

Title: Patient Financial Assistance/Charity Care	Page 1 of 13
Policy #: MA1023	
Type: Business Office	
Standard: N/A	

POLICY:

The purpose of this policy is to establish the criteria by which patients can apply for financial assistance and the process and guidelines used in that process in compliance with applicable financial assistance regulations. In keeping with its social mission and responsibility to the community, Methodist Hospital of Southern California (MHSC) will assist patients without insurance coverage in obtaining coverage through government means-tested programs such as Medi-Cal, Covered California (Affordable Care Act/ Medi-Cal HMOs) and other programs that may exist from time to time. Additionally MHSC may be able to provide temporary financial help for medical care (charity care) for uninsured patients with the greatest financial need.

MHSC provides a reasonable amount of its services without charge to financially eligible patients who cannot afford to pay for care. All emergency and medically necessary services as defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury, except for elective cosmetic procedures, can be considered for financial assistance. Financial assistance discounts will be written off based on a determination under this policy that the patient/other responsible party has demonstrated an inability to pay. However, in cases where it is determined that the account has not been paid and no demonstrated hardship under this policy has been provided, such accounts will be characterized as “bad debts” and collection of such accounts will be pursued, including referrals of such accounts to a collection agency.

1.0 DEFINITIONS

1.1 FINANCIAL ASSISTANCE previously referred to as CHARITY CARE, IS DEFINED AS FOLLOWS:

1.2 Financial Assistance is financial aid to a patient or responsible party and does not include discounts normally given to insurance policy holders, contract prices that are negotiated with insurance companies or other adjustments once the final bill has been created. When the patient is able to pay part of their bill, consideration will be given to writing off a portion of that account as partial financial assistance. Financial Assistance may also

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include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

- 1.3 Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay.
 - 1.4 REASONABLE PAYMENT PLAN: means monthly payments that are not more than 10 percent of the patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses of 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.
 - 1.5 If after a payment plan is established and there is a period of 90 days of no payment, the payment plan will be deemed to be no longer operative.
- 2.0 FINANCIAL ASSISTANCE PATIENTS ARE DEFINED AS FOLLOWS:
- 2.1 Uninsured patients (those without third party insurance, Medicare, Medicaid, or with injuries or conditions qualifying for coverage worker's compensation or automobile insurance for injuries) who do not have the ability to pay based on criteria described in the Eligibility section below.
 - 2.2 Insured patients whose insurance coverage and ability to pay are inadequate to cover their out of pocket expenses.
 - 2.3 Insured patient unable to pay for portion of the bill due to uncollected co-payments, deductibles and non-covered services. .
 - 2.4 An insured or uninsured patient with high medical costs, whose household income does not exceed 350% of the federal poverty level, but whose out-of-pocket medical costs or expenses exceed 10% of their income for the prior year.
 - 2.5 Any patient who demonstrates an inability to pay, versus bad debt, which is the unwillingness of the patient to pay.
- 3.0 AMOUNTS GENERALLY BILLED
- 3.1 The AGB, (Amounts Generally Billed) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a discount which is equal to the average amounts historically allowed as a

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percentage of billed charges for all services provided under the Medicare program for a 12-month look back period calculated in accordance with IRC 501(r). Please see appendix A for the AGB calculation.

3.2 The amount “charged” is the amount the patient is personally liable to pay, after applying deductions, discounts and the insurance reimbursement.

3.2.1 In the event the patient has insurance, the total payments may exceed the AGB, however, the individual will only be required to pay an amount at or less than the AGB.

3.2.1.1 Exceptions for a person qualifying for charity under this policy is the AGB does not apply to government agencies, nonprofits or businesses that assume an individual’s debt.

