Valley Presbyterian Hospital
15107 Vanowen Street
Van Nuys, Ca. 91405

Thank you for choosing Valley Presbyterian Hospital for your hospital services. This packet is designed to provide information regarding charity qualification, discounting processes, and an application for MediCal and other Government Programs to our uninsured patients.

Financial Assistance Program- Uninsured or underinsured patients who are unable to pay their bill may be eligible for 100% financial assistance, leaving you no financial obligation to the hospital for your bill. Qualifications are based upon verifiable income and family size, and determined by current Federal Poverty Guidelines. To qualify for our financial assistance program, you must submit the required documentation within **15 days** of discharge from the hospital. Please reference the attached policy and application for additional information and requirements.

Uninsured Discount Rate- Valley Presbyterian Hospital offers daily rates for inpatient services, and a significantly reduced charge rate for outpatient services. The reduced rates exclude high cost services such as implantable devices or high cost pharmacy products, which will be billed equivalent to the hospital's cost. Surgical inpatients will be billed $2,500 for the first day stay and $2,000 for subsequent days until discharged. Outpatient discounted rates are based upon 110% of Medicare reimbursable for the tests or procedures to be performed. Valley Presbyterian Hospital's three maternity plans are as follows: Normal Delivery: Up to a 2 day stay - $2500
C- Section: Up to a 3 day stay - $4000; C-Section: 4 day stay - $ 5500. 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 $800 for the hospital fees only.

Payment Plans- Your balance is due upon discharge from the hospital. If you do not qualify for state assistance or our financial assistance program, 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.

Medi-Cal and Government Programs- You may qualify for government programs to assist you with payment for all or part of your hospital expenses. Valley Presbyterian Hospital has an internal Medi-Cal Eligibility Unit to assist you with your Medi-Cal 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.

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.**

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
15107 Vanowen Street
Van Nuys, Ca. 91405

Gracias por escoger Valley Presbyterian Hospital para sus servicios del hospital. Este paquete es diseñado para proporcionar información con respecto calificacion de caridad, los procesos de descuento, y una aplicación para Médical y otros Programas del Gobierno para nuestros pacientes no asegurados.
El Programa De Caridad- Es para pacientes No asegurado que no pueden pagar su cuenta y pueden ser eligibles para ayuda de caridad. Calificando para la caridad es basado sobre el tamaño verificable de ingresos y familia, y determinado por Pautas Federales actuales de Pobreza. Para calificar bajo este programa de caridad, usted debe entregar la documentación requerida dentro de **15 días** de la descarga del hospital. Mencione por favor la políza incluida de caridad y la aplicación para información y requisitos adicionales.

La Tasa De Descuento Para No Asegurado- Valley Presbyterian Hospital ofrece tarifas diarias para los servicios de hospitalización, y una tasa de carga significativamente reducidos para los servicios ambulatorios. Los tipos reducidos no de los servicios de alto costo, como los dispositivos implantables o productos farmacéuticos de alto costo, que será facturado equivalente al costo del hospital. Pacientes quirúrgicos se le cobrará $ 2.500 para la estancia primer día y 2.000 dólares para los días sucesivos hasta su cancelación.ofrece una tasa diaria de $2000.00 para servicios de paciente internos, y una tasa apreciablemente reducida de la cargos de servicios de paciente externo. Las tasas reducidas excluyen los servicios altos del costo dispositivos tal como aparatos implantados o productos de farmacia de alto costo. Ambulatorios descuentos se basan en el 110% de reembolso de Medicare para las pruebas o procedimientos a realizar. Three Valley Hospital Presbiteriano de los planes de maternidad son los siguientes: el parto normal: Hasta una estancia de 2 días - $ 2500, C-Sección: Hasta una estancia de 3 días - $ 4000; C-Sección: 4 días de estancia - $ 5500. Si durante el ingreso, usted elige tener una circuncisión completa sobre su hijo, sino que está incluido en el plan de maternidad. Si se toma la decisión de realizar el procedimiento en una base de cirugía ambulatoria, el costo será de $ 800 para los gastos de hospitalización solamente.

El Plan De Pago - Su cuenta es debida cuando la descarga del hospital. Si usted no califica para la ayuda del estado, o nuestro programa de caridad, usted puede establecer un plan de pago con nuestro consejero financiero. Los arreglos de pago pueden ser hechos con ninguna penas de interés. Dejar de pagar en su plan de pago le descalificara de esta opción.

Médical y Los Programas Del Gobierno- Usted puede calificar para programas de gobierno para ayudarle con pago para todo o parte de sus gastos del hospital. Valley Presbyterian Hospital tiene un representante de elegibilidad Médica disponible que puede ayudarle con su aplicación de Médical. Para la ayuda con la aplicación, por favor llame 818-902-5125, o visite nuestra Oficina de Negocios. Es probable que Usted reciba cuentas de otras compañíías que cobran por cargos directos de medicos de emergencia, patologia, radiología, o ambulancia, etc. Para ayuda o preguntas adicionales con respecto a su cuenta del hospital, por favor contacte la Oficina de Negocios 818-902-2913.

Yo por el presente declaro que he sido avisado de los programas financieros de Valley Presbyterian Hospital. No tengo otros recursos de puesto terceros para cobertura que estubo disponible durante el tiempo que mis servicios fueron rendidos.

