VENTURA COUNTY MEDICAL CENTER ADMINISTRATIVE POLICY

Associated with the UCLA School of Medicine

SUBJECT: **CHARITY CARE POLICY** PROCEDURE:	PROCEDURE NO. - PAGE 1 OF
DEPARTMENT: PATIENT ACCOUNTING DEPARTMENT EFFECTIVE DATE: 01-07 REVISION DATES; AFFECTS: ALL DEPARTMENTS	
APPROVED BY:	REVIEW DATES:

VENTURA COUNTY MEDICAL CENTER, SANTA PAULA HOSPITAL, AND ALL AFFILIATED CLINICS

1. Purpose / Objective:
    a. To establish a policy to comply with AB774 for patients that are at or below 350% of poverty, applying for Charity Care.
        i. Patients, who have no payor source, are not eligible and have been denied Medi-Cal, Medicare, Healthy Families, and any and other payor sources.
        ii. This policy is developed for this population of indigent patients.
        iii. Excluded, are any patients that qualify for any of the discounted payment programs, Medicare, Medi-Cal, insurance, and or third party liabilities.
        iv. Excludes any patients with ELECTIVE, OR COSMETIC procedures.
        v. Life threatening, emergent services only.

2. Process:
    a. When a patient requests consideration for the Charity Care program, the patient must have already applied for the Discount Program, and shown efforts to comply with the Discount Program.
    b. The Patient must also have exhausted all avenues for payments with any of the other State and or Federal, or private payors, Medi-Cal, Medicare, Healthy Families, VVC, Veteran's Administration etc.,
    c. Patient will be asked to complete the Financial Information Form.
    d. According to AB774 we will adhere to the following:
        i. In determining eligibility under its charity care policy, a hospital may consider income and monetary assets of the patient. For purposes of this determination, monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans. Furthermore, the first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50% of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.
    e. The Patient Account Manager, and the Utilization Review Coordinator will review the patient's application for Charity Care for approval. The Patient Account Manager will review for monetary validation, and Utilization Review Coordinator will review for Medical Necessity issues.
    f. The patient will receive written notification of approval or denial, in writing, with the names, addresses and phone number of individuals to appeal any denials to.

SUBJECT: Self Pay Policy Hospital Services Including all ancillary services PROCEDURE:	PROCEDURE NO. -
DEPARTMENT: Patient Accounting Department EFFECTIVE DATE: 01-06	REVISION DATES; 03-93,02-04,01-06
AFFECTS: ALL DEPARTMENTS	
APPROVED BY:	REVIEW DATES:

VENTURA COUNTY MEDICAL CENTER, SANTA PAULA HOSPITAL, VENTURA COUNTY HEALTH CARE AGENCY AND AFFILIATED CLINICS.

1. Purpose/Objective:
    a. To establish a policy and procedure for patients who have no payor source for their healthcare, or are UNDERINSURED, with high deductibles, out of pocket expense, and low income, as a payor source for their healthcare.
        i. Patients who have no payor source frequently utilize the emergency room when they need medical care. Emergency Room visits incur a higher cost per visit than an office visit, and the patients' wait until their conditions are exacerbated, and in a costlier state.
        ii. V.C.M.C, S.P.H., H.C.A., has developed this Policy and Procedure to meet the needs of of improved access to healthcare for this growing population.
        iii. V.C.M.C.S.P.H.,, H.C.A., has modified their previous policy to meet the specifications of AB774.
        iv. Added programs may be but are not inclusive of insurance co-insurance payments, and deductibles with appropriate qualifications, referred to in the AB774 as "underinsured".

2. Process:
    a. If a patient presents for Hospital Services, (Inpatient, Outpatient and Same Day Surgery), with no third party payor, the patient will be notified of V.C.M.C.'s S.P.H., Self Pay Policy and the ability to obtain a discount on the charges for services. The discounts may be applied for within 150 days of service, provided the patients meet 350% of poverty level.
    b. The patient will be asked to complete a "Financial Statement". The patient's income and family size on the "Financial Statement" will be compared to the "Income/Family Size Schedule" to determine which program the patient qualifies for. The "Income/Family Size Schedule" is based upon the Federal Poverty Level (FPL) Guidelines, and the FPL, Guideline change, the "Income/Family Size Schedule" will be changed accordingly. If the services the patient is seeking is determined by V.C.M.C.'s S.P.H's Case Management to be a cosmetic procedure and or a personal comfort service the patient's discount will be the minimal amount reimbursed by the Medicare or Medi-Cal program, IF it is an approved procedure within those Federal or State Programs. If the procedure is NOT a payable procedure within those programs, then V.C.M.C. S.P.H., will hold the patient responsible for charges, as they deem necessary, which would include but not be limited to level 6.
    c. The patient will be notified of the program they have qualified for and an estimate of

their cost for the service they have received.