3.2.1.1.1 The AGB limitations will apply for other individuals who assume an individual’s debt.

4.0 COVERED ENTITIES

4.1 Only Hospital, which includes all services and areas listed on our license from the state of California including but not limited to inpatient and outpatient services, Colorectal Clinic and Gynecologic Oncology Clinic is covered under this financial assistance policy. Any ancillary physician billing that may be generated during a patient’s stay, i.e. pathology, radiology, anesthesia services are not covered under this policy.

4.2 Emergency Room physicians are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462. See appendix B for a list of providers that provide emergency and medically necessary services at Hospital.

5.0 PROCEDURES

5.1 The following are the procedures related to the Patient Financial Assistance/Charity Care at MHSC

6.0 NOTICE TO PATIENTS

6.1 Communication and notification of the availability of the financial assistance policy within the community of each hospital shall be in

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accordance with AB774, SB350, SB1276 and the federal Patient Protection and Affordable Care Act (PPACA).

- 6.2 The hospital will post notices informing patients of the hospital's financial assistance program. The notice will be posted in inpatient and outpatient areas of the hospital, including the emergency department, patient admissions and registration offices and outpatient settings. The notice will include contact information on how a patient may obtain more information on the financial assistance program.
 - 6.3 All patients will be informed of the hospital's financial assistance program at the time of admission or registration and will be offered a copy of the plain language version of the policy as well as an application for assistance.
 - 6.4 The hospital will provide the financial assistance policy and application translated into the language spoken by the patient consistent with section 12693.30 of the Insurance Code and Health and Safety Code Section 127410(a).
 - 6.5 All printed statements of accounts to the patient will include a summary of the financial assistance policy with contact information on how to obtain an application for assistance and the copy of the complete policy. A summary of the FAP, the application for assistance with instructions will be sent out with the first two statements of account to the guarantor.
 - 6.6 The financial assistance policy and the plain language summary are available on the hospital's web site and/or the on-line patient portal.
 - 6.7 All patients without insurance coverage will be counseled as to the financial options for paying their medical care upon registration, or as soon after presentation to the hospital as allowed under EMTALA.
 - 6.8 MHSC will include charity care services to patients for which MHSC is unable to assess the patient's financial condition prior to rendering services as required by the Emergency Medical Treatment & Active Labor Act (EMTALA). See amounts generally billed for charge amounts.
- 7.0 ELIGIBILITY DETERMINATION:
- 7.1 Gross income should fall within established standards for determination of the federal poverty level, considering family or household size, geographic area and other pertinent factors. {See grid in Appendix B}.
 - 7.2 The term "income" shall mean the annual family or household earnings and cash benefits from all sources before taxes, less payment made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family or household income. {see 2 (e) below for definition of Family or household}
 - 7.3 Financial assets will be considered to the extent allowed by financial assistance regulations.

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- 7.4 Employment status will be considered along with the projected availability of future earnings sufficient to meet the obligation within a reasonable period of time.
- 7.5 Family or household size will be considered. For this purpose, “Family or Household” for an adult patient is defined as spouse, domestic partner, dependent children under the age of 21, whether living at home or not and anyone else claimed as a dependent on the patient’s federal tax return. For patients under the age of 18, “Family or household” is defined as the patient’s parent(s) and/or caretaker relatives, other children under 21 years of age of the parent or caretaker relative and anyone else claimed as a dependent on the patient’s federal tax return.
- 7.6 Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.
- 7.7 Patients whose out-of-pocket medical expenses exceed 10% of their prior year income and whose household income is 350% or below of the federal poverty level are eligible for financial assistance.
- 7.8 A letter is requested to be submitted, along with the other documentation, detailing the patient’s need for financial assistance and stating a request for aid.
- 7.9 The amount(s) and frequency of the hospital bill(s) in relation to all of the factors outlined above will be considered.
- 7.10 There will be a credit report run to verify financial and related information that will assist in making a determination about the patient’s eligibility for financial assistance.
- 7.11 Before making any determination of whether all or part of an account qualifies for financial assistance treatment and the amount of any write-off that should be applied, the patient shall be required to assist the Hospital in obtaining payment from and helping to assure that all other resources will be first applied, including Medi-Cal, welfare and other third-party sources.
- 7.12 Patients that are eligible for Government sponsored low-income assistance programs (e.g. Medi-Cal /Medicaid, Healthy Families, California Children’s Services and any other applicable state or local low-income programs) to be automatically eligible for full financial assistance when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and some CCS) where the program does not make payment for all services or days during a hospital stay are eligible for Financial Assistance coverage. Under MHSC’s financial assistance policy, these types of non-reimbursed patient account balances are eligible for full write-off as financial assistance. Specifically, included as financial assistance are charges related to denied stays or denied days of care. All Treatment Authorization Request (TAR) denials provided to Medi-Cal/Medicaid and other patients covered by qualifying low-income programs, and other

