Community Care Financial Assistance Policy & Fair Billing Policies.	Manual: Patient Financial Services Section: Financial Counseling Issued by: Patient Financial Services	
Initial Approval Date: 02/2002	**Policy #: PFS 002**	**Page 1 of 13**
Dates of Review: 3/03, 5/03, 3/04,7/05, 9/06, 6/07,12/07,10/08, 5/09, 12/11, 12/14, 1/16, 8/17, 9/18	**Dates of Revision:**	5/03, 3/04, 6/04,7/05, 9/06, 12/06, 6/07, 5/09, 12/11, 09/13, 5/14, **12/14, 1/16, 8/17, 9/18, 1/22**

A-POLICY SUMMARY / INTENT

The purpose of this policy is to ensure a consistent uninsured/self pay Community Care Financial Assistance and Fair Billing policy. Oroville Hospital has previously established a uniform method of policy for Oroville Hospital and Emergency Physicians listed on section D of this policy that complied with Senate bill 1276 Fair Billing Policies. This policy also complies with 501 r section of Internal Revenue Code. The previous versions of this policy was consistent and compliant with Assembly Bill 774, Senate Bill 350, and AB 1503 which includes the availability of charity care and discounted payments for uninsured for emergency room physicians. It is the intent of this policy to comply with all federal, state, and local regulation for self-pay patients receiving emergency services. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

B- POLICY: COMPLIANCE – KEY ELEMENTS of SB 1276 & AB 1020

1- Oroville Hospital and the emergency room physicians listed on section D will adopt the following:

a- Negotiate with a patient regarding a payment plan, taking into consideration the patient's family income monetary assets, and essential living expenses.

b- Use a specified formula to create a reasonable payment plan for hospital as well as emergency physician services when patient is not able to pay in full for the services under the discounted fee schedule.

c- Consider in accepting self-attestation of family income and essential living expenses by a patient or a patient's legal representative when there is no indication to question the accuracy.

d- Assist and or obtain information as to whether the patient may be eligible for the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state- or county-funded health coverage programs.

e- Inform its contracted external collection agencies to comply with all aspects of this policy, AB 1020 in establishing reasonable payment plan by considering essential living expenses.

f- Under its Community Care Discount care policy, may consider income and monetary assets of the patient.

g- Monetary assets shall not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans.

h- The first ten thousand dollars ($10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000) be counted in determining eligibility.

i- Limit expected payment for services it provides to a self-pay, uninsured patient at or below 350 percent of the federal poverty level, to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare, Medi-Cal, the Healthy Families Program, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or any other government-sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.

j- Accept a recent pay stub(s) or income tax returns in determining eligibility for discounted payment.

k- Not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 180 days after initial hospital billing.

l- Not charge interest on extended payment plans.

m- Declare no longer operative after the patient's failure to make all consecutive payments due during a 90-day period.

n- Provide a written summary or statement of services provided.

o- If a patient applies or has a pending application for another health coverage program at the same time they apply for charity or discounted care at the hospital, then neither application shall preclude eligibility for the other program.

p- Hospital will provide patients with a referral to a local consumer assistance center housed at legal services offices.

B2- Compliance with 501 (r) of Internal Revenue Code: Oroville Hospital and its emergency room physicians will adopt the following:

a- Establish self-pay pricing for self-pay / uninsured, underinsured, and patient's eligible for financial assistance.
b- No self-pay or uninsured patient will be expected to pay full charges even if previously were referred to bad debt at full charges.
c- A self –pay / uninsured pricing will be applied as Community Care Rate or as a Community Care Discount from gross charges.

C- DEFINITIONS:

1. **ALLOWANCE FOR FINANCIALLY QUALIFIED PATIENT**: means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

2. **FINANCIALLY QUALIFIED PATIENT** means a patient who is both of the following:
   i. A patient who is a self-pay patient or a patient with high medical costs.
   ii. A patient who has a family income that does not exceed 400 percent of the federal poverty level.

3. **SELF-PAY PATIENT** means:
   a. 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.
   b. Patient's who are insured but are responsible for a large portion of their charges that are not covered by third-party coverage from a health insurer.
   c. Self-pay patients may include Community Care Discount patients.