i. Prior to the rendering of services (if applicable) the patient should be requested to make a 50% deposit towards the payment for services and complete the Payment and Security Agreement if the patient is applying for a discount, and has an income level ABOVE 350% of poverty. Patients with an income level of 350% and BELOW poverty will not be required to complete the Payment and Security Agreements. The patients will also be required to apply for the Medi-Cal program PRIOR to being assigned a Self Pay Discount Card with the appropriate Discount level assignment.

ii. The Financial Statement, and financial information will be sent to the Patient Accounting Department, and placed in the patient's financial jacket. The patient must re-apply for eligibility every 90 days, to remain eligible for the Self Pay Discount Program.

3. If the patient represents that they are eligible for the Programs 1-3, (S1,S2,S3.) the patient must provide proof of income, a copy of a pay stub, or tax return, the patient should also show proof that they have applied for the Medi-Cal programs services.
    a. A copy of their required data with the "Financial Statement" will be maintained in the patient's financial jacket.
    b. Patients applying for the Discount Program that qualify at 350% of poverty or below, they have 150 days to apply for the discount.
    c. Patients will be given an estimate of their total charges upon discharge from the hospital, patients will be notified that this is an estimate, and that their will be late charges coming from other departments on their final bill.

4. Based on the patient's representation of their income and family size, and the "Financial Statement" process, the Self Pay Discount Program will be identified. The patient will be assigned a level of discount, and with the level of discount, comes a specific Financial Class S1,S2,S3,S4,S5,S6, that drives the discount within the Patient Accounting Systems.
5. Patient's that are declined a discount may request a second level review with the Patient Account Manager.

SUBJECT: Self Pay Policy Hospital Services Including all ancillary services And all Services provided in a Clinic setting. PROCEDURE:	PROCEDURE NO. -	
DEPARTMENT: Patient Accounting Department	EFFECTIVE DATE: 01-06	REVISION DATES; 03-93,02-04,01-06
AFFECTS: ALL DEPARTMENTS		
APPROVED BY:	REVIEW DATES:	

FOR ALL VENTURA COUNTY MEDICAL CENTER, SANTA PAULA HOSPITAL, HEALTH CARE AGENCY CLINIC PATIENTS

6. Purpose/Objective:
   a. To establish a policy and procedure for patients who have no payor source for their healthcare, or are UNDERINSURED, with high deductibles, out of pocket expense, and low income, as a payor source for their healthcare.
      i. Patients who have no payor source frequently utilize the emergency room when they need medical care. Emergency Room visits incur a higher cost per visit than an office visit, and the patients' wait until their conditions are exacerbated, and in a costlier state.
      ii. V.C.M.C, S.P.H., H.C.A., has developed this Policy and Procedure to meet the needs of of improved access to healthcare for this growing population.
      iii. V.C.M.C. S.P.H., H.C.A., has modified their previous policy to meet the specifications of AB774.
      iv. Added programs may be but are not inclusive of insurance co-insurance payments, and deductibles with appropriate qualifications, referred to in the AB774 as "underinsured".

7. Process:
   a. If a patient presents for a V.C.M.C. or S.P.H or, clinic with no third party payor, the patient will be notified of V.C.M.C.'s S.P.H., H.C.A., Self Pay Policy and the ability to obtain a discount on the charges for services. The discounts may be applied for within 150 days of service, provided the patients meet 350% of poverty level.
   b. The patient will be asked to complete a "Financial Statement". The patient's income and family size on the "Financial Statement" will be compared to the "Income/Family Size Schedule" to determine which program the patient qualifies for. The "Income/Family Size Schedule" is based upon the Federal Poverty Level (FPL) Guidelines, and the FPL, Guideline change, the "Income/Family Size Schedule" will be changed accordingly. If the services the patient is seeking is determined by V.C.M.C.'s S.P.H. H.C.A., Case Management to be a cosmetic procedure and or a personal comfort service the patient's discount will be the minimal amount reimbursed by the Medicare or Medi-Cal program, IF it is an approved procedure within those Federal or State Programs. If the procedure is NOT a payable procedure within those programs, then V.C.M.C. S.P.H.,H.C.A., will hold the patient responsible for charges, as they deem necessary, which would include but not be limited to level 6.
   c. The patient will be notified of the program they have qualified for and an estimate of

their cost for the service they have received.

