CEDARS-SINAI MEDICAL CENTER.

As part of our mission, Cedars-Sinai is committed to providing access to quality health care for the community, and to treating all of our patients with dignity, compassion and respect.

It is our policy to provide services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for part or all of their care. In addition, we offer our patients a variety of payment plans and options to meet their financial needs.

These financial assistance policies and programs are designed to balance a patient's need for financial assistance with the medical center's responsibility to maintain its financial viability so that we may continue to serve the community.

- **Governmental Programs**

Cedars-Sinai participates in several governmental assistance programs, such as Medi-Cal, California Tobacco Control Program (Prop 99), Victims of Crime and Undocumented Alien Funding for Emergency Care (Section 1011). Assistance is available to help patients in identifying eligibility for these programs. If you would like information regarding these programs, please contact our Patient Financial Services office at **(323) 866-8600**.

- **Financial Assistance Programs**

Patients who need help in meeting their financial obligations for the healthcare they receive at Cedars-Sinai may apply for financial assistance. Emergency Physicians who provide emergency medical care at Cedars-Sinai are 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. Financial assistance is based on a patient's income and ability to pay. This requires completion of financial disclosure forms and a screening process to determine eligibility for the program. Please contact the Patient Financial Services office for details and assistance for hospital services at **(323) 866-8600** and Physician Billing Services (with regard to emergency physician services) at **(800) 851-0211.**

- **Cash Discounts**

Self-pay patients may receive a substantial discount from charges similar to the discounts we provide to managed care insurance plans. Eligible services include Outpatient Emergencies and Inpatient Admissions.

- **Cash Packages**

All patients, upon request, are eligible for cash package pricing for selected services. Cash packages generally cover the hospital and anesthesiologist fees for outpatient procedures. Cash packages must be paid in advance of receiving services, and insurance claims will not be prepared or provided. If you would like information on cash packages please contact the Pre-Registration Department at **(310) 423-4890**.

(over)

(over)

Rosenthal Fair Debt Collection Act

We do refer some delinquent accounts to third-party debt collection agencies. 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. Fore more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 877-FTC-HELP (877-382-4357) or online at www.ftc.gov/os/statutes/fdcpajump.shtm. Additionally, in the event your account is referred to a collection agency and you have problems with that agency, please contact us immediately at (323) 866-8600.

CEDARS-SINAI MEDICAL CENTER.

Como parte de nuestra misión, Cedars-Sinai se compromete a proveer a la comunidad acceso a cuidado de la salud de calidad, y a tratar a todos nuestros pacientes con dignidad, compasión y respeto.

Nuestra política es proveer servicios sin costo, o a un precio significativamente reducido, a los pacientes elegibles que no pueden pagar parte o la totalidad de su cuidado. Adicionalmente, ofrecemos a nuestros pacientes una variedad de planes de pago y opciones para cubrir sus necesidades financieras.

Estos programas y políticas de asistencia financiera han sido diseñados para equilibrar la necesidad del paciente de recibir asistencia financiera con la responsabilidad del centro médico de mantener su viabilidad financiera para poder continuar ofreciendo sus servicios a la comunidad.

- **Programas del gobierno**

Cedars-Sinai participa en varios programas de asistencia del gobierno, tales como Medi-Cal, el proyecto de ley 99 (Proposition 99) y Víctimas del Delitos y Crímenes (Victims of Crime). Se provee asistencia para ayudar a los pacientes a determinar su elegibilidad para estos programas. Si usted desea información acerca de estos programas, por favor comuníquese con la Oficina de Servicios Financieros para el Paciente llamando al **(323) 866-8600**.

- **Programas de asistencia financiera**

Los pacientes que necesitan ayuda para satisfacer sus obligaciones financieras por el cuidado de la salud que reciben en Cedars-Sinai pueden solicitar asistencia financiera. La asistencia financiera está basada en los ingresos del paciente y su capacidad de pagar. Para determinar la elegibilidad para el programa, se requiere completar formularios de declaración financiera y un programa de selección. Para obtener detalles y asistencia, por favor comuníquese con la Oficina de Servicios Financieros para el Paciente llamando al **(323) 866-8600**.

- **Descuentos por pago en efectivo**

Los pacientes sin seguro médico reciben un descuento substancial sobre los costos que es similar a los descuentos que proveemos a los planes de seguro de administración de la salud. Los servicios elegibles incluyen a pacientes no internados, las emergencias sin internación y las internaciones en el hospital.

- **Ofertas por pago en efectivo**

Todos los pacientes, al solicitarlo son elegibles para las ofertas por pago en efectivo para servicios selectos. Las ofertas por pago en efectivo cubren en general los costos del hospital y del anestesista para los tratamientos médicos sin internación. Las ofertas en efectivo deben pagarse por adelantado, y no se prepararán ni proveerán reclamos para el seguro. Si desea información sobre las ofertas por pago en efectivo, por favor comuníquese con el Departamento de Inscripción Previa llamando al **(323) 866-7979**.

(Ver al dorso)

Ley Rosenthal de Cobro Justo de las Deudas
(Rosenthal Fair Debt Collection Act)

Algunas de nuestras cuentas morosas son enviadas a agencias de cobro independientes. Las leyes estatales y federales exigen que quienes se dedican a cobrar deudas morosas lo traten a usted con justicia y prohíben a estas personas hacer declaraciones falsas o amenazas de violencia, utilizar lenguaje obsceno o profano y comunicarse de forma inapropiada con terceros, tales como su empleador. Excepto en circunstancias inusuales, quienes cobran deudas no pueden comunicarse con usted antes de las 8:00 a.m. o después de las 9:00 p.m. En general, quienes se encargan de cobrar deudas no pueden dar información sobre su deuda a otra persona, a menos que esa persona sea su abogado o cónyuge. Un recolector de deudas puede comunicarse con otra persona para confirmar la ubicación del deudor o hacer valer una decisión del tribunal. Para obtener más información sobre las actividades de cobro de deudas, puede comunicarse con la Comisión Federal de Comercio (Federal Trade Commission) por teléfono llamando al 877-FTC-HELP (877-382-4357) ó en línea yendo a 22.ftc.gov. Adicionalmente, si su cuenta es enviada a una agencia de cobro de deudas morosas y usted tiene alguna dificultad con esa agencia, por favor comuníquese con nosotros de inmediato llamando al (323) 866-8600.

