State, and County Assistance Programs. Such programs include, but are not limited to Medicaid, County Assistance Programs, MIA, MSI, AFDC, Food Stamps, and WIC.
1. **Family Members**—the Hospital will require patients to provide the number of family members in their household.
 - a. Adults—to calculate the number of family members in an adult patient’s household, include the patient, the patient’s spouse and/or legal guardian, and all of their dependents.
 - b. Minors—to calculate the number of family members in a minor patient’s household, include the patient, the patient’s mother/father and/or legal guardian, and all of their other dependents.
 2. **Income Calculation**—the Hospital requires patients to provide their household’s yearly gross income.
 - a. Adults—the term “yearly income” on the application means the sum of the total yearly gross income of the patient and the patient’s spouse.
 - b. Minors-If the patient is a minor, the term “yearly income” means the income from the patient, the patient’s mother/father, legal guardian and/or Caretaker relative, and all of their dependents.
 - c. Expired Patients-Expired patients may be deemed to have no income for purposes of the Hospital calculation of income if there is no surviving spouse or no other guarantor appears on the patient account. Although no documentation of income and no Confidential Financial Application are required for expired patients, the patient’s financial status will be reviewed at the time of death by a Hospital employee to ensure that a Charity Care adjustment is appropriate and an estate or probate do not show liquid assets in excess of \$10,000.
 - d. Catastrophic illness and documented hardship with the household may also be considered for Charity Care or discounted care.
- D. The Financial Assessment Coordinator will apply FPG guidelines by using the FPG Table (refer to *Exhibit A*), which is updated annually. The patient’s family size is used to determine whether monthly or annual income falls at, below, or exceeds **350%** of the FPG.
1. Uninsured income threshold 350% of FPG or below – 100% Charity care write off
 2. Uninsured income threshold over 350% FPG – see Uninsured Discount Policy.
- E. For patient accounts meeting the guidelines for Financial Assistance:
1. The Financial Assistance Coordinator will complete the Confidential Financial Application that indicates there are no other payment sources and the patient meets the income of the FPG to apply the appropriate discount.
 2. The Financial Assistance Packet should include a Confidential Financial Assistance Application (refer to *Exhibit B*), a Credit Bureau Report (obtained by hospital personnel), and the following: federal tax returns, recent pay stubs, current bank statements, and any other documents that substantiate the patient’s financial requirement for consideration of reduction on account balance.
 3. The Financial Assistance Coordinator will review the application for Charity Care for appropriateness and completeness ensuring that it has been reviewed and meets the requirements for submission to the facility for Charity Care consideration and administrative adjustment.
 4. Pending the completion of the application, the patient should be treated as a “pending discount” patient in accordance with the Hospital Financial Assistance Policy as set forth here. The patient’s account will have the financial class changed to “C” on the facility patient accounting system.

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DOCUMENT

I. Confidential Financial Application

- A. In order to qualify for Charity Care, the Hospital requires each patient or family to complete the Confidential Financial Application (refer to *Exhibit B*). This application allows the collection of information about income and the documentation of other requirements as defined below.
- B. The Financial Assessment Coordinator will attempt to secure supporting documentation. Income and/or assets may be verified by attaching one or more of the following:
 - IRS Tax Forms
 - Payroll Stubs
 - Declarations
 - Verbal Attestations
 - Other forms used to substantiate the needs for Charity Consideration
 - Credit Bureau Report (including the lack thereof)
- C. In cases where the patient is unable to complete the written application, verbal attestation is acceptable if is not disallowed by State law/regulation.

II. Income Verification

The Hospital requests patients to attest to the income set forth in the application. In determining a patient's total income, The Hospital may consider other financial assets and liabilities of the patient, as well as, the patient's family income, when assessing the ability to pay. If a determination is made that the patient has the ability to pay their bill, such determination does not preclude a reassessment of the patient's ability to pay upon presentation of additional documentation. **All of the following documents are appropriate for substantiating the need for Financial Assistance:**

- A. **Income Documentation**—Income documentation may include IRS form W-2, Wage and Earnings Statement, paycheck stub, tax returns, and/or bank statements. **If any of the above is not provided than a signed statement as to why the document is not available is required.**
 1. **Participation in a Public Benefit Program**—Public Benefit Program documentation showing current participation in programs, such as Social Security, Workers' Compensation, Unemployment Insurance, Medicaid, County Assistance Programs, AFDC, Food Stamps, WIC, or other similar indigence-related programs.
 2. Patients must provide income tax returns, current bank account statements, and/or recent pay stubs to Valley Presbyterian Hospital **within 15 days of discharging from the Hospital to determine if the patient is eligible for Financial Assistance.**
 3. **Financial Assistance Applications with supporting documentation must be submitted to the following address:**

Valley Presbyterian Hospital
15107 Vanowen Street
Van Nuys, Ca. 91405
Attention: Business Office Manager

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III. Information Falsification