4. **HIGH MEDICAL COSTS** means:
   a. A person whose family income does not exceed 400 percent of the federal poverty level.
   b. Annual out-of-pocket costs incurred by the individual at the hospital that exceed the lesser of 10 percent of the patient's family income in the prior 12 months or 10% of the patient's current family income. .
   c. Annual out-of-pocket expenses that exceed 10 percent 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.
   d. Patient responsibility balance (underinsured) after third party insurance payment or discount.

5. **PATIENT'S FAMILY MEANS THE FOLLOWING:**
6. 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.
7. For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.
8. **REASONABLE PAYMENT PLAN or FORMULA** means:
   Monthly payment that is not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
9. **ESSENTIAL LIVING EXPENSES** means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
10. **BAD DEBT:** Any unpaid account of uninsured or self pay patient over 180 days from the date of service that has not been converted to financial assistance, payment arrangement, or government sponsored medical assistance programs including California Health Benefit Exchange or Oroville Hospital sponsored Financial Assistance program despite the efforts of Financial Counseling or Credit and Collection departments. A bad debt account may also include:
11. A patient or guarantor that is not keeping with their obligation to pay for medical services rendered, including their co-payment, co-insurance, deductible, spend down, share of cost amount for 180 consecutive days.
12. A patient or guarantor who fails to comply with financial counseling requests by means of providing the necessary information to qualify for government sponsored medical assistance programs California Health Benefit Exchange or Oroville Hospital sponsored Financial Assistance program.
13. Mail returned account with unpaid balance and loss of patient contact.
14. For bad debt procedures please refer to Oroville Hospital Policy # PFS 001.

D – MEDICAL PROVIDERS COVERED UNDER OROVILLE HOSPITAL FINANCIAL ASSISTANCE PROGRAM:
The list of medical providers for Oroville Hospital is maintained by Administration and updated at least annually.

Oroville Hospital	Financial Assistance: Community Care Service Rate & Discount Policy	Manual:	Patient Financial Services	
		Section:	Credit and Collections	
		Issued by:	Patient Financial Services	
Initial Approval Date:	09/06	Policy #:	PFS 003	Page 1 of 5
Dates of Review:	9/06, 10/08, 9/09, 12/11, 7/13, 5/14, 12/14, 1/16, 08/17, 1/22	Dates of Revision:	9/06, 12/06, 90/9, 12/11, 9/13, 5/14, 12/14, 1/16., 08/17, 1/22	

A- POLICY SUMMARY/INTENT

The purpose of this policy is to ensure a consistent and uniform method of Oroville Hospital and emergency room Physicians compliance with Senate bill 1276 Fair Billing Policies which was signed into law in California on September 28, 2014 and is effective January 1, 2015. This policy also complies with 501 r section of Internal Revenue Code. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy. The previous versions of this policy was consistent and compliant with Assembly Bill 774, Senate Bill 350, and AB 1503 which includes the availability of charity care and discounted payments for emergency room physicians.

Efforts will be made to assist all patients who may qualify for government-sponsored programs, or financial assistance from the Hospital. Assistance will include applications to the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state or county-funded health coverage programs.

Oroville Hospital will accept Community Care Service Discount assistance applications from all patients regardless of their insurance coverage i.e. uninsured, insured, underinsured and negotiate a payment rate or arrangements based on income, non-exempt resources and eligibility guidelines described in this policy.

B-ELIGIBILITY GUIDELINES FOR DISCOUNTS & FEDERAL POVERTY LEVELS (FPL)

1- Community Care Discount determinations will be made based upon the Federal Poverty Income Levels which is updated on a yearly basis. Oroville Hospital will always use the most currently published poverty level information available but are NOT required to go back and change a Community Care Discount determination when a new FPL is issued. FPL's are effective when received by the hospital and are not service date driven.

A- Hospital Table #1: Hospital table # 1 will be used to determine patient's federal poverty level.