(Ver al dorso)

CEDARS-SINAI MEDICAL CENTER.

Медицинский центр Сидарз-Сайнай считает своим долгом предоставлять широкий доступ к качественному медицинскому обслуживанию и лечить всех своих пациентов, охраняя их чувство собственного достоинства, с состраданием и уважением.

Наша политика – предоставлять бесплатное обслуживание или делать значительные скидки тем пациентам, которые не в состоянии частично или полностью оплатить свое лечение. Кроме того, мы предлагаем своим пациентам разнообразные планы и варианты оплаты в соответствии с их финансовыми возможностями.

Эта политика и программы оказания финансовой помощи предназначены для того, чтобы сбалансировать потребности пациентов в финансовой помощи с ответственностью Медицинского центра по поддержанию своей финансовой жизнеспособности для дальнейшего медицинского обслуживания населения.

- **Государственные программы**

Сидарз-Сайнай участвует в нескольких государственных программах финансовой помощи, таких как Medi-Cal, Proposition 99 и Victims of Crime («жертвы преступлений»). Пациентам предлагается помощь в определении того, имеют ли они право на эти программы. Если Вы хотите получить информацию об этих программах, позвоните, пожалуйста, в Отдел финансового обслуживания пациентов по тел. **(323) 866-8600**.

- **Программы финансовой помощи**

Пациенты, нуждающиеся в помощи для выполнения своих финансовых обязательств по оплате их медицинского обслуживания в Сидарз-Сайнай, могут подавать заявления на финансовую помощь. Финансовая помощь оказывается в зависимости от доходов пациентов и их платежеспособности. Для рассмотрения наличия права на программу необходимо заполнить формы предоставления финансовой информации и пройти процесс проверки. Позвоните, пожалуйста, в Отдел финансового обслуживания пациентов по тел. **(323) 866-8600**, чтобы получить более подробную информацию и помощь.

- **Скидки при уплате наличными**

Незастрахованные пациенты получают существенные скидки, подобные тем, которые мы даем страховым планам управляемого медицинского обеспечения. Услуги, по которым предоставляются такие скидки, включают срочную амбулаторную помощь и госпитализацию.

(переверните страницу)

- **«Пакетные» расценки при уплате наличными**

На некоторые услуги все пациенты, по их просьбе, имеют право на оплату пакетной стоимости при условии уплаты наличными. Такие цены обычно даются на оплату услуг госпиталя и анестезиолога при амбулаторных процедурах. В этом случае оплата должна быть произведена до оказания услуг, и страховые заявки не готовятся и не подаются. Если Вы хотите получить информацию о пакетных расценках, позвоните, пожалуйста, в Отдел предварительной регистрации по тел. **(323) 866-7979**.

Закон Розенталя о справедливом сборе налогов

Мы передаем некоторые счета с просроченной задолженностью агентствам по сбору долгов. Штатные и федеральные законы требуют от сборщиков долгов справедливого обращения с должниками и запрещают им делать ложные заявления, угрожать насилием, употреблять непристойные или грубые выражения и недолжным образом связываться с третьими сторонами, включая Вашего работодателя. За исключением необычных обстоятельств, сборщики долгов не имеют права связываться с Вами до 8:00 a.m. и после 21:00. Вообще, сборщик налогов не имеет права сообщать о Вашем долге другому лицу, не являющемуся Вашим адвокатом или супругом(ой). Однако сборщик налогов может связаться с другим лицом для подтверждения Вашего местонахождения или приведения в исполнение судебного решения. Чтобы подробнее узнать о сборе долгов, можно обратиться в Федеральную торговую комиссию по тел. 877-FTC-HELP (877-382-4357) или через вебсайт 22.ftc.gov. Кроме того, если Ваш счет передадут в агентство по сбору долгов и у Вас с этим агентством возникнут проблемы, пожалуйста, немедленно свяжитесь с нами по тел. (323) 866-8600.

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ضمیمه الف

CEDARS-SINAI MEDICAL CENTER.

مرکز پزشکی سیدرز- ساینای

بعنوان قسمتی از ماموریت ما، سیدرز- ساینای خود را متعهد به ارائه دسترسی به مراقبت های پزشکی درجه اول برای جامعه و همچنین معالجه همه بیماران ما با عزت، دلسوزی و احترام می داند.

این سیاست ما است که خدمات خود را به بیماران واجد شرایط که توانائی پرداخت همه یا قسمتی از هزینه های درمانی خود را ندارند بصورت رایگان یا با قیمت های بسیار نازل عرضه کنیم. علاوه بر این، ما انواع برنامه های پرداخت و راه های انتخابی را به بیماران خود عرضه می کنیم تا بدین وسیله بتوانند نیاز های مالی خود را بپردازند.

این سیاست ها و برنامه های کمک مالی به منظور ایجاد تعادل در نیاز بیمار در رابطه با کمک مالی مربوط به مسئولیت های مرکز پزشکی در حفظ خودکفائی مالی این مرکز طرح شده است تا بدین وسیله بتوانیم به خدمت خود به جامعه ادامه دهیم.

- **بر نامه های دولتی (Governmental Programs)**

سیدرز- ساینای در چندین برنامه کمک دولتی از قبیل مدیکل، برنامه موسوم به "پیشنهاد ۹۹"، و برنامه "قربانیان جرم" شرکت دارد. کمک های لازم برای یاری رساندن به بیماران در جهت شناسائی واجد شرایط بودن خود برای این برنامه ها عرضه می شود. اگر مایلید در مورد این برنامه ها اطلاعاتی داشته باشید، لطفا با دفتر "خدمات مالی بیمار" ما با تلفن ۸۶۶-۸۶۰۰ (۳۲۳) تماس بگیرید.

