COALINGA REGIONAL MEDICAL CENTER

SECTION: 300.40
PROCEDURE: CHARITY CARE POLICY
EFFECTIVE DATE: January 1, 2007
REVISED ON: February 1, 20143
PREPARED BY: Sandra Earls

DATE(S) REVIEWED: 1/2011, 1/2012, 1/2013, 1/2014

SUBJECT: CHARITY CARE AND FINANCIALLY DISCOUNTED CARE

I. PURPOSE & SCOPE:

At Coalinga Regional Medical Center, an important part of our mission is to provide emergent or imminently necessary care to all those in need regardless of their ability to pay.

All patients should be treated fairly, with dignity, compassion and respect regardless of age, sex, race, creed, disability or national origin.

The purpose of this policy is to describe the Charity Care Policy and define the eligibility criteria for charity care assistance and to provide administrative guidelines for the identification and classification of patient accounts as Charity Care or Financially Discounted Care.

II. POLICY

A. GENERAL

Charity Care is defined as healthcare services provided at no charge or at a nominal charge.

A patient that is uninsured/self pay and who is at or below three hundred fifty (350%) percent of the federal poverty level is eligible to apply for Charity Care or Financially Discounted Care.

A patient that is insured but has high medical costs and who is at or below three hundred fifty (350%) percent of the federal poverty level is eligible to apply for Charity Care or Financially Discounted Care.

Effective this year, Tthere is availability of charity care and discounted payment policies from emergency room physicians. Patients/guarantors will still have to discuss any such discounts directly with the emergency room physicians' billing service. This policy may not apply to all other

medical providers that are not billed by the hospital. Patients/guarantors will have to discuss any such discounts with the individual medical practitioner directly.

Financial assistance provided by Coalinga Regional Medical Center is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay.

It is the responsibility of Coalinga Regional Medical Center to respond to all patient requests for Charity Care or Financially Discounted Care during any one or more of the following patient interactions: pre-registration, registration, discharge, and at any other time the Coalinga Regional Medical Center representative encounters information detailing the patient's financial need. Each request for charity care will be considered through a review process.

Charity approval will affect all accounts that the approved guarantor is responsible for. The approved charity percentage will be applied to all existing accounts incurred on or after January 1, 2013 07 with balances outstanding. Any patient credit balance created by applying the charity percentage will be refunded to the guarantor within thirty (30) days of receiving the charity care designation. Accounts may also be returned from Bad Debt if a review of the patient's financial circumstances warrants and Charity Care or Financially Discounted Care may apply.

Patients requesting charity care will be required to apply for Medi-Cal, Healthy Families, or other government sponsored programs. Applications that are approved will no longer qualify for Charity or Financially Discounted Care and those applications denied will be considered for further review. Applicants who refuse to pursue other benefit programs or are denied due to an incomplete application will not be eligible for the Charity or Financially Discounted program.

Coalinga Regional Medical Center has established guidelines that incorporate all applicable state and federal laws. The guidelines also detail the following:

- Admitting staff initiates the Charity Care process
- Procedures for information distribution (signage placement, application distribution, patient acknowledgment signature, etc.)
- Discount guidelines based on current federal poverty level for full charity care or discounted care based on income.

III. PROCEDURE:

A. Definitions:

1. Uninsured – self pay patient: a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

2. High medical costs: a person whose family income is less than 350% of the federal poverty level…if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, high medical costs means any of the following:

- Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's family income in the prior 12 months
- Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months

B. All uninsured patients shall receive a "language appropriate" written notice that contains information about the availability of Charity Care or Financially Discounted Care at the time services are provided. This written notice will be signed by the patient and valid for six (6) months from the date of service. (Attachment A and B) In addition, all uninsured patients shall receive an application for Medi-Cal and Healthy Families pprior to discharge for inpatients and to patients receiving emergency or outpatient care. (Attachment C and , D, E and F)

C. All uninsured patients shall receive additional information summarizing the charity care policy when the initial bill is sent. (Attachment EG)

D. Requests for charity care will be referred to the Patient Financial Services department. A patient requesting charity care must make every reasonable effort to provide Coalinga Regional Medical Center with documentation of income and health benefits coverage by completing the Charity Care and Financial Discounted Care application. (Attachment FH and GI) The failure to provide information that is reasonable and necessary to make a determination may be considered by Coalinga Regional Medical Center in making its determination, but will not be the direct cause for denial of

charity care. The application will be kept on file and valid for six (6) months from the date of service.