2022

Household Size	100%	138%	150%	200%	250%	300%	350%	400%
1	$13,590	$18,754	$20,385	$27,180	$33,975	$40,770	$47,565	$54,360
2	$18,310	$25,268	$27,465	$36,620	$45,775	$54,930	$64,085	$73,240
3	$23,030	$31,781	$34,545	$46,060	$57,575	$69,090	$80,605	$92,120
4	$27,750	$38,295	$41,625	$55,500	$69,375	$83,250	$97,125	$111,000
5	$32,470	$44,809	$48,705	$64,940	$81,175	$97,410	$113,645	$129,880
6	$37,190	$51,322	$55,785	$74,380	$92,975	$111,570	$130,165	$148,760
7	$41,910	$57,836	$62,865	$83,820	$104,775	$125,730	$146,685	$167,640
8	$46,630	$64,349	$69,945	$93,260	$116,575	$139,890	$163,205	$186,520

C- UNINSURED or SELF PAY – COMMUNITY CARE RATES & DISCOUNT LEVELS

1- **Effective 1/1/2016, patient believed to be Self-Pay or uninsured will be given Community Care rate or discount without having to complete any paperwork.** Community Care Rates and discounts are not entitlements and are subject to change based on income, family size, hardship and resources. No self-pay or uninsured will be issued a refund retroactively for previously paying higher rates than the Community Care Rates established on 1/1/2016.

2- Community Care Rates:

a. Inpatient per diem rate: $3,000

b. Outpatient rate: 50% discount from billed charges.

c. Laboratory Only: 75% discount if paid at the time of service, otherwise 50% discount from charges.

d. Clinic & Physician Fee rate: 25% discount from billed charges

3- Hospital will use best efforts in applying the self-pay rate within 30 days from the last date of service.

a. Community Care Rates are applied to all self-pay / uninsured patients regardless of their income level.

b. Underinsured patients balance after insurance responsibility will be evaluated upon request under the Financial Assistance Policy.

4- All other discounts are subject to Financial Assistance application, income and resource verification.

5- Uninsured income levels between 0% and 200% Federal Poverty Level:

a. May qualify for 100% Financial Assistance or charity adjustment.

6- On a case by case basis, underinsured patients may be given Community Care Rates if they meet income and resource test or by mean of financial assistance application eligibility.

7- **Hospital Table # 2**: This table can be used in conjunction with hospital table # 1, 3, 4.

Community Care Rates Table # 2 Uninsured - Self Pay Rates & Community Care Rates	
Income 0 - 200% of FPL	**100% Discount**
Professional Fee / Clinic Rates	**25% discount from gross charges**
Hospital Discount Rates	**Inpatient:$3,000 per diem**
	Outpatient Hospital Discount from gross charges:50%

8- **Hospital Table # 3:** This table will be used as a guide and is subject to negotiation, payment arrangements, Financial Assistance documentation. All decisions are made on individual basis and case by case circumstances will be taken in to consideration. This table can be used for self-pay and Community Care Discount calculations when the patient has cash resources for payment in full or down payment or monthly payments negotiations. The balance reflected on table # 3 are already reduced or discounted from gross hospital charges to self-pay rates

Resource Level Test	Hospital Table # 3 = For Uninsured Self Pay Patients Resource based Discount Guidelines when Hospital charges are reduced to Self-Pay Rates To be used in conjunction with Hospital Table # 2 & ~~3~~										
	Total balance after self-pay / uninsured Community Care discounts are applied.										
Available cash or equivalent after cash resource exemptions	**$100**	**$ 2,501**	**$ 5,001**	**$7,501.**	**$10,001**	**$15,001.**	**$20,001**	**$25,001**	**$35,001**	**$50,001**	**$ 75,001**
	$2500	**$5,000**	**$7,500**	**$10,000**	**$15,000**	**$20,000.**	**$25,000**	**$35,000.**	**$50,000**	**$75,000**	**$100,000***
$0 - $1,000	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
$1,001 - $2,500	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
$2,501 - $5,000	**0%**	**0%**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
$5,001- $7,500	**0%**	**0%**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
$7,501-$10,000	**0%**	**0%**	**0%**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
$10,001- $15,000	**0%**	**0%**	**0%**	**0%**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN- IL**	**TBN- IL**	**TBN-IL**	**TBN-IL**
$15,001 & over	**0%**	**0%**	**0%**	**0%**	**0%**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**	**TBN-IL**
IL =Income Level discounts are subject to negotiation, payment arrangements or financial assistance documentation. TBN = To be negotiated with the patient on a case by case basis. Discounts: All discounts are subject to resource tests.											