- **برنامه های کمک مالی (Financial Assistance Programs)**

بیمارانی که در رابطه با انجام تعهدات مالی مربوط به خدمات بهداشتی خود که از سیدرز- ساینای دریافت کرده اند نیاز به کمک دارند می توانند برای کمک های مالی تقاضا دهند. کمک مالی بر مبنای درآمد بیمار و قدرت او برای پرداخت می باشد. این کار مستلزم تکمیل فرم های افشای مالی و یک جریان بررسی است تا واجد شرایط بودن بیمار جهت این برنامه مشخص شود. برای آگاهی از جزئیات و کمک لطفا با دفتر "خدمات مالی بیمار" با تلفن ۸۶۶-۸۶۰۰ (۳۲۳) تماس بگیرید.

- **تخفیف های نقدی (Cash Discounts)**

بیماران بیمه نشده از یک تخفیف قابل توجه برخوردار می شوند که شبیه تخفیف هائی است که ما در رابطه با برنامه های بیمه موسوم به "managed care" عرضه می کنیم. خدمات واجد شرایط شامل فوریت های پزشکی سرپائی / همراه با بستری شدن و نیز پذیرش بیمارانی است که به بستری شدن نیاز دارند.

- **هزینه های نقدی یکپارچه (Cash Packages)**

همه بیماران چنانچه درخواست کنند در رابطه با خدمات انتخاب شده برای هزینه های نقدی یکپارچه واجد شرایط هستند. هزینه های یکپارچه معمولا هزینه های بیمارستان و بیهوشی مربوط به جراحی های سرپائی را زیر پوشش دارد. برای

(پشت صفحه)

ضمیمه الف

دریافت خدمات مربوطه، هزینه های یکپارچه باید از قبل پرداخت شوند و تقاضا برای پس گرفتن هزینه از بیمه آماده یا عرضه نمی شود. اگر در رابطه با هزینه های نقدی یکپارچه به اطلاعاتی نیاز دارید لطفا با بخش قبل از ثبت نام به شماره تلفن ۸۶۶-۷۹۷۹ (۳۲۳) تماس بگیرید.

قانون باز پس گیري منصفانه قروض رزنتال
Rosenthal Fair Debt Collection Act

ما در رابطه با برخی از حساب های وصول نشده به سازمان های وصول قرض از شخص ثالث مراجعه می کنیم. قانون ایالتی و فدرال سازمان های وصول قرض را موظف می سازند با شما عادلانه رفتار کرده و آنها را از ارائه بیانیه های جعلی یا تهدید به خشونت، استفاده از لحن زشت یا توأم با بی حرمتی، و ایجاد ارتباطات نامناسب با اشخاص ثالث، از جمله کارفرمای شما منع می کند. وصول کنندگان قرض نمی توانند قبل از ساعت ۸ صبح یا پس از ۹ شب با شما تماس بگیرند مگر آن که شرایط غیر عادی وجود داشته باشد. بطور کلی یک وصول کننده قرض نمی تواند اطلاعات مربوط به قرض شما را بجز وکیل یا همسرتان در اختیار شخص دیگری قرار دهد. وصول کننده قرض می تواند جهت تائید محل شما یا به اجرا درآوردن حکم با شخص دیگری تماس بگیرد. برای اطلاعات بیشتر درباره اقدامات مربوط به وصول قرض می توانید با کمیسیون تجارت فدرال به شماره تلفن ۳۸۲-۴۳۵۷ (۸۷۷) 877-FTC-HELP یا به تارنمای 22.ftc.gov مراجعه کنید. علاوه براین، در صورتی که حساب شما به یک سازمان وصول ارجاع شده و شما در رابطه با آن سازمان مشکلی دارید لطفا بلافاصله با ما با شماره تلفن۸۶۶-۸۶۰۰ (۳۲۳) تماس بگیرید.

(پشت صفحه)

Attachment B

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/34-COUNTY CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST)
2. SOCIAL SECURITY NUMBER (SSN)
3. MAIDEN OR OTHER NAME (IF ANY)
2A. DATE OF BIRTH (MM-DD-YYYY)
4. HOME ADDRESS: NUMBER STREET / CITY STATE ZIP CODE
5. MAILING ADDRESS (IF DIFFERENT) / CITY STATE ZIP CODE
6. TELEPHONE NUMBER(S): HOME ( ) WORK ( ) MESSAGE ( )
7. Is your home address permanent? ☐ YES ☐ NO ☐ NO HOME
If not permanent, please explain:
8. Is anyone applying for: Cash Aid ☐ YES ☐ NO; Food Stamps ☐ YES ☐ NO; Medi-Cal ☐ YES ☐ NO; 34-County CMSP ☐ YES ☐ NO
Any Other Program(s) ☐ YES ☐ NO If "YES", explain:
9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/34-County CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list: ☐ YES ☐ NO
TYPE OF AID/BENEFIT / DATE(S) RECEIVED / NAME(S) USED / RECEIVED WHERE? (COUNTY/STATE/COUNTRY)
10. The law says we must record your ethnic group, race and language. This won't affect your eligibility.
A. ETHNICITY *(Everyone must also answer B)*
Are you Hispanic or Latino? ☐ YES ☐ NO
B. RACE/ETHNIC ORIGIN - Check all boxes that apply to you. If you do not complete this question the county will do it for you.
☐ American Indian or Alaskan Native ☐ Black or African American ☐ White
☐ Asian *(If checked, please select one or more of the following)*
☐ Filipino ☐ Chinese ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian Indian
☐ Cambodian ☐ Laotian ☐ Other Asian *(specify)*
☐ Native Hawaiian or Other Pacific Islander *(If checked, please select one or more of the following)*
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)*
C. PRIMARY LANGUAGE:
☐ English ☐ Spanish ☐ Lao ☐ Tagalog ☐ American Sign ☐ Cantonese ☐ Cambodian
☐ Vietnamese ☐ Russian ☐ Other *(specify)*
11. Is anyone a migrant or seasonal farmworker? ☐ YES ☐ NO
12. Is anyone pregnant? ☐ YES ☐ NO If "YES", did she get a Presumptive Eligibility card? ☐ YES ☐ NO
13. Does anyone have a personal emergency? If "YES", check (✓) type: ☐ YES ☐ NO
☐ Immediate Medical Need ☐ Pregnancy ☐ Child Abuse ☐ Domestic Abuse
☐ Elder Abuse ☐ Other emergency which threatens health or safety. Explain:

IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENT ..... FILL IN ITEMS 14 - 18.
FOOD STAMP EXPEDITED SERVICE ..... FILL IN ITEMS 14 - 17.