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denials (e.g. restricted coverage) are to be classified as Financial Assistance.

- 7.13 In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, i.e., existing eligibility for Medicaid this source of information can be used to support and/or validate the decision for qualifying a patient for full financial assistance.
- 7.14 Unless a patient is informed otherwise, Financial Assistance provided under this Policy shall be valid for six months beginning on the first day of the month of the screening. However, Hospital reserves the right to re-evaluate a patient's eligibility for Financial Assistance during that six-month time period if there is any change in the patient's financial status. Additionally, financial assistance provided to non-responsive patients based on other sources of information will not be valid for the full year, and will only be applicable for the eligible retroactive dates of service.
- 7.15 Patients will be notified in writing of the financial assistance approval amount. If a full discount was not approved the notification will indicate why and what additional steps if any that could be taken to obtain additional coverage.
- 7.16 The business office has the final authority to determine if reasonable efforts have been made to determine FAP eligibility.
- 7.17 Patients completing Financial Assistance Applications are responsible for making reasonable effort to supply the information needed to make a determination. Failure to provide that information may result in a denial of the Financial Assistance Application.
- 7.18 To the extent the patient is determined to not be FAP eligible or at least not determined to be eligible at the time of the charge, (i.e. billing was issued prior to submitting a completed application), the patient may be charged in excess of the AGB.
- 7.19 Under no circumstances will a FAP application be considered in excess of 240 days from the date of first billing.
- 7.20 Financial Assistance status will be determined after the time of discharge by the Business Office after all required documentation is submitted by the patient or responsible party (see Section 7(a) below). There may be some instances where, because of complications unforeseen at the time of admission, the hospital charges turn out to be considerably greater than anticipated or estimated, and the patient is unable to pay the full amount. A patient may request a financial assistance application form from a financial counselor at any time. If the patient is unable to complete the form, the patient's surrogate decision maker may assist in completing the form, or the patient may ask for assistance from the financial counselor.
 - 7.20.1 Once the account is settled, the information used for determination will be kept on file in the Business Office.

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7.20.2 Patients who are not eligible for financial assistance or are eligible to receive partial assistance which leaves them owing a balance due to the Hospital may request a payment plan from the Business Office.

7.20.3 In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in the Billing and Collection policy. A copy of this policy can be obtained by contacting the business office.

7.21 For financial assistance consideration, (charity care policy), monetary assets are included in determining eligibility. 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. Discounts under other financial discount policies do not count monetary assets in determining eligibility.

8.0 FINANCIAL ASSISTANCE AND OTHER DISCOUNTS:

8.1 General Relief

8.1.1 General Relief patients usually do not qualify for Medi-Cal, because they are normally single, have no children, are unemployed and homeless. General Relief patients are considered financial assistance eligible patients.

8.2 Financial Assistance (full and partial)

8.2.1 To be eligible for financial assistance, a patient's or responsible family member's income must be at or below 350% of the federal poverty level. The patient or responsible family member must complete the financial assistance form and include the documentation as stated in Section IV.

8.2.1.1 Patients whose income and monetary assets are below 200% of the federal poverty level will receive financial assistance equal to 100% of the Amounts Generally Billed as defined in Section III above.