E. Coalinga Regional Medical Center will ensure that appropriate staff members are knowledgeable about the existence of the charity care and financially discounted policies. Training should be provided to staff members (i.e., billing office, admitting department, etc.) who directly interact with patients regarding their hospital bills.

F. When communicating to patients regarding Coalinga Regional Medical Center's policy on financial assistance, Coalinga Regional Medical Center will do so in the primary language of the patient and patient's family in accordance with all federal and state laws and regulations.

G. ELIGIBILITY REQUIREMENTS

1. All guarantors, with family income equal to or below three hundred fifty (350%) percent of the federal poverty level, adjusted for family size, shall be determined to be indigent qualifying for charity sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party payors. The Federal Poverty level is updated annually by Health and Human Services (Attachment HJ)

2. All guarantors, with family income between three hundred fifty (350%) percent and four hundred (400%) percent of the federal poverty level, adjusted for family size, shall be determined to be indigent qualifying for financial discounted care of hospital charges. The charges must relate to appropriate hospital-based medical services in accordance with the sliding fee schedule (Attachment I and JK, L).

3. Documentation of income for the purpose of determining eligibility will be required for Charity Care or Financially Discounted Care. Documentation of income is limited to: recent pay stubs or income tax returns. Only one of the two forms of documentation is required. Coalinga Regional Medical Center prefers the prior two (2) years tax returns but will accept the last six (6) months of check stubs if tax returns are not available. In the event that the guarantor is not able to provide the documentation described above, Coalinga Regional Medical Center shall rely upon written and signed statements from the guarantor to make a final determination of eligibility. Department management may recommend charity care approval in extenuating circumstances.

H. FINANCIALLY DISCOUNTED CARE SLIDING SCALE

1. A sliding scale fee schedule will be used to determine financially discounted care percentages. (Attachment I and JK,L) The minimum discounted care approval begins with incomes at four hundred (400%) percent of the federal poverty level and continues to increase discounts as the family income reaches three hundred fifty (350%) percent of the federal poverty level. As indicated above, any guarantor at or below three hundred fifty (350%) percent of the federal poverty level, as adjusted for family size, will be entitled to charity care for the full amount of the hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party payors.

I. EVALUATION PROCESS

1. The process for determining which patients qualify for Charity Care or Financially Discounted Care will include:

    - The patient has exhausted or is not eligible for any third-party payment sources, including but not limited to Medicare, Medi-Cal, worker's compensation insurance, automobile insurance, or private group insurance. All possible insurance payors have been billed, Medi-Cal or any other governmental sponsored program and benefits have been denied.
    - Coalinga Regional Medical Center making an initial determination whether the patient is eligible for charity care, prior to initiating any collection efforts, assuming the patient cooperates with the hospital's attempt to make the determination.
    - Coalinga Regional Medical Center making reasonable attempts to determine if a third-party payor or sponsor may pay some or all of the charges.
    - Coalinga Regional Medical Center will provide all patients who have met the criteria for charity care with notice at least sixty (60) days, or at such a time as may be reasonably necessary, given the patient's medical condition, to provide any required documentation before the hospital reaches a final decision. Coalinga Regional Medical Center will notify the patient of its final determination within thirty (30) business days of receiving the properly completed application and required documentation.

- Notify the patient of Coalinga Regional Medical Center's decision, (approval or denial), the reason for reaching the decision, and the process for appealing the decision if the request was denied.
- If Charity Care or Financially Discounted Care is denied, Coalinga Regional Medical Center will provide the patient thirty (30) days within which to appeal the decision, correct any deficiencies in documentation, or request a review of the denial. Within the first thirty (30) days following the denial, Coalinga Regional Medical Center may not refer the patient's account to an outside collection agency. If no request for review is made during that thirty (30) day period, Coalinga Regional Medical Center may then initiate collection activities. If Coalinga Regional Medical Center has initiated collection activities and then discovers a request for review has been made, Coalinga Regional Medical Center will stop collection efforts until the review is complete.