- A. Falsification of information will result in denial of the application for Financial Assistance. If, after a patient is granted financial assistance, the hospital finds material provision(s) of the application to be untrue, financial assistance status may be revoked and the patient's account will be forwarded for normal collection processes.
- B. Denied Financial Assistance Recommendations
- C. In the event that a patient's application for Financial Assistance is denied, documentation is to be placed in the facility patient accounting system as to the reason for the rejection. The determining Manager is also to indicate on the Confidential Financial Application the reason for denial and the date of the denial.
- D. Denied Charity Care Recommendations
- E. In the event the CFO/designee denies a patient's application for Charity Care, documentation is to be placed in the facility collection system as to the reason for the rejection of the recommendation. The CFO/designee is also to indicate on the Confidential Financial Application the reason for the denial and the date of the denial.

IV. Custodian of Records

The Business Office will serve as the custodian of records for all Charity Care documentation for all accounts identified as approved Charity Care.

Exhibit A – Federal Poverty Guidelines

2011

Family Unit	Monthly MMNL (\$)	Annual Income at 100%	Annual Income at 120%	Annual Income at 133%	Annual Income at 150%	Annual Income at 200%	Annual Income at 250%	Annual Income at 300%	Annual Income at 350%
1	\$908	\$10,890	\$13,068	\$14,484	\$16,335	\$21,780	\$27,225	\$32,670	\$38,115
2	\$1,226	\$14,710	\$17,652	\$19,564	\$22,065	\$29,420	\$36,775	\$44,130	\$51,485
3	\$1,545	\$18,530	\$22,236	\$24,645	\$27,795	\$37,060	\$46,325	\$55,590	\$64,855
4	\$1,863	\$22,350	\$26,820	\$29,726	\$33,525	\$44,700	\$55,875	\$67,050	\$78,225
5	\$2,181	\$26,170	\$31,404	\$34,806	\$39,255	\$52,340	\$65,425	\$78,510	\$91,595
6	\$2,500	\$29,990	\$35,988	\$39,887	\$44,985	\$59,980	\$74,975	\$89,970	\$104,965
7	\$2,818	\$33,810	\$40,572	\$44,967	\$50,715	\$67,620	\$84,525	\$101,430	\$118,335
8	\$3,136	\$37,630	\$45,156	\$50,048	\$56,445	\$75,260	\$94,075	\$112,890	\$131,705

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Exhibit B – Confidential Financial Application

Valley Presbyterian Hospital

Confidential Medical and Financial Assistance Application

Exhibit B

Patient Name	SSN	DOB
Patient Address:		
Patient Home Phone:	Patient Work Phone:	

FINANCIAL ASSISTANCE SCREENING

Total Number of Dependent Family Members in Household _____

(Include patient, patient's spouse and/legal guardian, and any children the patient has under the age of 18 living in the home. If the patient is a minor, include mother/father and/or legal guardian, and all other children under the age of 18 living in the home.)

Estimated Gross Annual Household Income \$_____ (see page 2)

Calculate Income to FPG Ratio: Gross Annual Income ÷ FPG Based on Family Size

_____ ÷ _____ = %

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In order to determine qualifications for any discounts or assistance programs the following information is necessary.

RESPONSIBLE PARTY/GUARANTOR

Responsibility Party:		Relationship to patient
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
	Hours Per Week:	
If income is \$0/unemployed, what is your means of support?	Circle One – <input type="checkbox"/> Living on Savings/Annuity <input type="checkbox"/> Live with parent/family/friends <input type="checkbox"/> Homeless <input type="checkbox"/> Shelter	

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SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #

Gross Income:	Circle One - <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
	Hours Per Week:

HOMELESS AFFIDAVIT

I, _____, hereby certify that I am homeless, have no permanent address, no job, savings, or assets, and no income other than potential donations from others. Patient/Guarantor Initials.

UNINSURED DISCOUNT PROGRAM

I, _____, hereby request that if I may not be found eligible for any Medical Assistance Program or granted Financial Assistance that I will be automatically deemed eligible for the Valley Presbyterian Hospital Uninsured Discount Program. _____ Patient/Guarantor Initials

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ATTESTATION OF TRUTH

I hereby acknowledge all of the information provided to be true. I understand that providing false information will result in the denial of this Application. Additionally, in accordance with state statute, providing false information to defraud a hospital for obtaining goods or services is a misdemeanor, and in accordance with statute, may be punishable by imprisonment and a fine. I also understand that a credit report may be obtained or other such measure may be taken to verify information provided herein. I fully understand that Valley Presbyterian Hospital Financial Assistance programs is a "Payor of Last Resort" and hereby assign all benefits due from any liability action, personal injury claims, forth settlements, and any and all insurance benefits which may become payable or fitness or injury for which Valley Presbyterian Hospital or its subsidiaries provided care.

PATIENT/GUARANTOR SIGNATURE

DATE

Originating Date: 03/2009 Reviewed/Revised Date: 02/2012	Approved By:
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