8.2.1.2 Patients whose income is between 200% and 250% of the federal poverty level will receive a financial assistance discount equal to 75% of the Amounts Generally Billed as defined in Section III above.

8.2.1.3 Patients whose income is between 250% and 300% of the federal poverty level will receive a financial assistance

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discount equal to 50% of the Amounts Generally Billed as defined in Section III above.

8.2.1.4 Patients whose income is between 300% and 350% of the federal poverty level will receive a financial assistance discount equal to 25% of the Amounts Generally Billed as defined in Section III above.

8.2.2 The remaining balance, for patients qualifying for partial financial assistance, may be paid in interest-free installments as mutually agreed upon between the patient and Methodist Hospital. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, the agency agrees to abide by the requirements of this policy and will not garnish wages or place a lien on a principal residence.

8.2.3 In accordance with this policy, Methodist Hospital of Southern California will appropriately determine the financial status of each patient to distinguish uncompensated costs between charity care and bad debt. CHARITY is defined as the demonstrated inability of a patient to pay, versus BAD DEBT as the unwillingness of the patient to pay.

9.0 ELIGIBILITY STANDARDS:

9.1 Sliding scale based on federal poverty guidelines will be used to evaluate the level of financial assistance. See MA1023 Appendix A for more details regarding the current federal poverty guidelines specific to MHSC

10.0 OTHER FUNDING

10.1 Victims of Crime (VOC)

10.1.1 Patients who are a victim of a crime could be eligible for State of California funding from the VOC program. The patient can apply at the District Attorney's office at the courthouse in Pasadena. The patient will not qualify if:

10.1.1.1 There is insurance involved

10.1.1.2 He/she initiated the crime

10.1.1.3 He/she expires

11.0 ITEMIZED BILLS

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- 11.1 The final bill will be produced within ten days after discharge. The Business Office will automatically send the itemized bill. If a bill is not received, one can be obtained by calling the Business Office Customer Service at (626) 574-3594.
- 11.2 If the patient wishes to request an itemized bill while still a patient in the hospital, they may do so by calling (626) 574-3594 or by asking a financial counselor. The patient should keep in mind that an itemized bill requested during their stay will be incomplete and only list charges that have been put in the system through midnight of the previous day.

12.0 FINANCIAL ASSISTANCE FORM

- 12.1 The financial assistance form is located in Appendix C of this policy.
 - 12.1.1 Instructions:
 - 12.1.2 Please print and complete the form. The following documents need to be included to complete the Financial Assistance qualification process:
 - 12.1.2.1 A financial hardship letter, explaining your circumstances and request for financial assistance regarding your current financial situation.
 - 12.1.2.2 A copy of your most recent year's tax form (all pages, including the electronic submission verification or signature page).
 - 12.1.2.3 Copies of your two most recent paycheck stubs for all jobs
 - 12.1.2.3.1 If you have no income, a letter of support from yourself or the person who is assisting you financially.
 - 12.1.2.3.2 Copies of any other documents assist in verifying income, such as social security, disability, unemployment. Proof of alimony or child support are also required.
 - 12.1.2.4 Copies of bank statements (all pages) for the past 2 months, for each account.
 - 12.1.2.5 If you have been denied support through a program like Medi-Cal, Social Security and etc. include copies of this as well.

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12.1.3 Then, hand deliver or mail the forms, letter, and supporting documents to:

Methodist Hospital of Southern California
 Attn: Business Office - Financial Assistance Program,
 Customer Service
 300 West Huntington Drive
 P.O. Box 60016
 Arcadia, CA 91066

12.1.4 For questions regarding this form, please call: (626) 574-3594 from 8:00am-4:30pm Monday - Friday.

12.1.5 Assistance completing the application, obtaining copies of this policy, or answering any related financial assistance questions can be obtained by calling (626) 574-3594 from 8:00am-4:30pm Monday - Friday.

