GLENDORA HOSPITAL

A COLLEGE BEHAVIORAL HEALTH HOSPITAL

MANUAL:	Business Office	POLICY #:	
SUBJECT:	Charity Care and Discount Payment	EFFECTIVE DATE:	06/17/2021
APPROVALS:	Chief Financial Officer	REVISED:	
		REVIEWED:	

I. Purpose:

All patients unable to meet their financial obligations to the hospital will be offered an opportunity to complete a Financial Evaluation Form. It is the goal to have all patients screened for eligibility for Medicare, Medi-Cal and other third-party coverage.

II. Affected Areas/Departments:

All staff and personnel.

III. Policy:

Glendora Hospital strives to provide quality services in a caring environment and to help meet the needs of the low-income uninsured and underinsured population in the community. The hospital's charity care and discount payment policy provide the means for Glendora Hospital to demonstrate its commitment to achieving its mission and values. The criteria Glendora Hospital will follow are documented in this policy.

Patient who do not have third-party insurance coverage for their entire hospital bill, and who have difficulty paying their hospital bills because of financial hardship, are covered under the terms of this policy.

IV. Procedure:

A. Discount Payment for all Uninsured, Self-Pay Patients

All Patients who do not have any third-party insurance coverage, and who do not qualify for any government payment program, will receive 50%

discount from billed charges without taking into consideration their ability to pay and before the application of any additional charity care discount, if eligible.

B. Financial Evaluation Form

By completing the financial evaluation form, uninsured and underinsured patients may have all or part of their hospital bills covered by the hospital's charity care and discount payment policy. The evaluation form is used to help determine the extend of a patient's financial means. Hospital staff will assist the patient with completion of the form during their stay. However, it is the patient's responsibility to cooperate with the information gathering process. Willful failure by the patient to cooperate will result in the denial of charity care or discount payment.

Each patient who completes the financial evaluation form enables Glendora Hospital to accomplish certain essential steps in the charity care process:

1. Allows the hospital to determine if the patient has declared income and/or assets giving them the ability to pay for the health care services they will receive;

2. Provides a document to support a financial status determination; and

3. Provides an audit trail in documenting the hospital's commitment to providing charity care and discount payment.

In order to determine that a patient does not have the ability to pay, hospital staff will make a good faith effort to obtain the following information:

1. Individual or family income, recent pay stubs or income tax return.

2. Employment status. This will be considered in the context of the likelihood future earnings will be sufficient to meet the cost of paying for these healthcare services.

3. Information on all monetary assets of the patient, but not including statements on retirement or deferred compensation plan qualified under the Internal Revenue Code, or nonqualified deferred compensation plan. As needed, waivers from the patient or the patient's family authorizing the hospital to obtain account information from financial or commercial institutions, or other entities that hold or maintain the monetary assets, to verify their value.

4. Family Size. This is used to determine the percentage of charity care, if income is at or below the established income levels.

5. Eligibility of Medi-Cal at present or potential for eligibility in the future.

Information used will be based upon a signed declaration of the patient or patient's family, verification through documentation provided by the patient or the patient's family. Additional information may be required for special circumstances or as determined by hospital management. It is understood that in some cases information will not be obtainable and Glendora Hospital staff will indicate this on the financial evaluation form. The hospital shall not use the information obtained by the hospital as part of the charity care and discount payment eligibility process for collection activities.

The charity care discount is based upon the current federal poverty guidelines, as updated annually by the Department of Health and Human Services.

Given the Glendora Hospital service area demographic and the organization's mission to meet the health care needs of its community, the primary qualifying levels are based upon incomes up to 200% of the federal poverty level guidelines for 100% write-off of patient balance for charity care, with the sliding scale of decreasing percentage write-offs for

incomes up to 350% of the federal poverty guideline, as shown in the following table.

Charity write-off for family incomes compared to the federal poverty guidelines:

0 to 200% of the federal poverty guideline –	100% charity write-off
201 to 250% of the federal poverty guideline -	75% charity write-off
251 to 300% of the federal poverty guideline -	50% charity write-off
301 to 350% of the federal poverty guideline -	25% charity write-off
Over 351% of the federal poverty guideline -	0% charity write-off

Glendora Hospital shall limit expected payment for services it provides to a patient at or below 350% of the federal poverty level to the amount of payment the hospital would expect, in good faith, to receive for providing services from Medicare.

To qualify for charity care coverage for either the entire hospital bill or a portion of the hospital bill, the following criteria must be met:

1. If the hospital is unable to obtain adequate information regarding ability to pay for any patient treated in the emergency department, the patient will be granted 100% charity care after appropriate billing and/or other attempts to collect information.