i. Prior to the rendering of services (if applicable) the patient should be requested to make a 50% deposit towards the payment for services and complete the Payment and Security Agreement if the patient is applying for a discount, and has an income level ABOVE 350%. Patients with an income level of 350% and BELOW poverty will not be required to complete the Payment and Security Agreements. The patients will also be required to apply for the Medi-Cal program PRIOR to being assigned a Self Pay Discount Card with the appropriate Discount level assignment.

ii. The Financial Statement, and financial information will be sent to the Patient Accounting Department, and placed in the patient's financial jacket. The patient must re-apply for eligibility every 90 days, to remain eligible for the Self Pay Discount Program.

8. If the patient represents that they are eligible for the Programs 1-3, (S1,S2,S3.) the patient must provide proof of income, a copy of a pay stub, or tax return, the patient should also show proof that they have applied for the Medi-Cal programs services.
    a. A copy of their required data with the "Financial Statement" will be maintained in the patient's financial jacket.
    b. Patients applying for the Discount Program that qualify at 350% of poverty or below, have 150 days to apply for the discount.

9. Based on the patient's representation of their income and family size, and the "Financial Statement" process, the Self Pay Discount Program will be identified. The patient will be assigned a level of discount, and with the level of discount, comes a specific Financial Class S1,S2,S3,S4,S5,S6, that drives the discount within the Patient Accounting Systems.
    a. Patient's will be given an estimate of their total charges at the time of service from the clinic. These charges will be for the most current charges posted within the system, and is not meant to be all inclusive as charges are posted after the patient has left the clinic..
10. Patient's that are declined a discount may request a second level review with the Patient Account Manager.

HOW TO GUIDE TO USE THE REVISED SELF-PAY DISCOUNT POLICY

This Revision of the Self Pay Discount Policy is to insure that Ventura County Medical Centers Health Care Agency is within compliance for AB774, which is effective January 1, 2007.

1. All patients that present with no payor source for their medical services must be notified of the self-pay discount policy. The patient can refuse to complete the information and pay 100% of charges, but ALL patients must be notified of the policy. The AB774 bill requires that the discount policy and charity care policy are posted in patient access areas, admitting, registration, etc., and that the patients are notified in writing of the availability of the discount and charity care policy, The patient must also be given a Medi-Cal application to complete, and send into H.S.A., at their convenience. Therefore, upon registration, and at ANY REGISTRATION POINT IN OUR SYSTEM, the patients must be notified of the discount policy and opportunities for the patients.

2. If the patient is interested in the discount, the patient must complete the Financial Statement. The asset portion does not need to be completed for anyone applying for the Charity Care Program, or for anyone whose income is at or BELOW 350% of poverty. The patient's are to apply for Medi-Cal however. Prior to being considered for the Charity Care Program, the patient's denial of Medi-Cal benefits must be presented to the Patient Accounting Department for final evaluation.

3. Any patient, or patient's legal representative, who requests a discounted payment, charity care, or other assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide the hospital with documentation of income and health benefits coverage. If the person requests charity care or a discounted payment and fails to provide information that is reasonable and necessary for the hospital to make a determination, the hospital may consider that failure in making its determination. This includes the patient's applying for Medi-Cal.

4. Once the Financial Statement is completed, you must determine their family size and income.

    a. Patient's family means the following, (according to the AB774 language): 1. For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.2. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
    b. Income is determined, using the guidelines of Attachment A of the policy, by determining the income of all members identified when determining Family size.

5. Once you have completed the Financial Statement, and have determined the family size and income, you will need to review the "Income/Family Size Schedule" to determine which program the patient is eligible for.
    a. If the patient represents that they are eligible for Programs 1-3 they are at or under 350% of the Federal Poverty Guidelines. The AB774 bill is very specific that patients in this category present a recent (most recent filed) tax return OR pay stub.
        i. Note, we no longer need information for this group of individuals that states Ventura County residents only or additional proof of income.

    b. To apply for programs 1-3 (350% of poverty of below) the patients have 150 days to apply for the discount. Until they apply for the discount and are approved for one, they will continue to receive a statement indicating total charges. Once assigned a level of

discount, the discount is taken immediately. If the patient's level of discount is done at point of registration (Example S1) then the discount is done prior to the patient receiving a statement.