12.1.5.1 If the electronic copies are not a viable option, this Charity Policy, Charity application form, Billing and Collection Policy and Plain Language Summary (PLS) of the Financial Assistance Program are available upon request and without charge both by mail and in public locations within the hospital facility, including, at a minimum, in the emergency room and admission areas.

12.1.6 The approved application and any discounts can be applied to any subsequent hospital visits in the same calendar year the application was first approved, pending it is within the valid for six months beginning on the first day of the month of the screening.

12.1.7 The application and accompanying documents must be returned to business office within 15 days. If an additional time is needed to complete the application please call the business office.

12.1.8 Copies of all the financial assistance policies and the application can be found on our website <https://www.methodisthospital.org/For-Patients-Visitors/Financial-Assistance-for-Patients.aspx>

12.1.9 These policies are also available translated into the following written languages. Refer to Appendix C for an outline of the current language translations.

13.0 FINANCIAL ASSISTANCE APPLICATION REVIEW/APPROVAL PROCESS

13.1 A Financial Assistance Application will be reviewed by a business office financial counselor. If gross income is at or below 250% of FPG, the

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counselor may approve the financial assistance application, based on the information submitted with the application (proof of income required). If the gross income is more than 250% but less than 350% of FPG, an assessment for qualification of partial financial assistance based on income, assets, and medical debt load will be made by the financial counselor.

- 13.2 Financial Assistance Applications will be reviewed and approved, denied or returned to the patient with a request for additional information within thirty (30) business days of receipt.
- 13.3 Collection agency requests for financial assistance or Financial Assistance Applications received from a collections agency shall be reviewed by a MHSC Financial Counselor. The counselor shall follow the review process described above in determining ability to pay and approving partial, total or no financial assistance. Standard transaction approval levels will apply, regardless of the application source.
- 13.4 An approved financial assistance determination is applicable to all services referenced in the application AND services provided up to the end of the calendar year within which the services were rendered, provided there is no change in the applications financial status that would warrant a reevaluation or the services were within the valid six month period beginning on the first day of the month of the screening, of the calendar year.
- 13.5 If financial assistance is approved at 100%, any patient deposits paid toward accounts approved for financial assistance must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and financial assistance will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. In the event the refund is \$5 or less, no monies will be refunded.
- 13.6 In the granting of charity care, no consideration will be placed on a patient's race, religion, ethnic background, sexual orientation, gender, residency status, political affiliation, or other discriminatory factors. However, patients requesting charity care, discounted care or other financial assistance must make every reasonable effort to provide MHSC with required documentation of insurance coverage and of financial status. Failure to provide information that is reasonable and necessary may be

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considered by the hospital in making its determination. Additionally, patients who are eligible for coverage through government insurance or programs that provide financial assistance to pay for coverage under the ACA but refuse to obtain such coverage may be excluded from MHSC's charity program.

- 13.7 For a patient deemed to be ineligible for charity care, MHSC provides a discount from charges to patients without insurance coverage (See Cash Discount Policy MA 1035). Insured patients with a co-pay and/or deductible are not eligible for a further cash discount, per contractual obligations, as the insurer has already negotiated a discounted rate with MHSC. However, financial assistance is available in accordance with this document and/or payment plans may be available.
- 13.8 Patients will be notified in writing regarding MHSC's decision to approve or, deny charity care coverage or if there is a need for additional documentation to make a decision.
- 13.9 In instances where MHSC determines that only a portion of a patient's financial liability qualifies as charity care due after applying all other resources, the patient is expected pay the remaining portion. If the patient refuses to pay the amount determined to be his/her responsibility, the uncollectible remainder would become bad debt.

14.0 DISPUTE RESOLUTION

- 14.1 In the event of a dispute, a patient may seek review from the Finance Director by calling (626) 574-3401 or using the address provided in section 12.1.3 of this policy.