D- **COMMUNITY CARE DISCOUNT FOR INSURED OR UNDERINSURED**

1- Community Service Discounts are not intended to offset share of cost obligations, deductibles, or coinsurance amounts under government or private health insurance programs unless high medical cost and financial hardship can be determined by means of financial assistance application.

2- Financial hardship on high medical cost for co-pay and deductibles can be considered upon request and self-attestation of family income and essential living expenses. Family expenses, Income and resources (cash) will be taken in to consideration when determining hardship. Financial hardship patients may be set up with affordable negotiated payment plans with no interest.

3- Patients whose outstanding balance is greater than 50% of their family unit's gross annual income may also qualify for greater discounts under Oroville Hospital's catastrophic allowances detailed in its Financial Assistance Policy. Patient's falling into this category should be validated through Oroville Hospital's Financial Assistance process.

4- Any underinsured patient receiving medically necessary services which are deemed non-covered by their health insurance, will be offered the Community Care Service Discount or financial assistance or charity assistance based on their applicable circumstances.

F-MEDI-CAL or RESTRICTED MEDI-CAL DENIALS:

1- A patient who is qualified for Medi-Cal is also presumed to qualify for a Community Care Service discount. Non-covered and denied services provided to Medicaid eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:

a. Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
b. Medicaid-pending accounts
c. Medicaid or other indigent care program denials
d. Charges related to days exceeding a length-of-stay limit
e. Medicaid claims (including out of state Medicaid claims) with "no payment"
f. Any service provided to a Medicaid eligible patient with no coverage and no payment

2-

3- RESTRICTED MEDI-CAL COVERAGE: A patient who is qualified for Medi-Cal is also presumed to qualify for a Community Care Service discount. Any charges for days or services written off (excluding billing timeliness, medical

records, missing invoices, or eligibility issues) as a result of a Medi-Cal or Restricted Medi-Cal denial (such as TAR denial) should be written off to a specific code and booked as Community Care Discount / charity.

4- Medi-Cal plans offer limited or restricted coverage for emergency and pregnancy related services. If a patient is eligible for Medi-Cal or restricted Medi-Cal any charges for days or services already rendered not covered may be written off to Community Care Service (Charity) discount without a completed Confidential Financial Statement.

G-CATASTROPHIC COMMUNITY CARE DISCOUNT (CHARITY) DISCOUNTS:

1- Based upon the patients' complete financial situation, when the patient liability amount exceeds 50% of the total annual family income, amounts greater than 50% of the income may be written off to a Community Care Discount / charity discount. Catastrophic allowances will require validation by prior year's tax return and will be discounted as follows:

a. If the combination of account balances are greater than 50% of the family unit's annual gross income but less than 100% of the annual income the patient will be granted a 50% discount.

b. If the combination of account balances is greater than 100% of the family unit's annual gross income the patient will be granted a 90% discount.

H- INSURANCE DEDUCTIBLES, SHARE OF COST AND FINANCIAL HARDSHIP

1- **Hospital Table # 4** This table can be used to assist insured and underinsured patients with their co-pay or high deductibles based on self declaration or verified income and resources. If the extended discount remains a financial hardship then a Community Care Financial Discount application and supporting documentation may be submitted for in depth review for assistance, payment arrangement or higher discount determination. The discount determination may include payment comparisons what self-pay pricing or Medicare would have paid versus payments received from insurance, patient and other sources. These discounts will not be applied automatically unless the patient asks for high cost balance or financial hardship discount and follows the required process.

Hospital Table # 4

- Discount for Insured or Underinsured Patient - Financial Hardship or High Medical Cost.
- Discount for patient responsibility balance after Third Party or insurance payment.
- Must be used in conjuction of Hospital Table # 3 available cash resources
- May be evaluated under Financial Assistance Policy

Patient Responsibility	$ 1.00	$1001	$3001	$5001	$7501	
	$ 1000	$3000	$5000	$7500	$15000	$15001 >
Income Level based on Family Size	Discount %	Discount %	Discount %	Discount %	Discount %	Discount %
0 - 100%	100%	100%	100%	100%	100%	100%
101% - 200%	50%	50%	50%	50%	50%	Case by Case/TBN/IL
201% - 350%	10%	20%	30%	40%	50%	Case by Case/TBN/IL
351%>	Case by Case/TBN/IL	Case by Case/TBN/IL	Case by Case/TBN/IL	Case by Case/TBN/IL	Case by Case/TBN/IL	Case by Case/TBN/IL

TBN = To be negotiated IL= Income level discount, R = Resource Test.