J. PUBLIC NOTICE

1. Notices regarding the availability of financial assistance to low-income uninsured patients will be posted in visible locations throughout the hospital such as admitting, billing, and other outpatient settings. (Attachment KM and LN)

2. Every posted notice should contain brief instructions on how to apply for Charity Care or Financially Discounted Care. The notices should also include a contact telephone number that a patient or family member may call to obtain additional information.

K. BILLING AND COLLECTION PRACTICES

1. Patient Financial Services must use their best effort to ensure that patient accounts are processed fairly and consistently.

2. Practices used by outside collection agencies will conform to the standards set forth in this policy with written commitments from such agencies that they will adhere to these standards. (Attachment MO) An assessment will be conducted annually of each collection agency's adherence to the policy.

3. When sending a bill to a patient, hospital should include: a) a statement that indicates that if the patient meets certain income

requirements the patient may be eligible for a government-sponsored program or for financial assistance from the hospital; and b) a statement that provides the patient with the name and telephone number of a hospital employee and office from whom or where the patient may obtain information about the policies and how to apply for such assistance.

4. Any patient seeking financial assistance from the hospital (or the patient's legal representative) shall provide the hospital with information concerning health benefits coverage, financial income, and any other information that is necessary for the hospital to make a determination regarding the patient's status relative to the policy, as stated earlier in Section G – 2.

5. For patients who have an application pending for either government-sponsored coverage or for the hospital's own Charity Care Program, the hospital will not knowingly send that patient's bill to an outside collection agency.

6. For patients that meet the criteria for Charity Care or Financially Discounted Care, the packet will be forwarded to the Patient Financial Services Supervisor for review and then to the Finance Committee. Upon approval, the packet will be sent to the Board of Directors for final approval. The hospital will notify the patient of its final determination within thirty (30) business days of receiving the required documentation. (Attachment NP and OQ)

7. For patients that do not meet the criteria for Charity Care or Financially Discounted Care, the hospital will notify the patient of its final determination within fourteen (14) business days of receiving the required documentation. (Attachment PR and QS)

8. All Charity Care and Financially Discounted Care documentation shall be kept confidential. No information about the patient or guarantor or the application shall be distributed to any party outside the hospital. The information contained on the application or attached thereto as supporting documentation shall not be used for any reason other than the determination for qualification of the Charity Care or Financially Discounted Care program.

IV. AUTHORITY & RESPONSIBILITY:

Admitting Staff
Patient Financial Services Staff
Patient Financial Services Supervisor
Chief Financial Officerontroller
Hospital Administrator/CEO
Finance Committee of Board
Board of Directors

GA REGIONAL MED CENTER

FOR THE HOSPITAL'S CHARITY CARE OF FINANCIALLY
POLICY. COALINGA REGIONAL MEDICAL CENTER
FOR SELF PAY AND OTHER FINANCIALLY QUALIFIED PATIENTS THAT MAY RESULT IN A REDUCTION OF THE PATIENT'S LIABILITY.

YOU HAVE BEEN GIVEN AN TWO APPLICATION S: ONE FOR MEDI-CAL. AND THE OTHER FOR HEALTHY FAMILIES. THE APPLICATIONS MUST BE COMPLETED AND SUBMITTED TO THE LOCAL DEPARTMENT OF HEALTH SERVICES:

COALINGA REGIONAL CENTER
311 COALINGA PLAZA,
COALINGA, CA 93210

ADDITIONAL INFORMATION EXPLAINING MORE ABOUT THE POLICY WILL BE SENT TO YOU WITH YOUR INITIAL BILL FROM THE HOSPITAL.

I UNDERSTAND THAT THE HOSPITAL HAS POLICIES AVAILABLE FOR SELF PAY AND OTHER FINANCIALLY QUALIFIED PATIENTS.

I HAVE RECEIVED AN APPLICATION FOR MEDI-CAL. AND HEALTHY FAMILIES.