15.0 SOURCES

- 16.0 Treasury Regulation § 1.501(r)
- 17.0 California SB 1276

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Attachments: [Office Use Form](#), [Financial Assistance Application](#), [Appendix A](#), [Appendix B](#), [Appendix C](#)

Approvals:

Board of Directors: 11/17, 4/18
CFO: 11/17, 3/18
Chief Financial Officer: 8/14
Director of Patient Financial Services: 8/14
Executive Dir Finance: 11/17, 3/18
Governing Policy and Procedure Committee: 8/14, 11/17, 3/18
MAPPS: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11

Effective Date: 5/90

Reviewed Dates: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 8/14, 11/17, 4/18

Revised Dates: 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 8/14, 11/17

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APPENDIX A

CALCULATION OF AMOUNT GENERALLY OWED BY INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

Methodist Hospital of Southern California (MHSC) limits the amount owed by individuals eligible under this Financial Assistance Policy who received services except for cosmetic and elective procedures to an Amount Generally Billed (AGB) to patients covered by Medicare. In addition, the hospital also limits the eligible patient's financial responsibility to less than total charges. The hospital shall periodically, at least once a year, update the AGB calculation and re-evaluate the method used. The AGB shall be based on all services provided to Medicare patients fully adjudicated as of the end of a recent 12-month look back period ending no more than 120 days prior to the effective date of the policy or every January 1st thereafter. The calculation of the current AGB is as follows:

1.0 Total Medicare Expected Reimbursement / Total Medicare Gross Charges = AGB Percentage
(AGB is 16% effective January 1, 2022)

2.0 The eligible individual's financial responsibility is calculated as follows and applied to the patient liability only (excluding any portion assumed or paid by insurance or other entities on behalf of the patient):

2.1 Total Gross Charges for the Services Rendered * AGB % = Patient Financial Responsibility

3.0 Below is the FAP Eligibility Percentage and the latest published Federal Poverty Level (FPL) Guideline:

Annual Income is	FAP Eligibility %
Below 200% of FPL	100% or FREE
200% to 267% of FPL	75%
268% to 335% of FPL	50%
336% to 400% of FPL	25%
Greater than 400% of FPL	0%

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Federal Poverty Guideline 2022					
Percent Discount		100%	75%	50%	25%
Household/ Family Size					
	100%	200%	267%	335%	400%
1	\$ 13,590	\$ 27,180	\$ 36,285	\$ 45,527	\$ 54,360
2	\$ 18,310	\$ 36,620	\$ 48,888	\$ 61,339	\$ 73,240
3	\$ 23,030	\$ 46,060	\$ 61,490	\$ 77,151	\$ 92,120
4	\$ 27,750	\$ 55,500	\$ 74,093	\$ 92,963	\$ 111,000
5	\$ 32,470	\$ 64,940	\$ 86,695	\$ 108,775	\$ 129,880
6	\$ 37,190	\$ 74,380	\$ 99,297	\$ 124,587	\$ 148,760
7	\$ 41,910	\$ 83,820	\$ 111,900	\$ 140,399	\$ 167,640
8	\$ 46,630	\$ 93,260	\$ 124,502	\$ 156,211	\$ 186,520

For Households/families with more than 8 persons, add \$4,720 for each additional person.

Note: The 2022 Federal Poverty Guideline is effective as of January 12, 2022

APPENDIX B

Hospital Emergency & Other Providers

- 1.0 Emergency Room physicians are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462.
- 2.0 The following providers may be utilized in providing emergency or medically necessary care, but these are NOT covered by the hospital's financial assistance policy. This list is not all inclusive. Only services provided by Hospital, excluding any professional services, are covered by the financial assistance policy.