14. How much liquid resources does everyone, including children, have?
☐ Cash, uncashed checks or money orders $
☐ Checking/savings or credit union account(s) $
☐ Trust deeds, notes receivable, stocks or bonds $
☐ Other (explain) $
15. How much income did everyone, including children, get or will they get this month?

Date	Amount	Date	Amount
	$		$
	$		$

16. How much is your rent or mortgage this month? $
17. How much are your utilities that are not included in your rent this month? $

	YES	NO
18. Do you have an eviction notice or notice to pay or quit?		
Have your utilities been shut off or do you have a shut-off notice?		
Will your food run out in 3 days or less?		
Do you need essential clothing, such as diapers or clothing needed for cold weather?		
Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?		

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.**

19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE / DATE SIGNED
SIGNATURE OF WITNESS TO MARK OR INTERPRETER / DATE SIGNED

COUNTY USE ONLY

CASE NAME
CASE NUMBER
DATE RECEIVED

TYPE OF APPLICATION:
CA: ☐ CA ☐ RCA
FS: ☐ Initial ☐ Recert ☐ Rest
MC: ☐ CMSP: ☐

Homeless:
FS: ☐ YES ☐ NO
CA: ☐ YES ☐ NO ☐ CW 42

☐ Pickle Screening

Ethnic Group:

Race:

Primary Language:

CA I.N.
☐ Denied/NOA prep
☐ Approved
☐ Expedited Grant
☐ Applicant requested CWD to complete SAWS 1
( ) (Initials)

FS E.S.
☐ E.S. questions not completed
☐ Screened for E.S.
Date:
( ) (Initials)

FS Referral for:
☐ E.S. Processing
☐ Regular Processing

☐ CWD records cleared
☐ MEDS CDB cleared
☐ IEVS initiated

☐ Copy of SAWS 1 and coversheet given to applicant

TRANSITIONING CASE NUMBER

COUNTY OF APPLICATION

COUNTY OF RESIDENCE (IF DIFFERENT)

CEDARS-SINAI

FINANCIAL ASSISTANCE APPLICATION

Patient Name:_____

Patient Account or Medical Record Number:_____

Date of Birth:_____ Social Security #_____

Best Daytime Telephone Number:( ) _____-_____

Address:_____

City, State, Zip:_____

Spouse Name:_____ Social Security #:_____

Are you a U.S. Citizen? Yes No

If not, a resident alien? Yes No

If not, non-resident alien? Yes No

Family Status: List all dependants that you support (If more than 4 use separate page)

Name	Age	Relationship

Employment and Occupation

Employer:_____ Position:_____

If self-employed, name of business:_____

Employer Address:_____

Phone: ( ) _____-_____ How long employed:_____

Spouse's Employer:_____ Position:_____

If self employed, name of business:_____

By signing this application, I agree to allow Cedars-Sinai Medical Center to check my employment and request a credit history.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Spouse) (Date)

CEDARS-SINAI

FINANCIAL ASSISTANCE APPLICATION

Current Monthly Income	Patient	Spouse	Joint
Gross Pay	$	$	$
Income from Business (if self employed)	$	$	$
Interest and Dividends	$	$	$
From Real Estate and Personal Property	$	$	$
Social Security/Retirement Income	$	$	$
From Alimony, support payments	$	$	$
Other Income	$	$	$
Total Monthly Income	$	$	$

Assets (if applicable)	Patient	Spouse	Joint
Stocks and Bonds	$	$	$
Money Market Accounts	$	$	$
Brokerage Accounts	$	$	$
Certificates of Deposit/Savings Accounts	$	$	$
Total Assets	$	$	$

Current Monthly Expenditures	Patient	Spouse	Joint
Rent or Mortgage	$	$	$
Real Estate Taxes	$	$	$
Utilities	$	$	$
Alimony, Support Payment	$	$	$
Auto Loan/Lease Payment	$	$	$
Education	$	$	$
Food	$	$	$
Payroll Deductions	$	$	$
Medical, Dental, Medicines	$	$	$
Other Expense	$	$	$
Total Monthly Expenses	$	$	$
Net Monthly Income After Expenses	$	$	$

Attachment D

CEDARS-SINAI MEDICAL CENTER

Business Hours:
Mon. – Fri. 9 – 11:45am; 1:00pm - 4:30pm
24 hour Access by fax: (323) 866- 8685

Telephone Number (323) 866-8600
E-mail: Patient.Billing@cshs.org

Name
Address
City, State, Zip

Re:
Account Number:
Admission Date:
Account Balance: $

In response to your request for financial assistance under the Cedars-Sinai Medical Center's policy regarding Full and Partial Financial Assistance For Financially Qualified Patients regarding the services described above, and in order to properly assess your ability to pay all or part of the hospital bill(s), additional documentation is required. It is possible that the services referenced above may be eligible for coverage under the Cedars-Sinai Medical Center Financial Assistance policy. Attached for your review is a policy summary. To assist us in our evaluation, please submit the following documentation no later than (15) days from the date of this letter. You may send your information by mail, Fax, or in an attachment to an E-mail in accordance with the contact information shown at the top of this letter:

(1) Fully completed charity care application (enclosed with this letter).