I- **Oroville Hospital Clinic: Office Visit Self Pay & Community Care Discount**

Clinic / Professional Fee Discount Table #1 – The following clinic table # 1 will be used for clinic patients who choose not to declare income or complete a Community Care Discount application.

Professional fee self-pay / uninsured pricing will be 25% Community Care Discount from regular charges. All other discounts will be based on income, resources, financial assistance application documentation and case by case negotiations.

Professional Fee Table # 1 for services rendered at the hospital.

Professional Fee Self-Pay Discount Table #1

Office Visit or services rendered at the Hospital Discount Percentage when patient chooses not to declare Insurance, income or complete Community Care Discount application.	
Discount Percentage from Charges	25% Community Care Discount

J - Discovery of Patient Financial Assistance Eligibility During Collections

While Oroville Hospital strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. Oroville Hospital collection agencies shall be made aware of this possibility and are requested to refer-back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, Oroville Hospital will reverse the account out of bad debt and document the respective discount in charges as charity care.

K - Insured Patients Not Under Contract with the Hospital

Negotiations with insurance carriers involving inferred contractual relationships for insured patients not under contract with Oroville Hospital will be conducted by Hospital Administration at Oroville Hospital. Although Oroville Hospital may agree to the terms of the negotiations with insurance companies, an inferred contractual relationship is not representative of a patient "under contract" with Oroville Hospital. Oroville Hospital considers any reimbursement less than 25% [subject to discussion with Oroville Hospital] of cost to be charitable event. Any care provided to a presumptive or actual case of COVID-19 is provided at an amount no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. All unreimbursed amounts are a form of patient financial assistance and determined as the difference between gross hospital charges and hospital reimbursement.

L - Clinic Table # 2 - Clinic: Office Visit Self Pay & Community Care Discount Matrix:

Clinic self-pay / uninsured pricing will be 25% Community Care Discount from regular charges.

All other discounts will be based on income, resources, financial assistance application documentation, payment arrangements and case by case negotiations.

Community Care Rates can be applied based on self-declaration of income and family size.

If no income declaration is made the discount will be limited to 25% from the regular price.

Clinic Table # 2 - 2022 Clinic Self Pay - Uninsured Community Care Rates

2022 CLINIC OFFICE VISITS ONLY - SLIDING TABLE FOR UNINSURED / SELF PAY PATIENTS												
COMMUNITY CARE DISCOUNT UNINSURED INCOME BASED SLIDING FEE SCHEDULE												
Family Size	FPL 100%	FPL 130%	FPL 150%	FPL 170%	FPL 200%	FPL 225%	FPL 250%	FPL 275%	FPL 300%	FPL 325%	FPL 350%	FPL 351% & Higher
1	$13,590	$17,667	$20,385	$23,103	$27,180	$30,578	$33,975	$37,373	$40,770	$44,168	$47,565	25% discount of the regular billed charges
Visit Co-Pay	$5	$10	$15	$20	$25	$30	$35	$40	$45	$50	$55	
2	$18,310	$23,803	$27,465	$31,127	$36,620	$41,198	$45,775	$50,353	$54,930	$59,508	$64,085	
Visit Co-Pay	$5	$10	$15	$20	$25	$30	$35	$40	$45	$50	$55	
3	$23,030	$29,939	$34,545	$39,151	$46,060	$51,818	$57,575	$63,333	$69,090	$74,848	$80,605	
Visit Co-Pay	$5	$10	$15	$20	$25	$30	$35	$40	$45	$50	$55	
4	$27,750	$36,075	$41,625	$47,175	$55,500	$62,438	$69,375	$76,313	$83,250	$90,188	$97,125	