2. Services denied or non-covered by Medi-Cal or other programs, which provide care to low-income patients, will be considered for write-off under the charity care policy.

3. Patient’s co-pays, deductibles, and share of cost will not be reduced further under this policy. Charity care and discount payments will be determined after co-pays, deductible and coinsurance.

4. Hospital staff will be responsible for calculating the charity discount recommendations using the Financial Evaluation Form (Exhibit A) and the current Federal Poverty Guidelines (Exhibit B).

5. Hospital Staff will determine if the case is catastrophic or non-catastrophic by diving the patient's responsibility of the hospital charges by the patient's gross annual income. Should the result be greater than 100% write-off for charity care for incomes up to 350% of the federal poverty guidelines.

C. Charity Care Determination Process

Every reasonable effort will be made to make an individual patient's charity care determination as soon as possible. This may occur before or after services to the patient begin. Glendora Hospital will 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 initial billing. If it is determined that the patient does not have the ability to pay during the billing and collection process, charity care will be considered according to the criteria in this policy. Glendora Hospital will work to assist any patient unable to pay and who cooperatively provides information regarding their ability to pay. The hospital staff will make the recommendation and the Billing Manager, including the Patient Financial Services Director, or Chief Financial Officer will make the final decision.

D. Appeals

If the patient disagrees with the decision on the application, he/she has the right to dispute and appeal concerning the patient's qualification. A patient may seek review from the Patient Financial Services Director and/or Chief Financial Officer for further review.

E. Extended Payment Plan

If a patient cannot pay the total charges, the patient can request payment options within a reasonable extended payment plan. This payment plan will be interest free. The plan shall negotiate the terms of the payment plan, and the hospital shall take into consideration the patient's family income and essential living expenses. The hospital staff may extend a payment plan for up to 12 months. Payment from 13 to 24 months must be approved by the Billing Manager. Payment plans in excess of 24 months must be approved by the Patient Financial Services Director or Chief

Financial Officer. If the Hospital and the patient are unable to agree on an extend repayment plan, the Hospital will offer a plan that includes monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means for purposes of this provision, 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.

F. Emergency Physicians

An emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level. An "emergency physician" means a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code who is credentialed by a hospital and either employed or contracted by the hospital to provide emergency medical services in the emergency department of the hospital, except that an "emergency physician" shall not include a physician specialist who is called into the emergency department of the hospital or who is on staff or has privileges at the hospital outside of the emergency department. This requirement does not impose any obligation on the hospital other than to note the requirement in this policy.

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Exhibit A

2021 Poverty Guidelines

U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs

The following figures are the 2021 HHS poverty guidelines which will be published in the Federal Register on February 01, 2021 (Additional information will be posted after the guidelines are published.)

2021 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	**POVERTY GUIDELINE**
1	$12,880
2	$17,420
3	$21.960
4	$26,500
5	$31,040
6	$35,580
7	$40,120
8	$44,660
For families/households with more than 8 persons, add $4,540 for each additional person	

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Exhibit B

Charity Evaluation Form

Patient Name:		FIN #:	
CHARITY CARE EVALUATION FORM			
Schedule of Current Income and Expenditures			
Patient's Last, First and Initial			
Mailing Address:			
City, State:		Zip Code:	
Home Tel Number:		Cell Phone No.	
(Patient) Social Security No:			
(Spouse) Social Security No:			
EMPLOYMENT AND OCCUPATION			
Employer Name:			
Position Title:			
Contact Person:			
If self-employed, give name of business:			
Spouse's Employer:			
Position:			
Contact Person:			
If self-employed, give name of business:			

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Patient Name:		FIN #:	

CURRENT MONTHLY INCOME

	Patient	Spouse
Gross pay from employment: (Before deductions)	$	$
Income from operating business: (If self-employed)	$	$
Tax Return:	$	$
Total Current Monthly income: (Add all figures from above)	$	$

ASSETS AND DEBTS

Please provide your best estimate of the value of any homes, cars or similar assets. Also, indicate how much debt you currently have.

Assets:	
a. Home and Property	$
b. Automobiles	$
c. Retirement plan:	$
d. Investments/other (Specify):	$
Debts:	
a. Amount owed on mortgages:	
b. Amount owed on automobiles:	
c. Amount owed on credit cards:	
d. Other	

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Patient Name:		FIN #:	

FAMILY STATUS

List all dependents you support

Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	
Name:		Age:		Relationship:	

I certify that the above stated information is true and correct. I authorize Glendora Hospital to contact the employer's institutions on this application or a credit reporting agency to verify its accuracy. I further authorize the employers, institutions and/or credit reporting agencies to release such information to Glendora Hospital.

Signature of Patient or Guarantor:		Date:	
Signature of Spouse:		Date:	