(2)
- A copy of your most current federal tax return (Form 1040).
- If not available, a copy of your most recent pay stub from all employment during the last six (6) months.
- Please note, that this also includes public assistance (for example, Unemployment, Disability payments, General Relief) or your Social Security check stub. If you receive your income in cash, please provide us a written statement from your employer stating your monthly income.

If you currently are not receiving any income that would be reflected in the foregoing documents, please prepare a brief statement stating your current financial situation. If you are receiving financial assistance from a family member or friend, please have that person(s) submit a signed statement confirming the financial assistance provided to you. Be sure to sign and date the statement.

(3) Rent or Mortgage verification.

(4) A copy of your prior month's bank statement (All Pages). (Savings, Checking, IRA, Stock and Bond certificates, Money Market accounts, Certificate of Deposits, Brokerage account statements, and 401(K) and 403(B) statements.)

(over)

We ask that you send copies of the above referenced documents as they will not be returned to you.

Please note that it is imperative to include all requested documents or include a signed statement explaining why any of the above items do not pertain to your situation. For instance, if you do not pay rent or have a mortgage, please explain why. If you live with someone, please have that person(s) submit a signed statement confirming the living situation.

Please understand that submission of a complete application does not mean that the services will qualify under the Medical Center's Financial Assistance Policy. There are a number of considerations involved in our review. We will promptly review your application and let you know its status.

The Medical Center's Financial Assistance Policy provides assistance for patients whose family incomes do not exceed 450% of the federal poverty level. There are a number of other federal, state, local and private sources available to fund care to low-income individuals. We are available to provide you assistance in identifying sources that may apply to your situation.

Should you have any questions, please contact the Customer Service Representatives at 323 866-8600 for assistance.

Sincerely,

CSMC Department of Patient Financial Services

(over)

CEDARS-SINAI

Dear Patient:

State law requires us to inform you that there are several non-profit Credit Counseling Services available in this area. Two of them are listed below. Please understand that these companies are neither endorsed by nor recommended by Cedars-Sinai Medical Center:

1. The Credit Association
   (888) 835-1800
2. Delray Credit Counseling
   (877) 740-5958

Should you have any questions, please contact our Customer Service Department at (323) 866-8600.

Sincerely,

CSMC Department of Patient Financial Services

Attachment F

Helpful Information About Your Statement

The Medical Center will bill your hospital claim to your insurance plan. If payment is not received from your insurance in 45 days, we may request your assistance in obtaining payment. Once your insurance has processed your claim, the Medical Center will present a bill for all balances due.

Please note: There may have been several physicians who participated in your medical care, for which you should receive separate billings. Some or all of the physicians who treated you may or may not be associated with your insurance plan. For your reference, please direct physician related billing questions to the following: General Anesthesia Specialists Partnership (213) 637-3700, Consultants for Pathology (866) 222-4160 or (818) 338-8100, Cedars-Sinai Cardiology (310) 423-4860, Cedars-Sinai Imaging & MRI (800) 303-3044, Cedars-Sinai Laboratory Services (310) 423-1211, Pathology Consultants Medical Group (866) 222-4160 or (818) 338-8100 and The Physicians Billing Service (323) 866-8800.

Notice of availability of financial assistance

Cedars-Sinai Medical Center offers a variety of financial assistance programs for our patients who are unable to pay for all or part of the hospital-provided treatment at our facility.

If you need assistance with your hospital bill, please call the customer service line in the patient financial services department at (323) 866-8600.

Thank you for making Cedars-Sinai your hospital of choice.

Health News & Information

Remember to take advantage of our HEALTH TOPICS Library where you get general health information on the latest happenings and advances in the medical world. Each topic provides you with useful information to help you make better health care decisions. Visit www.cedars-sinai.com or call Cedars-Sinai Physician and Service Referral Program at 1-800-233-2771.

Change of Address and Insurance Information

MEDICARE

Health Insurance

SOCIAL SECURITY ACT

Name of Beneficiary

Claim Number Sex

Is Entitled To Effective Date

SIGN HERE _____

BLUE CROSS

Blue Cross
Blue Shield

SUBSCRIBER NAME

GROUP NO. SERVICE CODE

CONTRACT NUMBER BC PLAN CODE

Commercial Insurance

INSURANCE COMPANY NAME
INSURANCE ADDRESS
SOCIAL SECURITY NUMBER
POLICY NO/GROUP NUMBER
POLICYHOLDER'S NAME
EMPLOYER
EMPLOYER'S ADDRESS

CHANGE OF ADDRESS

Name _____

Address _____

City _____ State _____ Zip _____

CEDARS-SINAI MEDICAL CENTER

FULL AND PARTIAL FINANCIAL ASSISTANCE DISCOUNTS

Eligibility Scale

Column A	Full Column B	Partial Column C	Partial Column D	Partial Column E	Partial Column F
Financial Assistance (Uninsured) Discount Percentage	100%	95%	90%	85%	85%
Financial Assistance (Underinsured) Discount Percentage	100%	90%	80%	70%	60%

Size of Family Unit					
1	$22,340	$27,925	$ 33,510	$ 39,095	$ 50,265
2	$30,260	$37,825	$ 45,390	$ 52,955	$ 68,085
3	$38,180	$47,725	$ 57,270	$ 66,815	$ 85,905
4	$46,100	$57,625	$ 69,150	$ 80,675	$103,725
5	$54,020	$67,525	$ 83,010	$ 94,535	$121,545
6	$61,940	$77,425	$ 92,910	$108,395	$139,365
7	$69,860	$87,325	$104,790	$122,255	$157,185
8	$77,780	$97,225	$116,670	$136,115	$175,005
2012 FPL*	200%	250%	300%	350%	450%

(*Note: FPL = Federal Poverty Level)

Column GB shows qualifying salaries at the 200% of the FPL. Column C reveals qualifying salaries at 250% of the FPL, Column D at 300%, Column E at 350% and Column F at 450%.