Visit Co-Pay	**$5**	**$10**	**$15**	**$20**	**$25**	**$30**	**$35**	**$40**	**$45**	**$50**	**$55**
5	**$32,470**	**$42,211**	**$48,705**	**$55,199**	**$64,940**	**$73,058**	**$81,175**	**$89,293**	**$97,410**	**$105,528**	**$113,645**
Visit Co-Pay	**$5**	**$10**	**$15**	**$20**	**$25**	**$30**	**$35**	**$40**	**$45**	**$50**	**$55**
6	**$37,190**	**$48,347**	**$55,785**	**$63,223**	**$74,380**	**$83,678**	**$92,975**	**$102,273**	**$111,570**	**$120,868**	**$130,165**
Visit Co-Pay	**$5**	**$10**	**$15**	**$20**	**$25**	**$30**	**$35**	**$40**	**$45**	**$50**	**$55**
Each Additional Person add $ $4180 to each category											

Note about the All the Hospital and Clinic Tables:

These percentages are subject to review and change each fiscal year.

Greater discount amounts may be available at Oroville Hospital's discretion.

All the figures are guidelines and may be subject to documentation, verification and negotiation.

M - Access to Healthcare During a Public Health Emergency:

An Access to Healthcare Crisis must be proclaimed by [hospital leadership / approved by the BOD] and attached to this patient financial assistance document as an addendum. An Access to Healthcare Crisis may be related to an emergent situation whereby state / federal regulations are modified to meet the immediate healthcare needs of Oroville Hospital community during the Access to Healthcare Crisis. During an Access to Healthcare Crisis Oroville Hospital may "flex" its patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis)

Financial Assistance Eligibility Procedure		Manual:	**Patient Financial Services**
		Section**:**	**Financial Counseling**
		Issued by:	**Patient Financial Services**
Initial Approval Date:	**2/02**		Page 1 of 3
Dates of Review:	**3/03, 5/03, 3/04,7/05, 9/06, 6/07,12/07,10/08, 5/09, 12/11, 12/14, 1/16,**	Dates of Revision:	5/03, 3/04, 6/04,7/05, 9/06, 12/06, 6/07, 5/09, 12/11**,9/13, 5/14, 12/14, 1/16, 1/22**

A-ELIGIBILITY PROCUDURE

The purpose of this procedure is to ensure fair and accurate implementation of Oroville Hospital Financial Assistance and compliance with Senate Bill 1276 & AB1020. Efforts will be made to assist all patients who may qualify for government-sponsored programs, or financial assistance from the Hospital. Assistance will include applications to the California Health Benefit Exchange and to include in the information provided to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state or county-funded health coverage programs.

B- PROCEDURE FOR COMMUNITY SERVICE DISCOUNT & FINANCIAL ASSISTANCE

1- Any self-pay /uninsured patient will be given Community Care Rates or Discount upon determination of no insurance or within 30 days from last date of service.
2- Any self-pay, uninsured or underinsured patient who indicates an inability to pay will be screened for Community Care Financial Assistance discount.
3- Any "high cost" patients will also be screened for a Community Care discount or when the patient requests such screening.

4- The screening process will optimally occur at the time of service but may occur anytime during the collection process including post assignment to an outside collection agency.
5- Any uninsured or underinsured patient receiving medically necessary service which are deemed non-covered by their health insurance, will be informed of the Community Service Discount or Financial Assistance programs.
6- Discount or financial assistance to individuals who do not reside in the community of Oroville may be limited to 50% of billed charges or Community Care rates. Any exceptions to this rule must have Administration approval. All non-emergent requests must be reviewed by Administration for final disposition.

C-**DOCUMENTATION REQUIREMENTS**

1- Application: Except in those instances where the hospital has determined that minimum application and documentation requirements apply (as described above), in order to qualify for Financial Assistance a Confidential Financial Application should be completed and may be accompanied with a denial or approval from Medi-Cal or CMSP or other Governmental programs.

2- If a denial from other assistance sources is not obtained, the hospital may at its discretion approve the financial assistance request based on the Confidential Financial Statement completed by the patient. Pending the completion of such application, the patient will be treated as a pending Community Care Financial Assistance account.

D-UNCOOPERATIVE PATIENTS

1- Uncooperative, non-compliant patients are defined as patients or guarantors who are unwilling to disclose any financial or other required information as requested for Medi-Cal, CMSP, California Health Benefit Exchange and community care or discount determination during the screening process. In these cases, the account will not be processed as Community Care Financial Assistance and the hospital or clinic discount will be limited to Community Care self–pay /uninsured rates or 50% of charges. No further consideration will be given for Community Care Financial Assistance.
2- If the person or representative 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. The hospital may limit the discount to Community Care self-pay / uninsured rates or to 50% of charges, when is not able to determine eligibility because of patients failure to provide.