6. Once the determination has been made for the patients Discount status, the appropriate Self Pay program is assigned, S1,S2,S3,S4,S5,S6, the patient is given the Discount card with the appropriate financial class indicated. This process will help the patient navigate through the H.C.A.,'s facilities, and clinics, without delay. The person verifying the patient's eligibility in this program must make notations in STAR, PLUS or whatever billing system they are using to note that the patient was determined to be eligible for that specific program with the effective date and their expiration date

7. Usually the patient has not yet had services so it is difficult to determine which level of service the patient will receive, and what they should pay. If the patient has determined to be eligible for a specific program with their current discount card, the registration and or front office staff should attempt to collect for the monies due for the lowest level of service available in the clinic. It should be explained that this is an estimate, and that this payment is not meant to be payment in full.

8. The appropriate financial class identifies to the PLUS, and STAR system what level of discount is to be applied, and with the input of the Financial Class, the adjustment is made within the system prior to bill/statement drop.

Dear Patient,

If you do not have insurance, Medi-Cal or Medicare, you may qualify for discounted rates. In order to determine your eligibility for a discount, we will need the following information:

- Financial Statement – Blank form contained in this packet.
- Copy of most recent Federal Tax Return, W2 or last Check Stub for you and your spouse

If your insurance has a high co-payment or deductible, you may also qualify for a discount, by completing the Financial Statement.

Please return the documentation items checked above to either the clinic or to the Central Billing Office at:

VCMC Patient Accounting Department
133 West Santa Clara Street
Ventura, CA 93001

Questions and assistance with the form can be directed to the Central Business Office at (805) 648-9553 or your local VCMC clinic.

Sincerely,

Ventura County Medical Center, Santa Paula Hospital and Affiliated Medical Clinics

Estimado/a Paciente,

Si no tiene seguro medico, Medi-Cal o Medicare, usted puede calificar para pagos con descuento. Para poder determinar su elegibilidad para un descuento, necesitamos la siguiente información:

- Declaración Financiera – La forma en blanco contenida en este paquete.
- La copia mas reciente de su Income Tax Federal, la forma W2 o el ultimo talón de cheque suyo o el de su esposo/a.

Si su seguro medico tiene un alto deducible o co-pago, usted también puede calificar para un descuento llenando la Declaración Financiera.

Por favor regrese los documentos indicados ya sea a la clínica o a la Oficina Central de Cobros a la dirección:

VCMC Departamento de Cuentas del Paciente
133 West Santa Clara Street
Ventura, CA 93001

Para preguntas y asistencia con la forma puede ser dirigida a la Oficina Central de Negocios al (805) 648-9553 o a su oficina local de VCMC.

Sinceramente,

El Centro Medico del Condado de Ventura, Hospital de Santa Paula y las Clínicas Medicas Afiliadas.

ATTACHMENT B

Ambulatory Care Self Pay Policy

Program Definitions and Applicable Discounts.

Program 1: If the patient meets the criteria for Program 1, the patient's payment responsibility would be equal to 50% of the Medicare allowable for Area 17 for all Ambulatory Care Services

Program 2: If the patient meets the criteria for Program 2 the patient's payment responsibility would be equal to 70% of the Medicare allowable for Area 17 for all Ambulatory Care Services.

Program 3: If the patient meets the criteria for Program 3 the patient's payment responsibility would be equal to 80% of the Medicare allowable for Area 17 for all Ambulatory Care Services.

Program 4: If the patient meets the criteria for Program 4 the patient's payment responsibility would be equal to 80% of the Medicare allowable for Area 17 for all Ambulatory Care Services.

Program 5: If the patient meets the criteria for Program 5 the patient's payment responsibility would be equal to 100% of the Medicare allowable for Area 17 for all Ambulatory Care Services.

Program 6: If the patient meets the criteria for Program 6 the patient's payment responsibility would be equal to 120% of the Medicare allowable for Area 17 for all Ambulatory Care Services.

