

- Facility:  
 System-wide Corporate Policy  
 Standard Policy  
 Model Policy:

Policy No. PFS-112  
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Department: PFS

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**POLICY: Uninsured Patient Billing: Charity Care**

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**POLICY SUMMARY/INTENT:**

The purpose of this policy is to ensure a consistent and uniform method among all Adventist Health facilities for compliance with the California Hospital Association's "Voluntary Principles and Guidelines on Hospital Billing and Collection Practices for Services Provided to Low-income Uninsured Patients." While adopted by the California Hospital Association, this policy is applicable to all Adventist Health Facilities.

It is the intent of this policy to comply with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supercede this policy.

**BACKGROUND:**

Most hospitals have and use financial assistance policies as they work with uninsured patients who have limited financial resources. However, hospital billing and collection practices are not consistently applied, and are communicated with varying degrees of effectiveness. These inconsistencies have been used by certain interest groups to the collective disadvantage of all hospitals. During the past two years, much time and attention has been devoted to this issue to the detriment of hospitals across the country. The CHA Board of Trustees has adopted the following Voluntary Principles and Guidelines on Hospital Billing and Collection Practices for Services Provided to Low-Income Uninsured Patients:

**Principles**

- ❖ Fear of a hospital bill should never prevent any patient from seeking emergency health care services.
- ❖ Each hospital should have financial assistance policies that are consistent with the mission and values of the hospital. These policies, which should be broadly communicated, should reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.
- ❖ Financial assistance policies must balance a patient's need for financial assistance with the hospital's broader fiscal responsibilities.
- ❖ Financial assistance provided by the hospital is not a substitute for personal responsibility. All patients should be expected to contribute to the cost of their care, based upon their individual ability to pay.

**Guidelines**

- ❖ Each hospital should maintain understandable, written financial assistance policies for low-income uninsured patients, addressing both the hospital's charity care policy, as well as its discount payment policy for the low-income uninsured.
- ❖ Each hospital's financial assistance policies should clearly state the eligibility criteria (i.e., income, assets) and the process used by the hospital to determine whether a patient is eligible for financial assistance. Such process should take into account where and how far a particular patient falls relative to existing Federal Poverty Levels (FPL). See Exhibit C for current FPL.
- ❖ Any patient who believes that they are qualified may apply for financial assistance under each hospital's charity care policy or discount payment policy.
- ❖ Hospitals should use their best efforts to ensure all financial assistance policies are applied consistently.
- ❖ In determining a patient's eligibility for financial assistance, hospitals should assist the patient in determining if he/she is eligible for government-sponsored programs.

### **Communication of Financial Assistance Policies with Patients and the Public**

- ❖ Each hospital should post notices regarding the availability of financial assistance to low-income uninsured patients. These notices should be posted in visible locations throughout the hospital such as admitting/registration, billing office, emergency department and other outpatient settings.
- ❖ Every posted notice regarding financial assistance policies should contain brief instructions on how to apply for charity care or a discounted payment. The notices also should include a contact telephone number that a patient or family member can call to obtain more information.
- ❖ Hospitals should ensure that appropriate staff members are knowledgeable about the existence of the hospital's financial assistance policies. Training should be provided to staff members (i.e., billing office, financial department, etc.) who directly interact with patients regarding their hospital bills.
- ❖ When communicating to patients regarding their financial assistance policies, hospitals should attempt to do so in the primary language of the patient, or his/her family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations.
- ❖ Hospitals should share their financial assistance policies with appropriate community health and human services agencies and other organizations that assist such patients.

### **Summary**

Adventist Health hospitals exist to serve patients. Hospitals are built on a team of dedicated health care professionals – physicians, nurses and other health care professionals, management, trustees and volunteers. Collectively, these individuals protect the health of their communities. Their ability to serve well requires a relationship with their communities built on trust and compassion. Through mutual trust and good will, hospitals and patients will be able to meet their responsibilities. These voluntary principles and guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of Adventist Health's commitment to caring.