Anesthesiology

Pacific Valley Medical Group
ABC Billing Solutions
8905 SW Nimbus Ave, Suite 300
Beaverton, OR 97008
503 372-2740

Pathology – Professional Fees

Medical Billing Management, Inc.
2320 Cotner Ave
Los Angeles, CA 90064
310 696 -5400

Emergency Physicians

Emergency Group Office
180 Via Verde, Suite 100
San Dimas, CA 91773
626 821 5702

Radiology – Interpretation Fees

California Medical Business Services
223 N. First Avenue, Suite 201
Arcadia, CA 91006
626 821-1411

- 3.0 In accordance with the state regulations the following specialties of physicians have medical staff privileges at MHSC however, the physician-patient relationship is affiliated with the independent physician practice. These groups may offer financial assistance programs but are NOT covered by this policy. It is the patient's responsibility to contact the physician and or group to inquire about any financial assistance programs offered.
- 4.0 Physician Specialties NOT included in the policy:

Physician Specialties Types		
Allergies	Hospitalist	Pathology
Anesthesiology	Infectious Disease	Pediatrics
Cardiology	Internal Medicine	Perinatology
Clinician	Med Neurology	Plastic Surgery
Colon/Rectal Surgery	Neonatology	Podiatry
Dermatology	Nephrology	Psychiatry
Emergency Medicine	Neurosurgery	Pulmonology

Endocrinology	Ob/Gyn	Radiology
Family Practice	Ophthalmology	Rheumatology
Gastroenterology	Oral Surgery	Thoracic Surgery
General Hospital Sta	Orthopedics	Urology
General Surgery	Other	Vascular Surgery
Gynecology	Otolaryngology	Vascular Surgery
Hematology/Oncology	Palliative Care	

- 5.0 As a normal act of the Hospital business, the physician specialties will be added or removed accordingly. As such the above listing is a reasonable representative sample of the physician / surgeons on staff that may vary at times.
- 6.0 In addition, MHSC owns and operates two clinics; these are the MHSC Colorectal Clinic and the MHSC Obstetrics/Gynecology Clinic. MHSC will bill for services provided at these clinics and ARE included in this financial assistance program. However, the physicians seeing the patient at these clinics are entitled to bill for their professional fees of which are NOT included under this financial assistance program. As such, this physician will bill for these professional fees under a separate billing and may have a separate financial assistance program for which the patient may inquire.

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APPENDIX C

FAP Application with Instruction Including the Medi-Cal Screening

The following is the Financial Assistance Program Application. This application, policy and other related information are also available translated into the following written languages:

Mandarin (Standard Chinese), Spanish and Cantonese (Standard Chinese).

The following pages are the Methodist Hospital of Southern California Financial Assistance Program Application complete with the related instructions and includes the Medi-Cal Screening document.

Financial Assistance Program

If you need help paying for your medical services you may be eligible for Methodist Hospital's Financial Assistance Program. Please use this brochure to help determine if you qualify, as well as to apply for financial assistance. The Financial Assistance Program is a discretionary program offered by Methodist Hospital to all patients for services that are medically necessary. You must apply within six months of when you received the services you are applying for.

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Applying for the Financial Assistance Program

You must meet the following criteria to be eligible for the Financial Assistance Program:

Types of Care: You must be receiving medically necessary services.

Other Payer Sources: We recommend that you apply for any private or public sector sources of medical financial assistance for which you're eligible, such as Medi-Cal or Healthy Families. You may be required to submit documentation of your application (or of the approval or denial of your application) to those sources. For services received which are the result of an accident you must show proof that there was no settlement before financial assistance can be considered.

Income: Your household income must be at or below 350 percent of the Federal Poverty Guidelines (FPG).