Printed 2/10/04

Ventura County Medical Center Self Pay Discount & Fee Schedule Effective May 1, 2010

A. Primary Care Clinic Visits - Patient Payment (each visit)*

			LEVEL 1	LEVEL 2
Evaluation & Management Code	**Description of Service**	**0-200% of FPL (1)**	**201%- 500% of FPL**	**501%-700% of FPL**
99201-99205	New Patient: Office or Other Outpatient Visit	$23	$45	$85
99212-99215	Established Patient: Office or Other Outpatient Visit	$23	$45	$85
99391-99397	Established Patient: Periodic Comprehensive Preventive Medicine	$23	$45	$85
	Urgent Care Visit- Must be paid at the time of visit	$75	$75	$75

***Includes Clinic Room Charges and Professional Fee but does not include Laboratory Tests and X-ray Procedures**

B. Specialty Clinic Visits & Consults - Patient Payment (each visit) * LEVEL 1 LEVEL 2

Evaluation & Management Code	**Description of Service**	**0-200% of FPL(I)**	**201%- 500% of FPL**	**501%-700% of FPL**
99381-99387	New Patient: Initial Comprehensive	$50	$85	$125
99391-99397	Established Patient: Periodic Comprehensive	$23	$45	$85

***Includes Clinic Room Charges and Professional Fee but does not include Laboratory Tests and X-ray Procedures**

C. Emergency Services **

Evaluation & Management Code	**Description of Service**	**0-200% of FPL(I)**	**201%- 500% of FPL**	**501%-700% of FPL**
99281-99285	New or Established Patient: Professional Fees Emergency Department Visit	$50	$75	$150
Technical Component	New or Established Patient: Hospital Emergency Department Visit	$100	$150	$200
	Total Patient Payment	$150	$225	$350

****Does not include Laboratory Tests and X-ray Procedures**

D. Mobile Clinic Services***

Evaluation & Management Code	Description of Service	0-200% of FPL(I)	201%- 500% of FPL	501%-700% of FPL
99201-99215	New or Established Patient: Office or Other Outpatient Services	$23	$45	$85
4 -6 Hours Lease: $800	Other Non County Requested Site Service without Physician Assistant	n/a	n/a	n/a
4 - 6 Hours Lease: $1,200	Other Non County Requested Site Service with Physician Assistant	n/a	n/a	n/a

*****Includes Clinic Room Charges and Professional Fee but does <u>not</u> include Laboratory Tests and X-ray Procedures**

E. Surgical Services: Payments per Procedure (excludes OB- Table F below)
Includes: Pre-op Laboratory Tests, Chest X-ray, Other required tests- see Ancillary Services Table

Type of Patient	Type of Service	0-200% of FPL(I)	201%- 500% of FPL	501%-700% of FPL
Inpatient	Surgery-Professional Fee, includes follow up visit	a) $500 or b) 15% of charges (whichever payment is lesser)	a) $750 or b) 20% of charges (whichever payment is lesser)	a) $1,000 or b) 25% of charges (whichever payment is lesser)
	Anesthesiology-Professional Fee	a) $500 or b) 15% of charges (whichever payment is lesser)	a) $750 or b) 20% of charges (whichever payment is lesser)	a) $1,000 or b) 25% of charges (whichever payment is lesser)
	Hospital Component	a) ICU: $3,500 per day b) Med/Surg: $1,500 per day	a) ICU: $3,700 per day b) Med/Surg: $1,800 per day	a) ICU: $4,000 per day b) Med/Surg: $2,000 per day
	Implantable & Inpatient Chemo	@ cost	@ cost + 5%	@ cost + 10%
Outpatient/ Same Day Surgery	Surgery-Professional Fee, includes follow up visit	a) $500 or b) 15% of charges (whichever payment is lesser)	a) $750 or b) 20% of charges (whichever payment is lesser)	a) $1,000 or b) 25% of charges (whichever payment is lesser)
	Anesthesiology-Professional Fee	a) $500 or b) 15% of charges (whichever payment is lesser)	a) $750 or b) 20% of charges (whichever payment is lesser)	a) $1,000 or b) 25% of charges (whichever payment is lesser)
	Hospital Component	a) $350 or b) 15% of charges (whichever payment is lesser)	a) 400 or b) 20% of charges (whichever payment is lesser)	a) $450 or b) 25% of charges (whichever payment is lesser)
	Implantable & Inpatient Chemo	@ cost	@ cost + 5%	@ cost + 10%

F. Hospital Stay - Per Day Rate; excludes Implantable, Inpatient Chemo, Dialysis, Nuclear Studies, MRI, CT, IR & Other Purchased Services sent out to other facilities.