To calculate the potential eligibility, select the size of the Family Unit (number of immediate members in the household) in Column A. Then find the annual income in Columns B or C or D or E of F. This will identify the potential Financial Assistance Discount that may become eligible, once all documentation is verified.

Examples: If the family size is 3 and the annual income is $40,000, look at the number in Column B. The income of $40,000 is greater than the $38,180 (column B) and less than $47,725 (Column C). Next, look at the Financial Assistance Discount (Uninsured) Percent line in Column B. It is 100%. A Partial Financial Assistance (Underinsured) patient would look at the Partial Financial Assistance Discount line in Column B. It is also 100%

If the family size is 1 and the annual income is $40,000, look at the Annual Income in Column E. $40,000 is greater than $39,095 (Column E) and less than $50,265 (Column F). Next, look at the Financial Assistance Discount (Uninsured) Percentage in Column E for a family size of 1. It is 80%. A Partial Financial Assistance (Underinsured) patient would look at the Partial Financial Assistance Discount Percentage line in Column E. It is 70%.

For each additional member of a unit size of 8, add $3,960 to each Annual Salary number.

Uninsured Inpatient Maximum: Patients treated on an inpatient basis and qualified for a Financial Assistance discount of less than 100% will not be financially responsible for more than the amount of the Medicare DRG.

Uninsured Outpatient Maximum: Patients that were treated on an outpatient basis and qualified for a Financial Assistance discount less than 100% will not be financially responsible for more than our average outpatient Medicare reimbursement rate of 15% (see note below).

Income levels are based upon the published Federal Poverty Guidelines in effect at the time of Medical Center's receipt of the Financial Assistance care application calculated at 200% of the published minimum level. Each level represents the maximum family income to qualify.

Note: The average outpatient Medicare reimbursement rate is calculated by the Manager of Reimbursement, Department of Finance, Cedars-Sinai Medical Center. The number comes from the monthly contractual adjustment. This is based on a closed account analysis.

Attachment H

CEDARS-SINAI MEDICAL CENTER.

January 2008

Patient Name:
RE: Application for Charity Care
Medical Record #
Patient Balances: $

Dear ,

We have received your application for financial assistance under the Cedars-Sinai Medical Center Charity Care Policy. In order to complete our review, we need the following information from you:

- ☐ Prior year (1040) Income Tax Return
- ☐ Prior Month's Bank Statement *(All Pages)*
- ☐ Current period pay stub
- ☐ Verification of employment
- ☐ Unemployment, Social Security, or Disability stub
- ☐ Rent verification
- ☐ Proof of Residence

Other: _____

Unless we receive this information within the next fifteen (15) business days, your Charity Care application will be denied, and you will be fully responsible for the balance owed as indicated above. If the application is for an elective procedure, you will be financially responsible for the cost of the Services you have requested.

If you are unable to provide any of the requested items, submit an explanation in writing. Remember to sign and date the letter.

We appreciate your timely attention to this matter. If you have any questions, please call us at (323) 866-8600

Sincerely,

CSMC Department of Patient Financial Services

Attachment I1

CEDARS-SINAI HEALTH SYSTEM.
Patient Financial Services

Date

Name
Address
City

Business Hours:
Mon. - Fri. 9-11:45 am; 1-4:30pm
Tel. # (323)866-8600

24 Hour Fax Access: (323)866-8685
E-mail: Patient.Billing@cshs.org

Re: Application for Financial Assistance

Dear ,

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, we are unable to grant Financial Assistance because your property/assets exceed Cedars-Sinai Medical Center's guidelines. However, please note that we have provided a significant discount for your health care services that are similar to what we offer our contracted insurance companies.

We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $ will be due within 30 days.

Sincerely,

CSMC Department of Patient Financial Services

Attachment I2

CEDARS-SINAI HEALTH SYSTEM.
Patient Financial Services

Date

Name
Address
City

Business Hours:
Mon. - Fri. 9-11:45 am; 1-4:30pm
Tel. # (323)866-8600

24 Hour Fax Access: (323)866-8685
E-mail: Patient.Billing@cshs.org

Re: Application for Financial Assistance

Dear ,

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, we are unable to grant Financial Assistance because your income level exceeds Cedars-Sinai Medical Center's guidelines. However, please note that we have provided a significant discount for your health care services that are similar to what we offer our contracted insurance companies.

We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $ will be due within 30 days.

Sincerely,

CSMC Department of Patient Financial Services

Attachment I3

CEDARS-SINAI HEALTH SYSTEM
Patient Financial Services

Date

Business Hours:
Mon. - Fri. 9-11:45 am; 1-4:30pm
Tel. # (323)866-8600

24 Hour Fax Access: (323)866-8685
E-mail: Patient.Billing@cshs.org

Name
Address
City

Re: Application for Financial Assistance

Dear ,

Thank you for submitting your application for financial assistance. Our goal is to make our quality health care services accessible and affordable for you, from providing significant discounts to offering adjustments based on financial need.

Unfortunately, after careful review of your application, **we are unable to grant Financial Assistance because you have not provided the requested information necessary to determine your eligibility.** However, please note that we have provided a significant discount listed below for your health care services that are similar to what we offer our contracted insurance companies.

We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

You may appeal this determination by submitting documents to support your inability to pay that were not part of the initial consideration. If you wish to appeal, please submit the additional documents within fifteen working days from the date of this letter or contact us. If your appeal is not received, the decision will be final and the balance of $ will be due within 30 days.