La Fecha	Firma De Paciente	Testigo

POLICY

The determination for Financial Assistance generally should be made at admission or shortly thereafter. However, events after admission or at the time of service could change the ability of the patient to pay. Therefore, retrospective determination may be necessary. Designation for Financial Assistance will only be considered after all payment sources that may be a source of payment for the patient's bill have been exhausted. Patient account transactions for Financial Assistance must be posted in the month the determination is made. If an uninsured 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 FULL CHARGE WRITE-OFF UNTIL THE DETERMINATION HAS BEEN MADE.

PURPOSE

To define Financial Assistance up to 100% reduction in charges, to distinguish full Financial Assistance benefits from accounts assigned to VPH's Uninsured Discount Program and Bad Debts, and to establish policies and procedures to ensure consistent identification, accountability, and recording of such, at Valley Presbyterian Hospital

FACTORS TO BE CONSIDERED

Factors to be considered in determining eligibility for Financial Assistance must includecomparing the patient's gross income to the annually published Federal Poverty Guidelines (FPG) Patients must provide income tax returns, current bank account statements, and/or recent pay stubs to Valley Presbyterian Hospital **within 15 days ofdischarging from Valley Presbyterian Hospital to determine if the patient is eligiblefor Financial Assistance.**

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 Director

For patient accounts meeting the guidelines for Financial Assistance:

The Financial Assistance Packet should include a Confidential Financial Assistance Application (refer to *Exhibit B),* a Credit Bureau Report(obtained by hospital personnel), and two of 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.

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.

DOCUMENTATION

CONFIDENTIAL FINANCIAL APPLICATION

In order to qualify for Financial Assistance, Valley Presbyterian Hospital requests 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. Pending the completion of the application, the patient should be treated as a "pending discount" patient in accordance with Valley Presbyterian 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.

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**—Valley Presbyterian Hospital will require patients to provide the number of family members in their household.

   a. Adults—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—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**—Valley Presbyterian 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 and/or legal guardian, and all of their other dependents.

INCOME VERIFICATION

Valley Presbyterian Hospital requests patients to attest to the income set forth in the application. In determining a patient's total income, Valley Presbyterian Hospital may

consider other financial assets and liabilities of the patient, as well as, the patient's familyincome, when assessing the ability to pay. If a determination is made that the patient hasthe ability to pay their bill, such determination does not preclude a reassessment of thepatient's ability to pay upon presentation of additional documentation. Any two of thefollowing documents are appropriate for substantiating the need for Financial Assistance:

3. **Income Documentation**—Income documentation may include IRS form W-2, Wage and Earnings Statement, paycheck stub, tax returns, and/or bank statements.

- **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.

INFORMATION FALSIFICATION

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.

Denied Financial Assistance Recommendations

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.

CUSTODIAN OF RECORDS

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

Family Unit	Monthly MMNL ($)	Annual Income at 100%	Annual Income at 120%	Annual Income at 133%	Annual Income at 150%	Annual Income 200%	Annual Income 250%	Annual Income 300%	Annual Income 350%
1	$903	$10,830	$12,996	$14,404	$16,245	$21,860	$27,075	$32,490	$37,905
2	$1,214	$14,570	$17,484	$19,378	$21,855	$29,140	$36,425	$43,710	$50,995
3	$1,526	$18,310	$21,972	$24,352	$27,465	$36,620	$45,775	$54,930	$64,085
4	$1,838	$22,050	$26,460	$29,327	$33,075	$44,100	$55,125	$66,150	$77,175

5	$2,149	$25,790	$30,948	$34,301	$38,685	$51,580	$64,475	$77,370	$90,265
6	$2,461	$29,530	$35,436	$39,275	$44,295	$59,060	$73,825	$88,590	$103,355
7	$2,773	$33,270	$39,924	$44,249	$49,905	$66,540	$83,175	$99,810	$116,445
8	$3,084	$37,010	$44,412	$49,223	$55,515	$74,020	$92,525	$111,030	$129,535

Exhibit A – Federal Poverty Guidelines

2009

Exhibit B – Confidential Financial Application

Valley Presbyterian Hospital

Confidential Medical and Financial Assistance Application

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

___________________________ ÷ ________________________ = %

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 - • Hourly • Daily • Weekly • Monthly • Yearly	
	Hours Per Week:	
If income is $0/unemployed, what is your means of support?	Circle One – • Living on Savings/Annuity • Live with parent/family/friends • Homeless • Shelter	

SPOUSE

Responsibility Party:		
SSN:	DOB	
Home Address:		Phone #
Work Address:		Phone #
Gross Income:	Circle One - • Hourly • Daily • Weekly • Monthly • Yearly	
	Hours Per Week:	

HOMELESS AFFIDAVIT

I, ______________________________________, herby 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

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 statue, 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**

OFFICE USE ONLY

Family Size:	Account Number(s) Total Acct#:	Balance Total Balance:	Patient Type (Inpatient, Outpatient, ER)
Gross Annual Family Income:			
FPG based on Family Size:			
Current Hospital Charges:			
Income/FPG:			
Income X 2:			
Recommendation:			

____ ____________ ______________
Prepared by Date Unit

____
Approved or Denied by Date Title