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## **POLICY: COMPLIANCE – KEY ELEMENTS**

### **CHARITY CARE**

Any self-pay, uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the hospital, any insured patient who indicates an inability to pay their liability after their insurance has paid may be screened for charity care. At minimum, Charity Care will be granted to patients with emergency medical conditions including obstetrics patients. Adventist facilities, at their own discretion, may grant charity to other classifications of patients. The facility PFS Director must define the types of services approved for charity care at their facility as part of the hospital's Charity Care Procedures. Screening for charity care will occur only after all other potential resources have been exhausted. 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.

Hospitals PFS Directors will develop internal procedures to be certain that they are meeting minimum standards for screening as defined in this corporate standard policy. Hospitals may develop abbreviated screening procedures for those service areas where charges are low such as clinics, rural health clinics, emergency departments and outpatient ancillary areas (defined below). At a minimum, the hospital will document family size and gross family income and a credit report will be secured. In those service areas where charges are higher such as inpatient and outpatient surgery, the hospital will complete a full financial screening and require income verification from the patient.

Charity care will be granted based upon the following suggested income levels. These levels are a minimum. Hospitals may not go below 200% of the FPL for the 100% discount but they may go higher. Hospitals may not go below 400% as the level at which the patient pays full charges. They may go higher.

**Income Level**

Less than 200% of the Federal Poverty Level  
200% to 300% of the Federal Poverty Level  
301% to 350% of the Federal Poverty Level  
350% to 400% of the Federal Poverty Level  
Greater than 400% of Federal Poverty Level

**Discount Amount**

100% Discount  
75% Discount off Self Pay Liability  
50% Discount off Self Pay Liability  
25% Discount off Self Pay Liability  
Patient Pays Full charges

**DURATION**

Approved charity adjustments are considered valid for all existing accounts and for an additional 90 days after approval.

**CATASTROPHIC CHARITY CARE**

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 charity care.

**CLASSIFICATION AS STATUTORY OR NON STATUTORY**

Charity care will be classified into two categories: statutory and non-statutory.

**Statutory Charity Care**

Statutory charity care will be defined by facility participation in various federal, state, and/or county indigent care programs. Criteria must comply with governmental guidelines and/or state or county regulations.

Each patient who appears eligible for statutory charity care determination and who requests such determination must complete a Confidential Financial Statement (exhibit A in English and Spanish). Additionally, he/she must provide supporting documentation to the financial counselor as required to verify his/her financial condition. Statutory charity care will generally be identified at the time of admission or while the patient is in-house by the facility financial counselor, however, it may also be identified after discharge or whenever a patient declares an inability to pay.

The following adjustment codes will be added for standardization:

- 9703463 Charity Discount-Statutory

**Non-Statutory Charity Care**

Non-Statutory Charity Care is defined as charity care for patients known to meet the general charity care criteria. The determination of non-statutory charity care 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.

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. Patients stating that they are homeless and without income, at the discretion of the PFS Director, do not need to complete a Confidential Financial Statement. Instead, charity care determination may be made by the financial counselor's completion of the eligibility worksheet. Non-statutory charity care should be used for homeless patients that have no income or documentation to report. Additionally, charity discounts will be used to write off accounts of patients who are deceased and research has shown that there is no estate or other responsible relative and no possibility of further collection. Finally, charity discounts will be used to write off accounts of patients where the court has entered a final bankruptcy judgment and there is no potential for further collection.

The following adjustment codes will be added for standardization:

- 9703398 Charity Discount-Non Statutory

### **MEDICAID DENIALS**

Patients who qualify for Medicaid are also presumed to qualify for full charity write off. Any charges for days or services written off (excluding billing timeliness, medical records, missing invoices, or eligibility issues) as a result of a Medicaid denial (such as TAR denial) should be written off to a specific code and booked as charity.

### **RESTRICTED MEDICAID COVERAGE**

Some Medicaid plans offer coverage for a limited or restricted list of services. If a patient is eligible for Medicaid, any charges for days or services not covered by the patient's coverage may be written off to charity without a completed Confidential Financial Statement. This does not include any Share of Cost (SOC) amounts, as SOC's are determined by the state to be an amount that the patient must pay before the patient is eligible for Medicaid.