Sincerely,

CSMC Department of Patient Financial Services

Attachment J

Financial Assistance Worksheet

January __, 2012

Patient Name:

Medical Record Number:

Recommendation/Comment:

Monthly Income: $

Yearly Income: $

Family Size:

Total Patient Balances **$0.00**

Determination Based on Financial Assistance Guidelines

100 % _____ 95 % _____ 90% _____ 85% _____

80 % _____ 70 % _____ 60% _____ Ineligible _____

Approvals:

Financial Specialist: _____ Date: _____

Supervisor: _____ Date: _____

Manager: _____ Date: _____

Director: _____ Date: _____

Vice President: _____ Date: _____

Financial Assistance 2012 Federal Poverty Guidelines

Uninsured Charity Discount	100%	95%	90%	85%	85%
Underinsured Charity Discount	100%	90%	80%	70%	60%

Size of Family Unit	2012 FPL Annual Salary					
1	$11,170	$ 22,340	$ 27,925	$ 33,510	$ 39,095	$ 50,265
2	$15,130	$ 30,260	$ 37,825	$ 45,390	$ 52,955	$ 68,085
3	$19,090	$ 38,180	$ 47,725	$ 57,270	$ 66,815	$ 85,905
4	$23,050	$ 46,100	$ 57,625	$ 69,150	$ 80,675	$ 103,725
5	$27,010	$ 54,020	$ 67,525	$ 83,010	$ 94,535	$ 121,545
6	$30,970	$ 61,940	$ 77,425	$ 92,910	$ 108,395	$ 139,365
7	$34,930	$ 69,860	$ 87,325	$ 104,790	$ 122,255	$ 157,185
8	$38,890	$ 77,780	$ 97,225	$ 116,670	$ 136,115	$ 175,005
For Each additional Per person, add	$3,960					
FPL Level		200%	250%	300%	350%	450%

CEDARS-SINAI MEDICAL CENTER. January , 2010

Business Hours:
Mon. – Fri. 9 – 11:45am and 1 – 4:30pm
Customer Service Telephone Number: (323) 866-8600
24 Hour Facsimile Access: (323) 866-8685
Email: Patient.Billing@cshs.org

RE: Application for Financial Assistance
Patient Name:
Medical Record No.:
Account(s) #

Dear ,

We have reviewed and approved your application for financial assistance under the Cedars-Sinai Medical Center Financial Assistance Policy. We want you to know that we value you as a patient and appreciate the opportunity to provide services to you. There are various accounting rules and laws that direct the Medical Center to run its financial assistance program in a relatively formal manner. Please understand that it remains your responsibility to secure a treating physician.

This approval has several limitations attached to it. They are as follow:

(a) Based upon the information you submitted, you are eligible for a discount of %. Accordingly, you will owe a balance of $ to the Medical Center for outstanding account balances with service dates prior to the date of this letter. The same percentage discount will apply to outstanding faculty physician accounts with service dates prior to the date of this letter.

(b) Services rendered by other private, attending physicians (who are not providing Services to you as a member of the Medical Center's faculty) must be paid by you, unless other arrangements have been made with them.

(c) If you need additional services at the Medical Center during the period through (the "expiration date"), you will continue to be eligible for the same discount amount described in paragraph (a). The Medical Center will need to specifically agree, in advance and in writing, to provide the discount for non-emergency service. Should you request additional services during this period, we will ask you to re-confirm

that there have been no material changes in your family's financial condition or the size of your family.

(d) Any time that you access services at the Medical Center before the expiration date, please bring this letter with you and show it to the registration representative.

(e) Because the Medical Center may be entitled to reimbursement for the services it provides to you from other sources, we will require that you continue to cooperate in the application for funding from such sources. Funding sources may include Victim of Crime, QueensCare, Medi-Cal, Proposition 99, Section 1011, etc.

(f) Established patients of the Medical Center's Primary Adult Care Center (ACC) are eligible for a discounted pharmacy price for their prescriptions. To qualify for this discount, please bring this letter with you.

(g) The Medical Center reserves the right to retroactively cancel this determination of financial assistance eligibility in the event the Medical Center discovers your application was not truthful or materially misleading.

(h) Should your financial situation change, you must notify the Medical Center of those changes. Changes may be of a material, financial and/or family size change that could impact your financial assistance status with the Medical Center.

Sincerely,

CSMC Department of Patient Financial Services
(323) 866-8600

Attachment L

CEDARS-SINAI MEDICAL CENTER

January , 2010

Business Hours:
Mon. – Fri. 9-11:45am; 1-4:30pm
Tel. # (323) 866-8600

24 Hour Facsimile Access: (323) 866-8685
E-mail: Patient.Billing@cshs.org

RE: Financial Assistance Determination After Appeal
Patient Name:
Medical Record No:
Account Number(s):
Patient Liability:

Dear ,

We have received your appeal to our initial ineligibility determination for financial assistance. After review of your appeal submission, we are unable to honor your appeal based on the following reason(s):

You are responsible to pay the remaining amount of $. We encourage you to contact us at (323) 866-8600 to discuss our multiple payment options, which include check, credit card or a monthly payment schedule.

Sincerely,

CSMC Department of Patient Financial Services

CEDARS-SINAI MEDICAL CENTER

CEDARS-SINAI MEDICAL CENTER

POLICY: Fair and Reasonable Debt Collection Practices: Consumer Account Collection

I. Purpose:

This policy is to ensure that the Medical Center and its contracted debt collection agencies use fair and reasonable methods, and comply with all applicable federal and state laws, in collection of the Medical Center's consumer debt accounts.

II. Policy:

In keeping with its goal of providing compassionate care, the Medical Center strives to treat all patients fairly, with dignity, compassion and respect. Therefore, the Medical Center will use its best efforts to ensure that its collection efforts related to patient accounts are fair, reasonable and consistent. This policy sets forth the general standards for Medical Center's debt collection practices, and relationships with collection agencies that act on its behalf. For specific policies and procedures related to the Medical Center's internal process for communicating with patients in connection with account collection, please see the Patient Financial Services Policy and Procedure Manual. As used in this policy, "collection agency" means an outside, non-Medical Center agency engaging in any patient/guarantor collection activities, but does not include outsource vendors which simply carry out the Medical Center's normal billing functions. Notwithstanding the immediately preceding sentence, the provisions of this policy that are applicable to carrying out the Medical Center's normal billing functions shall be applicable to outsource vendors who perform those functions.