I UNDERSTAND THAT ADDITIONAL QUESTIONS MAY BE ANSWERED BY CALLING OUR PATIENT FINANCIAL SERVICES RESPRESENTATIVE SYLVIA RIOS IN THE PATIENT FINANCIAL SERVICES DEPARTMENT AT 935-6469.

_____ _____

PATIENT'S SIGNATURE TODAY'S DATE

ATTACHMENT A

COALINGA REGIONAL MED CENTER

USTED PODRIA CALIFICAR PARA RECIBIR DEL HOSPITAL ATENCION MEDICA DE CARIDAD SEGUN LA POLITICA DE ATENCION MEDICA CON DESCUENTO. EL CENTRO MEDICO REGIONAL DE COALINGA OFRECE UNA POLITICA A PACIENTES QUE PAGAN POR CUENTA PROPIA O QUE REUNAN LOS REQUISITOS FINANCIEROS QUE PODRIA REDUCIR LAS DEUDAS DEL PACIENTE.

LE HAN ENTREGADO DOS SOLICITUDES: UNA PARA MEDI-CAL. Y LA OTRA PARA HEALTHY FAMILIES. LAS SOLICITUDES SE DEBEN COMPLETAR Y ENTREGAR AL DEPARTMENTO LOCAL DE SERVICIOS DE SALUD:

CENTRO REGIONAL DE COALINGA
311 COALINGA PLAZA
COALINGA, CA 93210

USTED RECIBIRA MAS INFORMACION EXPLICANDO ESTA POLITICA JUNTO CON SU FACTURA INICIAL DEL HOSPITAL.

ENTIENDO QUE EL HOSPITAL TIENE POLITICAS DISPONIBLES PARA PACIENTES QUE PAGAN POR CUENTA PROPIA O QUE REUNEN LOS REQUISITOS FINANCIEREOS.

HE RECIBIDO UNA SOLICITUD PARA MEDI-CAL Y HEALTHY FAMILIES.

ENTIENDO QUE SI TENGO PREGUNTAS ADICIONALES PUEDO LLAMAR A REPRESENTANTE DEL DEPARTMENTAL DE FINANCIEROS PARA PACIENTES SYLVIA RIOS DEL DEPARTMENTO DE SERVICIOS FINANCIEROS PARA PACIENTES AL 935-6469.

_____ _____
FIRMA DEL PACIENTE FECHA DE HOY

ATTACHMENT B

COALINGA REGIONAL MEDICAL CENTER

THANK YOU FOR ALLOWING COALINGA REGIONAL MEDICAL CENTER TO MEET ALL OF YOUR HEALTHCARE NEEDS.

ENCLOSED IS YOUR FINAL BILL FOR SERVICES RENDERED.

YOU **MAY** QUALIFY FOR THE HOSPITAL'S CHARITY CARE OR FINANCIALLY DISCOUNTED CARE POLICY OR A GOVERNMENT-SPONSORED PROGRAM.

TO ASSIST YOU WITH THE DETERMINATION PROCESS, YOU MUST COMPLETE THE FOLLWING:

-PROVIDE PROOF OF DENIAL FOR APPLICATIONS SUBMITTED TO DHSMEDI-CAL
-PROVIDE PROOF OF INCOME WITH COPIES OF FEDERAL TAX RETURNS FOR PRIOR TWO YEARS, OR THE PRIOR SIX MONTHS OF PAY STUBS
-PROVIDE FAMILY SIZE TO DETERMINE THE FEDERAL POVERTY LEVEL CRITERIA
-PROVIDE COMPLETED CHARITY CARE/FINANCIALLY DISCOUNTED CARE APPLICATION

UPON RECEIPT OF THE ABOVE-MENTIONED ITEMS, THE HOSPITAL WILL NOTIFY YOU WITHIN FOURTEEN (14) DAYS OF RECEIVING THE NECESSARY DOCUMENTATION.

PLEASE CALL OUR PATIENT FINANCIAL SERVICES REPRESENTATIVES SYLVIA RIOS AT (559) 935-6469 TO OBTAIN AN APPLICATION OR TO ANSWER ANY ADDITIONAL QUESTIONS YOU MAY HAVE REGARDING THE HOSPITAL'S CHARITY CARE POLICY.