### **DOCUMENTATION REQUIREMENTS**

#### **Application**

Except in those instances where the hospital has determined that minimum application and documentation requirements apply (as described below), in order to qualify for charity care, a Confidential Financial Statement should be completed. The Confidential Financial Statement allows for the collection of information. Income and documentation requirements are defined below. Pending the completion of such application, the patient should be treated as a pending charity care patient in accordance with the hospital's policies and the appropriate financial class recorded to reflect this status.

**Family Members:** Patients will be required to provide the number of family members in their household.

- **Adults:** In calculating the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all dependents.
- **Minors:** In calculating the number of family members in a minor patient's household, include the patient, the patient's mother and/or father and/or legal guardian and any other dependents.

**Income Calculation:** Patients will be required to provide their household's yearly gross income.

- **Adults:** The term "yearly income" on the Confidential Financial Statement means the sum of the total yearly gross income of the patient and patient's spouse.
- **Minors:** If the patient is a minor, the term "yearly income" on the Confidential Financial Statement means income from the patient, the patient's mother and/or father and/or legal guardian and any other dependents.

#### **Income Verification**

Patients will be required to verify the income set forth in the Confidential Financial Statement in accordance with the documentation requirements identified below in cases where documentation is available. Any of the following documents is appropriate for verifying income:

- **Income Documentation:** Income documentation may include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, bank statements, or other appropriate indicators of income.

- **Participation in a Public Benefit Program:** Documentation showing current participation in a public benefit program including Social Security, Workers' Compensation, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, or other similar indigence related programs.

### **Documentation Unavailable**

In cases where the patient is unable to provide documentation verifying income, the following procedures should be followed:

- **Obtain Patient's Written Attestation:** Have the patient sign the Financial Assistance Application attesting to the accuracy of the income information provided; or
- **Obtain Patient's Verbal Attestation:** The Financial Counselor who is completing the Confidential Financial Statement may provide written attestation that the patient verbally verified the income calculation. In all cases, at least two attempts must be made and documented to attempt to obtain the appropriate income verification.
- **Expired Patients:** Expired patients may be deemed to have no income for purposes of the financial calculation. Although no documentation of income is required for expired patients, an asset verification process should be completed to ensure that a charity care adjustment is appropriate.

### **Uncooperative Patients**

Uncooperative patients are defined as unwilling to disclose any financial information as requested for Medicaid and/or charity care determination during the screening process. In these cases, the account will not be processed as charity care. The patient will be advised that unless they comply and provide the information, no further consideration will be given for charity care processing, and standard A/R follow-up will begin. Non-Compliant patients are defined as not meeting all required documentation for Medicaid/Medi-Cal screening, but qualifying for charity care. In these cases, the Financial Counselor may process the account for charity care, and the account will remain in the charity-pending financial class until the facility processes a charity write-off adjustment.

### **Abbreviated Application Process**

**Hospitals may establish an abbreviated application and verification process for those service areas in which they have determined that the typical level of charges are not high such as clinics, rural health clinics, emergency departments, and outpatient ancillary areas. In these service areas, the registration department or the financial counselor must at minimum document the family size and the total family gross income in order to determine the level of charity discount if any. In lieu of income documentation, the hospital must, at minimum, pull a credit report to be certain that the patient or the patient's guarantor seems to have a credit standing in line with their reported income. For example, if the patient reports \$1,000 of gross income per month but is making a large mortgage payment along with several credit card payments, the hospital should require further income verification. If a credit report is not available, document that fact in the patient notes. No further effort is required.**

### **Communication**

Adventist Health facilities are required to post signs in their admitting and registration areas that inform patients about their financial assistance policies. Additionally, patient statements should have standard language informing patients that they may request financial screening to determine eligibility for charity care. To the extent possible, these communications should be in the primary language of the patient.

Once a charity determination has been made, the outcome must be communicated to the patient. That communication may be accomplished by sending the patient Exhibit B (equivalent to MS4 system letters 72-74).