A. General Requirements Prior to Collection Agency Action

1. Consistency in Billing Statements. At the time of billing, the Medical Center will provide to all low-income uninsured patients the same information concerning services received and charges related to those services as it provides to all other patients who receive care at the Medical Center. As used in this policy, the term "low income uninsured patient" means a patient who is at or below 450 percent of the Federal Poverty Level (FPL).

2. Notice of Financial Assistance Availability. In its bills to all patients, the Medical Center will include a statement to the effect that if the patient meets certain income requirements the patient may be eligible for government-sponsored payor programs or financial assistance from the Medical Center. Bills will also include the name/title or department and telephone number to contact for more information about the Medical Center's financial assistance program and application process.

3. Cash Discount Availability. When a patient inquires about whether the Medical Center offers a discount from its charges based on a patient's status as a cash-paying patient, the Medical Center will describe the Medical Center's cash discount policy to the patient and will keep a record of the conversation in the patient's file.

B. Relationships with Collection Agencies

1. Compliance with Law, Medical Center Standards. Collection agencies with which the Medical Center contracts must at all times comply with the federal Fair Debt Collection Practices Act, the California Rosenthal Fair Debt Collection Practices Act, and any other laws applicable to the collection of consumer debts. Collection agencies with which the Medical Center contracts also must at all times treat Medical Center patients, their families and other contacts fairly, with dignity, compassion and respect.

2. Standards for Contracting with Collection Agencies. The Medical Center shall not engage any collection agency to collect patient accounts unless: (i) the arrangement is set forth in a written agreement signed by the collection agency and the Medical Center's Vice President, Patient Financial Services; and (ii) the written agreement attaches this policy as an exhibit and requires the collection agency to comply with this policy.

3. Assignment of Patient Accounts to Collection Agencies.

(a) The Medical Center shall not assign any patient account to a collection agency unless the Medical Center (or a subcontractor acting on the Medical Center's behalf) has first performed to the best of its ability a patient profile/screen and determined to the Medical Center's satisfaction that the patient (i) does not qualify for alternative payor sources, (ii) is not agreeable to a payment plan or is no longer cooperating with a negotiated payment plan, (iii) does not qualify for the Medical Center's financial assistance program (or has qualified and been given financial assistance, in which case only the amount as adjusted to reflect the financial assistance available is forwarded for collection) and (iv) has sufficient assets available to pay the amount owing. For purposes of this policy, the Medical Center has performed the determinations listed above to the best of its ability where the Medical Center has made a reasonable attempt to gather the necessary information from a patient and the patient either does not respond within a reasonable time or is uncooperative in providing the necessary information.

(b) When the Medical Center assigns an account to a collection agency, the amount that will be assigned for collection will be the amount remaining after any prior discount arrangements or waivers have been applied to the account balance.

(c) For patients who have an application pending for either government-sponsored coverage or for the Medical Center's own financial assistance program, the Medical Center shall not knowingly send or assign such patient's bill to an outside collection agency prior to 120 days from the date of the Medical Center's initial billing of that account.

(d) For patients who have qualified for financial assistance or who have negotiated a payment plan and are reasonably cooperating with the Medical Center in settling an outstanding bill, the Medical Center will not knowingly send or assign such patient's bill to an outside collection agency if the Medical Center knows that doing so may negatively impact a patient's credit.

(e) If a debt collection agency determines that a patient account qualifies for an alternative source of payment, or determines that the patient does not have significant assets, the collection agency shall return the account to the Medical Center with an explanation of the determination and the supporting data.

(f) If a patient asks a debt collection agency whether the Medical Center offers a discount from its charges based on a patient's status as a cash-paying patient, the debt collection agency will promptly notify the Medical Center's Supervisor, Patient Financial Services, who will have authority to adjust the account in compliance with the Medical Center's cash discount policy.

(g) Prior to filing any legal action against a patient, the debt collection agency will (i) perform an analysis of the patient's assets and income to determine whether the patient has assets and income sufficient to justify filing the legal action, (ii) present this analysis to the Medical Center's Supervisor, Patient Financial Services, in such format as the Medical Center may request, and (iii) obtain the Supervisor's approval for filing the legal action against the patient.

4. Required Approvals of Specific Collection Practices. When providing services on the Medical Center's behalf, collection agencies may only take the following actions upon receipt of the approval noted below:

Action	Low-Income, Uninsured Patients	Other Patients
Adverse report to Credit Bureau[1]	Supervisor	Supervisor
Negotiated payment plan	No separate approval needed	No separate approval needed
Filing a Lawsuit[2]	Supervisor	Supervisor
Debtor examination /subpoena for information	Director	Director
Enforcing judgment through lien or record abstract on primary residence	Never permitted	President/CEO
Enforcing judgment through lien or record abstract on other property	President/CEO	Director
Enforcing judgment through wage garnishment/levy	Never permitted	Director
Enforcing judgment through bank account levy	Director	Director
Enforcing judgment through a keeper	Vice President	Vice President

[1] The assignment of the account to the collection agency by the Supervisor is sufficient approval for this action.
[2] In addition, the requirements of Section II(B)(3)(g) above must be met.

5. No Assignment or Subcontracting. Collection agencies engaged by the Medical Center may not assign or subcontract the collection of any account without (i) the prior written consent of the Medical Center's Vice President, Patient Financial Services, and (ii) the assignee's or subcontractor's written agreement to comply with this policy.

III. Recordkeeping

Patient Financial Services shall maintain adequate notations and documentation in the Medical Center's patient accounting system to document Medical Center's compliance with the requirements of this policy. Each collection agency is also required to maintain adequate documentation in its files to show that the collection agency has complied with the requirements of federal and state consumer debt collection laws and with all other requirements of this policy applicable to the collection agency.

IV. Sources: California Civil Code, Section 1788 et seq.

15 USC Section 1692 et seq.

California Hospital Association: California Hospital Billing and Collection Practices – Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients

V. Policy Approval: Patricia Emmett Kittell, Vice President, Patient Financial Services