ATTACHMENT EG (FRONT)

ALINGA REGIONAL MEDICAL CENTER

GRACIAS POR PERMITIR QUE EL COALINGA REGIONAL MEDICAL CENTER CUBRA TODAS SUS NECESIDADES DE ATENCION MEDICA

ADJUNTAMOS SU FACTURA FINAL POR LOS SERVICIOS MEDICOS RECEIVIDOS

USTED **PODRIA** CALIFICAR PARA PARTICIPAR EN LA POLITICA DEL HOSPITAL DE ATENCION MEDICA DE CARIDAD O CON DESCUENTO O DE UN PROGRAMA FINANCIADO POR EL GOBIERNO

PARA AYUDARLO EN EL PROCESO DE DETERMINACION, DEBE HACER LO SIGUIENTE:

-PRESENTAR UNA PRUEBA DE RECHAZO DE LAS SOLICITUDES PRESENTADAS MEDI-CAL AL DEPARTMENTO DE SERVICIOS DE SALUD
-PRESENTAR PRUEBAS DE INGRESOS CON COPIAS DE LA DECLARACIONES DE IMPUESTOS DE LOS DOS (2) ANOS ANTERIORES, O LOS TALONES DE PAGO DE LOS SEIS (6) MESES ANTERIORES
-PRESENTAR EL NUMERO DE INTEGRANTES DE LA FAMILIA PARA DETERMINAR LOS CRITERIOS DEL NIVEL DE POBREZE FEDERAL
-PRESENTAR LA SOLICITUD COMPLETA DE ATENCION DE CARIDAD / ATENCION CON DESCUENTO

AL RECIBIR LA DOCUMENTACION MENCIONADA ARRIBA, EL HOSPITAL LO NOTIFICARA DENTRO DE LOS CATORCE (14) DIAS HABILES DE HABER RECIBIDO LA DOCUMENTACION NECESARIA

FOR FAVOR LLAME A REPRESENTANTE DEL DEPARTMENTAL DE FINANCIEROS PARA PACIENTES SYLVIA RIOS AAL (559) 935-6469 PARA OBTENER UNA SOLICITUD O RESPONDER CUALQUIER PREGUNTA ADICIONAL QUE PUEDA TENER CON RESPECTO A LA POLITICA DE ATENCION DE CARIDAD DEL HOSPITAL.

ATTACHMENT EG (BACK)

CHARITY CARE AND FINANCIALLY DISCOUNTED CARE APPLICATION

PATIENT
NAME_____

GUARANTOR
NAME_____

ITEMS CHECKLIST:

- ❑ PROOF OF DENIAL FOR APPLICATIONS SUMITTED TO MEDI-CALDHS

- ❑ PROOF OF INCOME – PRIOR TWO YEARS FEDERAL TAX RETURNS
  OR
- ❑ PROOF OF INCOME – SIX MONTHS CHECK STUBS

- ❑ A COPY OF THE BILL YOU RECEIVED FROM THE HOSPITAL

FAMILY SIZE: (INCLUDE NAMES AND SOCIAL SECURITY NUMBERS OF SPOUSE AND DEPENDENT CHILDREN)

NAME_____DOB_____SS#_____

NAME_____DOB□□□_____SS#_____

NAME_____DOB_____SS#_____

NAME_____DOB_____SS#_____

NAME_____DOB_____SS#_____

NAME_____DOB_____SS#_____

NAME_____DOB_____SS#_____

PLEASE RETURN THIS APPLICATION INCLUDING THE REQUIRED DOCUMENTATION FROM THE ITEMS CHECKLIST ABOVE. THE REVIEW PROCESS WILL BE COMPLETED AND YOU WILL RECEIVE FINAL DETERMINATION WITHIN FOURTEEN (14) BUSINESS DAYS.