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**AUTHOR:** Patient Financial Services

**APPROVED:** SLT

**EFFECTIVE DATE:** 1/1/10

**DISTRIBUTION:** CFO, PFS Directors

**REVISION:** 2-18-05, 1-27-06, 1-24-08, 1-23-09 (Updated Federal Poverty Levels); 12/21/09

**EXHIBIT A**

Patient Name _____	Facility: _____	DOS: _____
Patient Number _____	<b>Confidential Financial Statement (Application)</b>	

**RESPONSIBLE PARTY**

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)		Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net
		Length of current employment

**SPOUSE**

Name	Social Security Number
Employer Name and Address	Business Phone
Position / Title	Monthly income – Gross
	Monthly income – Net
	Length of current employment

**DEPENDENTS**

Name & Year of Birth of all dependents in household	Total Number of dependents in household _____	Do Any Other Persons Contribute? If Yes, Amount: Yes/No _____ Amount _____
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**INCOME PER MONTH & ASSETS**

Dividends, Interest	\$	Child Support / Alimony	\$
Public Assistance / Food Stamps	\$	Rental Income	\$
Social Security	\$	Grants	\$
Unemployment Compensation	\$	IRA	\$
Workers' Compensation	\$	Other	\$
Savings	\$		

**EXPENSES PER MONTH**

Mortgage / Rent Payment:	\$	Balance:	\$	Medical / Dental	\$
Own Home? (Yes/No)				Doctor – Name	\$
Food	\$			Doctor – Name	\$
Utilities:	\$			Doctor – Name	\$
Electric	\$			Credit Cards:	\$
Gas	\$			Visa	Limit \$
Water / Sewer	\$			Mastercard	Limit \$
Trash	\$			Discover	Limit \$
Phone	\$			Other	Limit \$
Cable	\$			Installment Loans	\$
Auto Payments	\$			Child Support	\$
Auto Expenses	\$			Miscellaneous Expenses	\$
Insurance:					
Auto Premium	\$				
Life Insurance	\$				
Health Insurance	\$				

OFFICE USE ONLY  
 Gross income \_\_\_\_\_  
 Net income \_\_\_\_\_  
 Total Expenses \_\_\_\_\_  
 Total Net income(loss) \_\_\_\_\_

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

\_\_\_\_\_  
 PATIENT/GUARANTOR SIGNATURE

\_\_\_\_\_  
 DATE

**Note:** The Financial Statement (Application) is available in Spanish

Nombre del Paciente _____	OFICINA _____ DOS
Número del Paciente _____	<b>DECLARACION CONFIDENCIAL DE ESTADO FINANCIERO</b>

**PERSONA RESPONSABLE**

Nombre	Estado Civil	Número de Seguro Social
Dirección, ciudad, estado, código postal	¿Cuánto tiempo ha vivido en esta dirección?	Teléfono de su domicilio
Nombre y dirección de su empleador (Si está desempleado, ¿por cuánto tiempo?)		Teléfono de su trabajo
Empleo/Puesto	Ingreso mensual-Bruto	Ingreso mensual-Neto
		Tiempo en su empleo actual

**ESPOSA/ESPOSO**

Nombre	Número de Seguro Social
Nombre y dirección del empleador	Teléfono de su trabajo
Empleo/Cargo	Ingreso mensual-Bruto
	Ingreso mensual-Neto
	Tiempo en su empleo actual

**DEPENDIENTES**

Nombre y año de nacimiento de todos los dependientes que viven en su casa	Número total de dependientes que viven en su casa: _____	¿Alguna otra persona contribuye? Si la respuesta es sí, ¿con qué cantidad? : Sí/No _____ Cantidad _____
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**INGRESO MENSUAL Y ACTIVOS**

Dividendos, Intereses	\$	Manutención para hijos menores/esposa	\$
Ayuda pública/Cupones de alimentos	\$	Ingreso por alquileres	\$
Seguro social	\$	Acciones, bonos	\$
Compensación por desempleo	\$	Subvenciones ( <i>grants</i> )	\$
Compensación por accidente de trabajo	\$	Cuenta de jubilación individual ( <i>IRA</i> )	\$
Ahorros	\$	Otros inmuebles, sin incluir a su vivienda	\$