E-INCOME AND PROPERTY AND VERIFICATION OF ESSENTIAL LIVING EXPENDITURES

1- Patients will be required to verify their income, property and their essential living expenditures.
2- **Income Documentation:** Income documentation may include a current pay check stub, IRS Form W-2, wage and earnings bank statements, or other appropriate indicators of income.
3- **Property Documentation**: Property documentation may include bank statements or other indicators of cash and property.
4- **Participation in a Public Benefit Program**: Documentation showing current participation in a public benefit program including Social Security, Workers' Compensation, Unemployment Insurance Benefits, Medi-Cal, County Indigent Health, cash assistance, Food Stamps, WIC, or other similar indigence related programs.
5- **Essential Living Expenditures:** Documentation of rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

F-PAYMENT ARRANGEMENTS

1- In cases where the patient or the patient's guarantor has a liability under the Community Care Discount program and when requested to do so by the patient or guarantor, the hospital will negotiate a monthly payment plan with the patient or guarantor.
2- Any extended payment plan agreed to by the hospital to assist patients eligible under the Community Care Discount care policy shall be interest free.
3- Therefore, a payment plan does not limit or alter the obligation of the patient to make payments from the first date due on the obligation owing to Oroville Hospital pursuant to any contract or applicable statute, in the event that the patient fails to make payments for 90 days, or to renegotiate the payment plan. Extended payment plans may be declared inoperative when the patient or guarantor fails to make all consecutive payments due during a 90-day period.

4- Before declaring the agreement inoperative, the hospital or collection agency shall make a reasonable attempt to contact the patient by phone and, to give notice in writing, that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan.
5- Before the hospital can declare the extended payment plan inoperative, they must attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient or their guarantor.
Neither the hospital nor the collection agency may report adverse information to a credit reporting bureau before the extended payment plan has been declared inoperative.
6- A collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after the initial account assignment.
7- Reasonable monthly payment is defined as monthly payment that is not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.

G- COMMUNICATION

1- Oroville Hospital posts signs in the business office, the admitting and registration areas and the emergency department informing patients about our financial assistance policies and the availability of Community Care Discounts.
2- Additionally, patient statements include standard language informing patients that they may request financial screening to determine eligibility for Community Care Discounts and how that request may be made.
3- All statements sent to patients contain a plain language summary of the patient's rights pursuant to SB1276 and AB 774 and the Rosenthal Fair Debt Collection Practices Act.
4- Once a Community Care Discount determination has been made, the outcome is communicated to the patient by a letter and/or phone call and is documented in the patient's account notes.
5- Patient communication will include information to a local consumer assistance center housed at legal services offices.

H- DURATION OF COMMUNITY CARE FINANCIAL ASSISTANCE

Financial Assistance is considered valid on a case by case basis only. A new application may be requested at hospital discretion for each medical service or date a patient seeks consideration for financial assistance.

I- CLASSIFICATION AS STATUTORY OR NON STATUTORY

Community Care Financial Assistance will be classified into two categories: statutory and non-statutory.

1 - STATUTORY COMMUNITY CARE FINANCIAL ASSISTANCE / CHARITY

a- Each patient who appears eligible for a statutory charity discount determination and who requests such determination must complete a Confidential Financial Statement.
b- Must provide supporting documentation to the financial counselor as required and to verify his/her financial condition.
c- Statutory charity discounts will generally be identified at the time of admission or while the patient is in-house by the financial counselor, however, it may also be identified after discharge or whenever a patient declares an inability to pay.

2- NON-STATUTORY COMMUNITY CARE FINANCIAL ASSISTANCE / CHARITY

a- A Non-Statutory Charity discount is defined as a charity discount for patients known to meet the general discount criteria. The determination of non-statutory discounts will be made at admission or while the patient is in-house; however, this determination could also be made after discharge or whenever patient declares an inability to pay.
b- Unless the patient qualifies for the abbreviated screening procedure, every effort will be made to secure a signed application, but this may not be possible in all cases.
c- Patients stating that they are homeless and without income, at the discretion of the CFO, PFS Director, do not need to complete a Confidential Financial Statement. Instead, Community Care Discount determinations may be made by the financial counselor's completion of the eligibility worksheet.
d- Non-statutory charity discounts should be used for homeless patients that have no income or documentation to report.