ATTACHMENT FH

SOLICITUD DE ATENCION MEDICA DE CARIDAD Y ATENCION CON DESCUENTO

NOMBRE DEL
PATIENTE_____

NOMBRE DEL
GARANTE _____

LISTA DE CONTROL

- UNA COPIA DE LA FACTURA QUE RECIBIO DEL HOSPITAL
- PRUEBA DE RECHAZO DE LA SOLICITUDES PRESENTADAS AL MEDI-CALDHS
- PRUEBA DE INGRESOS – DECLARACIONES DE IMPUESTOS FEDERALES DE LOS DOS ANOS ANTERIORES (O)
- PRUEBA DE INGRESOS – TALONES DE PAGO DE LOS SEIS MESES ANTERIOES

INTEGRANTES DE LA FAMILIA: (INCLUIR NOMBRES Y NUMEROS DE SEGURO SOCIAL DEL CONYUGE E HIJOS DEPENDIENTES)

NOMBRE_____DOB_____SS#_____

NOMBRE_____DOB□□□_____SS#_____

NOMBRE_____DOB_____SS#_____

NOMBRE_____DOB_____SS#_____

NOMBRE_____DOB_____SS#_____

NOMBRE_____DOB_____SS#_____

NOMBRE_____DOB_____SS#_____

POR FAVOR ENTREGUE ESTA SOLICITUD CON LA DOCUMENTACION REQUERIDA EN LOS PUNTOS DE LA LISTA DE CONTROL QUE APARECE ARRIBA

EL PROCESO DE REVISION SE LLEVARA A CABO Y RECIBIRA LA DETERMINACION FINAL DENTRO DE CATORCE (14) DIAS HABILES

ATTACHMENT GI

COALINGA REGIONAL MEDICAL CENTER
1191 PHELPS AVENUE
COALINGA, CA 93210

CHARITY CARE/FINANCIALLY DISCOUNTED CARE SLIDING SCALE USING 20143 HHS POVERTY GUIDELINES

FAMILY SIZE 350% FEDERAL POVERTY LEVEL %	**ADJUSTMENT %**
350.0	**100%**
355.5	**90**
361.0	**80**
366.5	**70**
372.0	**60**
377.5	**50**
383.0	**40**
388.5	**30**
394.0	**20**
400.0	**10**
401.0	**0**

CHARITY CARE
ROW 1

0-350% ABOVE THE FEDERAL POVERTY LEVEL QUALIFIES FOR 100% DISCOUNT

FINANCIALLY DISCOUNTED CARE
ROW(S) 2 – 10

INCOME 351% - 400% ABOVE THE FEDERAL POVERTY LEVEL QUALIFIES FOR DISCOUNTS RANGING FROM 90% - 0%.

ATTACHMENT I-1K

COALINGA REGIONAL MEDICAL CENTER
20143 HHS POVERTY GUIDELINES MATRIX

FAMILY SIZE	48 CONT. STATES AND D.C.
1	11,670490
2	15,730510
3	19,790530
4	23,850550
5	27,910570
6	31,970590
7	365,030610
8	4039,090630

ATTACHMENT J

L

NOTICE TO PATIENTS

THE HOSPITAL PROVIDES A POLICY FOR SELF PAY AND OTHER FINANCIALLY QUALIFIED PATIENTS THAT MAY REDUCE THE PATIENT'S LIABILITY

ADDITIONAL INFORMATION WILL BE GIVEN DURING THE REGISTRATION PROCESS

FOR QUESTIONS, CONTACT OUR PATIENT FINANCIAL SERVICES

REPRESENTATIVES
SYLVIA RIOS
AT 935-6469

ATTACHMENT KM

AVISO A LOS PACIENTES

EL HOSPITAL OFRECE UNA POLITICA PARA PACIENTES QUE PAGAN POR CUENTA PROPIA Y PARA AQUELLOS QUE REUNAN LOS REQUISITOS FINANCIEROS, QUE PODRIA REDUCIR LAS DEUDAS DEL PACIENTE

SE DARA MAS INFORMACION DURANTE EL PROCESO DE INSCRIPCION

SI TIENE ALGUNA PREGUNTA, COMUNIQUESE CON REPRESENTANTE DEL DEPARTMENTAL DE SYLVIA RIOS EN SERVICIOS FINANCIEROS PARA PACIENTES AL 935-6469

ATTACHMENT LN

COALINGA REGIONAL MEDICAL CENTER
1191 PHELPS AVENUE
COALINGA, CA 93210

DATE:

PATIENT'S NAME
ADDRESS
CITY, STATE, ZIP

Your Charity or Financially Discounted Care application has been reviewed. The final determination is:

_____ Charity Care approved. No balance will be due.

_____ Financially Discounted Care approval – your hospital bill has been adjusted Based on a sliding fee scale. Please pay the amount due listed below.