Acuity Level	0-200% of FPL(l)	201%- 500% of FPL	501%-700% of FPL
Medical/Surgical	$1,500	$1,800	$2,000
Intensive Care Unit	$3,500	$3,700	$4,000
NICU	N/A - will be referred to Medi-Cal and/ or CCS		

G. Obstetrics (OB)

Type of OB Delivery	Description of Service	Type of Service	0-200% of FPL(l)	201%- 500% of FPL	501%-700% of FPL
Vaginal	Professional Fee	Anesthesiology (incl. epidural)	$400	$450	$450
		OB/Gyn Surgeon	$400	$450	$550
	Clinic Visits	20 Antepartum Visits 4 Postpartum Visits	$200	$350	$450
	Inpatient Stay	Two Days	$2,200	$2,500	$2,700
		Each Additional Day	$1,200	$1,250	$1,300
	Nursery	Two Days	$200	$250	$350
		Total Patient Payment- Two Days Stay	**$3,400**	**$4,000**	**$4,500**
C-Section	Professional Fee	Anesthesiology	$550	$550	$550
		OB/Gyn Surgeon	$800	$875	$975
	Clinic Visits	20 Antepartum Visits 4 Postpartum Visits	$350	$450	$550
	Inpatient Stay	Three Days	$3,600	$3,750	$3,900
		Each Additional Day	$1,200	$1,250	$1,300
	Nursery	Three Days	$300	$375	$525
		Total Patient Payment- Three Days Stay	**$5,600**	**$6,000**	**$6,500**
Circumcision BABY BOY	Professional Fee & Room Charge	Circumcision INFANTS ONLY	$180	$180	$180

H. Ancillary Services

Department	Type of Services	0-200% of FPL(l)	201%-500% of FPL	501%-700% of FPL
Radiology (per series)	X-ray	$65	$90	$120
	Mammogram: Screening	$65	$65	$65
	Diagnostic	$65	$65	$65
	Interventional Radiology	$800	$875	$975
	CT Scan	$250	$300	$350
	Dexa Scan	$35	$45	$60

	Nuclear Medicine	$250	$300	$350
	Ultra Sound- Internal Organ	$150	$200	$250
	Ultra Sound – Fetal	$100	$125	$150
	MRI Service	$250	$300	$350
Laboratory (per test)	Inhouse Test	$10	$15	$20
	Lab Send Out	Cost	Cost + 5%	Cost + 10%
Rehabilitation (per visit)	Physical Therapy	$60	$75	$90
	Occupational Therapy	$60	$75	$90
Infusion	Infusion Chemo Therapy- Administration	$30	$45	$60
	Infusion Chemo Drug	Cost	Cost + 5%	Cost + 10%

Department	Type of Services	0-200% of FPL(l)	201%-500% of FPL	501%-700% of FPL
Unlisted CPT codes	Professional	5% of charges	15% of charges	25% of charges
Unlisted Services	Technical component	5% of charges	15% of charges	25% of charges

(1)CHARITY CARE: Patients that can show income of 100% FPL or less may qualify. The patient's financial statement will be reviewed with a complete credit report to validate the needs of the patient. Charity care is not offered for elective, cosmetic, or experimental services

HOMELESS PATIENTS: Homeless may qualify for charity care with the validation of income, credit reporting and/or living arrangements.

ACE: Patients who qualify for and are accepted into the ACE program shall be charged co-payments in accordance with Ventura County Health Care Agency Contract No. 07-1448-VE56 Amendment A-02.

Refer to the Table below for Federal Poverty Level determination

2009/2010 Federal Poverty Level Guidelines

Persons in family	Poverty guideline	200% of FPL	500% of FPL	700% of FPL
1	$10,830	$21,660	$54,150	$75,810
2	14,570	$29,140	$72,850	$101,990
3	18,310	$36,620	$91,550	$128,170
4	22,050	$44,100	$110,250	$154,350
5	25,790	$51,580	$128,950	$180,530
6	29,530	$59,060	$147,650	$206,710
7	33,270	$66,540	$166,350	$232,890
8	37,010	$74,020	$185,050	$259,070
For families with more than 8 persons, add $3,740 for each additional person.				