J- APPEALS

1- Patient's wishing to dispute charges on an account may do so for up to 60 days from the date of service and/or discharge.

2- Patients have the right to appeal facility Community Care Discount or Financial Assistance decisions.
3- Patients must provide written appeals outlining the reasons they believe the Community Care Discount or Financial Assistance determination was incorrect.
4- The facility CFO and/or PFS Director is responsible for reviewing all appeals and making a final determination.
5- The final determination must be communicated to the patient in writing.
6- **All written requests may be submitted to:**
Oroville Hospital – Patient Financial Services
Financial Assistance Reconsideration Dept.
2767 Olive Hwy. Oroville, CA 95966

K- COMMUNITY CARE FINANCIAL ASSISTANCE WRITE-OFF MATRIX:

Community Care Financial Assistance

Approval and Account Write-Off Matrix

CEO and/or CFO	Greater than $10,000
Patient Financial Services Director and /or Controller	Up to $10,000
Patient Access Manager or PFS Supervisors	Up to $5,000

Financial Assistance Review Process		Manual:	**Patient Financial Services**
		Section**:**	**Financial Counseling**
		Issued by:	**Patient Financial Services**
Initial Approval Date:	**2/02**		Page 1 of 1
Dates of Review:	**3/03, 5/03, 3/04,7/05, 9/06, 6/07, 12/07, 10/08, 5/09, 12/11, 12/14, 1/16**	Dates of Revision:	5/03, 3/04, 6/04,7/05, 9/06, 12/06, 6/07, 5/09, 12/11, **9/13, 12/14, 1/16, 1/22**

A- REVIEW PROCESS FOR FINANCIAL ASSISTANCE/CHARITY CARE

1- Financial Counselors will make every effort to assist patient or their family members in applying for the California Health Benefit Exchange or Medi-Cal or other governmental health programs.
2- Financial Counselors or registrars will provide information to a patient that has not shown proof of 3rd-party coverage a statement that the consumer may be eligible for coverage through the California Health Benefit Exchange or other state- or county-funded health coverage programs.
3- Except in those instances where the hospital has determined that minimum application and documentation requirements apply, a Confidential Financial Statement must be completed. The Confidential Financial Statement allows for the collection of information which is necessary in order to determine eligibility for financial assistance. Pending the completion of such application, the patient will be treated as a pending charity care patient.
4- Any patient requesting to be screened for financial assistance must submit with their Confidential Financial Statement an approval or denial letter from CMSP or Medi-Cal or (denial cannot be related to a lack of follow through by the patient), a current pay stubs for all working members of the family, or the most recent Income Tax Return.
5- If the Confidential Financial Statement is incomplete or the Confidential Financial Statement received is missing the necessary information, the person asking for financial assistance will be sent a letter requesting the missing information and the account(s) will be put on hold for thirty (30) days.

6- When completed documentation is received the patient's financial status is reviewed in conjunction with the Oroville Hospital Financial Assistance or Discount tables and all discounts/adjustments will be applied as appropriate.
7- Once a charity determination has been made, the outcome is communicated to the patient by a letter and/or phone call and is documented in the patient's account notes.

B-PROCUDURE

1- Determine the patient Federal Poverty Level based on the family size and income.
2- Use Hospital Table 2 to determine the discount level the patient would qualify.
3- Inform the patient of their discount level and verify the payment method
4- Self-pay Uninsured patients will be given Community Care Rates or Discount.
5- Patient who choose not the report their income or financial resources or non-compliant may be given a 50% discount from hospital gross charges.

C-PROCUDURE SELF-PAY ESTIMATE & COMMUNITY CARE RATE

1- Self-pay Uninsured patients will be offered the following self-pay /uninsured Community Care rates:
   a. Inpatient procedures: $3,000 per diem
   b. Outpatient procedures: 50% discount from gross charges.
   c. Physician Professional services rendered at the clinic or hospital setting will be given 25% discount from gross charges as Community Care discount.
   d. All other discounts will be based on financial assistance application documentation