If you have any questions regarding this determination, please call Patient Financial Services at (559) 935-6556.

Thank you for letting Coalinga Regional Medical Center meet all of your healthcare needs.

Sincerely,

Judy ScottKelly Maldonado
Patient Financial Services Manager

Adm #	Patient Name	Adm. Date	Disc. Date	Amount Due
627982	Sample	12/12/08	12/12/08	$339.00

AT THE PRESENT TIME YOUR BALANCE IS $339.00

ATTACHMENT NP

COALINGA REGIONAL MEDICAL CENTER
1191 PHELPS AVENUE
COALINGA, CA 93210

DATE:

PATIENT'S NAME
ADDRESS
CITY, STATE, ZIP

Su solicitud de Atencion medica de caridad o con descuento ha sido analizada. La determinacion final es:

_____ Atencion de caridad aprobada. No tendra que pagar ningun

_____ Atencion con descuento aprobada. Su factura del hospital ha sido ajustada

basandose en una escala de tarifas movil. Por favor pague la suma pendiente detallada mas abajo.

Si tiene alguna pregunta sobre esta determinacion, por favor llame a Patient Financial Services at (559) 935-6556.

Gracias por dejar que el Coalinga Regional Medical Center cobra todas sus necesidades de atencion medica.

Atentamente,

Kelly MaldonadoJudy Scott
Gerente de Servicios financieros para pacientes

Adm #	Patient Name	Adm. Date	Disc. Date	Amount Due
627982	Sample	12/12/08	12/12/08	$339.00

AT THE PRESENT TIME YOUR BALANCE IS $339.00

ATTACHMENT OQ

COALINGA REGIONAL MEDICAL CENTER
1191 PHELPS AVENUE
COALINGA, CA 93210

DATE:

PATIENT'S NAME
ADDRESS
CITY, STATE, ZIP

Your Charity or Financially Discounted Care application has been reviewed and is denied for the following reason(s):

_____ You exceed the Federal poverty level income maximum.

_____ You did not provide the required documentation requested or your application was not complete.
_____ You are eligible for a government sponsored program.

You have the right to appeal this denial. A letter must be received by our office within thirty (30) days. Upon review, you will be notified in writing of the final determination of your appeal.

If you have any questions regarding this determination, please call Patient Financial Services at (559) 935-6556.

Thank you for letting us meet all of your healthcare needs.

Sincerely,
Kelly MaldonadoJudy Scott
Patient Financial Services Manager

Adm #	Patient Name	Adm. Date	Disc. Date	Amount Due
627982	Sample	12/12/08	12/12/08	$339.00

AT THE PRESENT TIME YOUR BALANCE IS $339.00

ATTACHMENT PR

COALINGA REGIONAL MEDICAL CENTER
1191 PHELPS AVENUE
COALINGA, CA 93210

DATE:

PATIENT'S NAME
ADDRESS
CITY, STATE, ZIP

Su solicitud de Atencion medica de caridad o con descuento ha sido analizada y se rechaza por lo(s) siguiente(s) motivo:

_____ Usted exceed el maximo ingreso segun el nivel de probreza
_____ No presento la documentacion requerida o su solicitud estaba incomplete
_____ Es elegible para un programa financiado por el gobierno.

Uted tiene derecho a apelar este rechazo. Debe llegar una carta a nuestra oficina dentro de treinta (30) dias. Despues que la revisemos, sera notificado por escrito sobre la determinacion final de su apelacion.

Si tiene alguna pregunta sobre esta determinacion, por favor llame a Patient Financial Services al (559) 935-6556.

Gracias por dejarnos cubrir todas sus necesidades.

Atentamente,
Kelly MaldonadoJudy Scott
Gerente de Servicios financieros para pacientes

Adm #	Patient Name	Adm. Date	Disc. Date	Amount Due
627982	Sample	12/12/08	12/12/08	$339.00

AT THE PRESENT TIME YOUR BALANCE IS $339.00

ATTACHMENT QS