**GASTOS MENSUALES**

Pagos de hipoteca/alquiler	Saldo	\$	Gastos médicos/dentales	\$
¿Es propietario de su vivienda? (Sí/No) :				
Alimentos	\$		Doctor-Nombre	
Servicios públicos:	\$		Doctor-Nombre	
Electricidad	\$		Doctor-Nombre	
Gas	\$		Tarjetas de crédito:	
Agua-Alcantarillado	\$		Visa	\$
			Límite	\$
Recolección de basura	\$		Mastercard	\$
			Límite	\$
Teléfono	\$		Discover	\$
			Límite	\$
Cable	\$		Otras	\$
			Límite	\$
Pago de vehículos	\$		Préstamos a plazo	\$
Gasto de vehículos	\$		Manutención para hijos menores	\$
Seguro :	\$		Gastos misceláneos	\$
Prima de vehículos	\$			
Seguro de vida	\$			
Seguro médico	\$			

SOLO PARA USO DE LA OFICINA Ingresos brutos _____ Ingresos netos _____ Total de gastos _____ Ingreso neto total (pérdida) _____	Hasta donde me es posible saber, la información arriba proporcionada es correcta. Autorizo al Hospital o a su representante, para que obtengan un reporte de crédito para la verificación de mi situación financiera.
	_____ <b>FIRMA DEL PACIENTE/GARANTE</b>
	_____ <b>FECHA</b>

**EXHIBIT B**

Hospital Name \_\_\_\_\_ Date \_\_\_\_\_  
Hospital Address \_\_\_\_\_  
Hospital Phone \_\_\_\_\_

Guarantor Name \_\_\_\_\_  
Guarantor Address \_\_\_\_\_

RE: Account Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Dates of Service: \_\_\_\_\_  
Account Balance: \_\_\_\_\_

- Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do meet eligibility guidelines for full charity assistance on this account.
- Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do not meet eligibility guidelines for full charity assistance on this account.
- Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you meet eligibility guidelines for partial charity assistance on this account. (account balance) is the remaining portion, which is your responsibility to pay.

If you believe this decision is in error, you have the right to submit an appeal. Your appeal must be made in writing, addressed to the Patient Financial Services Director and mailed to the address on this letter.

If you have any questions, please feel free to contact us at (hospital phone) during normal business hours.

Patient Financial Services Department  
Hospital Name \_\_\_\_\_  
Hospital Phone Number \_\_\_\_\_

Hospital Name  
Hospital Address  
Hospital Phone

Date

Guarantor Name  
Guarantor Address

RE: Número de Cuenta:  
Nombre del Paciente:  
Fechas de Servicio:  
Balance de la Cuenta:

- Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted satisface las normas de elegibilidad para la asistencia de caridad por completo en esta cuenta.
- Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted no satisface las normas de elegibilidad para la asistencia de caridad por completo en esta cuenta.
- Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted satisface las normas de elegibilidad para la asistencia de caridad parcial en esta cuenta. \$(account balance) es la porción remanente, la cual es su responsabilidad de pagar.

Si usted cree que esta decisión está equivocada usted tiene el derecho de someterse una apelación. Su apelación debe ser escrita, dirigida al Director de Servicios Financiero, y enviado a la dirección en esta carta.

Si tiene alguna pregunta, por favor siéntase libre de llamarnos al (hospital phone) durante horas normales de oficina.

Departamento de Servicios Financieros del Cliente  
Hospital Name  
Hospital Phone Number

**EXHIBIT C****2009 Federal Poverty Levels (FPL)**

<b>Persons in family</b>	<b>48 Contiguous States and the District of Columbia</b>	<b>Alaska</b>	<b>Hawaii</b>
1	\$10,830	\$13,530	\$12,460
2	14,570	18,210	16,760
3	18,310	22,890	21,060
4	22,050	27,570	25,360
5	25,790	32,250	29,660
6	29,530	36,930	33,960
7	33,270	41,610	38,260
8	37,010	46,290	42,560
Each additional person	\$3,740	\$4,680	\$4,300

<http://www.aspe.hhs.gov/poverty/08poverty.shtml>