2021 Federal Poverty Guidelines					
Household/ Family Size	Poverty Base Line at 100%	200% and Below	201% to 250%	251% to 300%	301% to 350%
% WriteOff	➡	100%	75%	50%	25%
— Income Levels for ALL income sources to the Household —					
1	\$12,880	\$25,760	\$32,200	\$38,640	\$45,080
2	\$17,420	\$34,840	\$43,550	\$52,260	\$60,970
3	\$21,960	\$43,920	\$54,900	\$65,880	\$76,860
4	\$26,500	\$53,000	\$66,250	\$79,500	\$92,750
5	\$31,040	\$62,080	\$77,600	\$93,120	\$108,640
6	\$35,580	\$71,160	\$88,950	\$106,740	\$124,530
7	\$40,120	\$80,240	\$100,300	\$120,360	\$140,420
8	\$44,660	\$89,320	\$111,650	\$133,980	\$156,310
8+ *	\$4,540	\$9,080	\$11,350	\$13,620	\$15,890
Source: Federal Register/Vol. 86, No. 19/Monday, February 1, 2021/Page 7733					
* For households with more than 8 persons, add \$4,540 for each additional person					

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Special Circumstances: If you have unusually high medical costs or you've experienced a catastrophic event, you may be eligible for the Financial Assistance Program under special circumstances, regardless of whether you meet the household income requirements described above. To qualify, you'll need to provide income documentation and copies of your out-of-pocket medical expenses for the past 12 months indicating that these expenses equal 10 percent or more of your annual gross income.

Please note: Not all medical expenses qualify for financial assistance. Exclusions include, but are not limited to, expenses for premiums and dues, optical and hearing aids, medical supplies, health education classes, transportation, over-the-counter drugs and lifestyle medications (fertility, cosmetic, etc.).

Documentation required:

- A financial hardship letter, explaining your current financial situation.
- A copy of your most recent federal tax return with electronic submission verification or your signature (include all pages and schedules); and
- A copy of a current pay stub with year-to-date (YTD) income included. If YTD income is not listed, then copies of two consecutive pay stubs; or
- Copies of other documents to verify income, such as letters from disability, social security, unemployment agencies, or proof of alimony/child support payments; or
- If you have no income, a letter of support that explains your means of living, and
- A copy of the most recent bank statement for all accounts; and
- Any other documentation that may be requested

Be sure to send only photocopies as originals will not be returned to you. You'll have an opportunity to appeal the decision if your application is denied. Corrected and/or additional documentation will be required to support your appeal request. Upon finalization of your application, notification of your determination will be mailed to the address on file.

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Submit Your Application To:

Methodist Hospital of Southern California
Business Office - Financial Assistance Program
300 West Huntington Drive
P.O. Box 60016
Arcadia, CA 91066-6016

Phone: (626) 574-3594
Fax: (626) 821-6917

Hours: Monday-Friday, 8:00 am – 5:00 pm

Help in Your Language

Interpreter lines are available during regular business hours to assist you with questions regarding the financial assistance program. In addition, you are able to get materials written in the languages outlined above (on page one of this appendix). For more information, call our Customer Service Line at (626) 574-3594, weekdays from 8:00 am to 5:00 pm.

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METHODIST HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Methodist Hospital reserves the right to amend or retrace awards

APPLICATION

Patient Name: _____ Acct.# _____

Patient/Guarantor (Responsible Party Information):

Name: _____

Relationship to Patient: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____ Date of Birth: _____

Social Security Number: _____ Mother's Maiden Name: _____

Patient's Birth City/State/Country _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow(er) ☐ Single ☐ Domestic partner

Spouse/Domestic Partner Information:

Name: _____

Social Security Number: _____ Date of Birth: _____

Household size (including yourself, your spouse or domestic partner and all dependents): _____

List All Household Members you Financially Support:

Dependent's name: _____

Date of birth: _____ Relationship: _____

Dependent's name: _____

Date of birth: _____ Relationship: _____

Dependent's name: _____

Date of birth: _____ Relationship: _____

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Employment Status:

Patient currently employed? ☐ Yes ☐ No Employer: _____

Spouse/Domestic partner employed? ☐ Yes ☐ No Employer: _____

SECTION A: CURRENT MONTHLY GROSS INCOME (All income from household must be reported).

If household income is zero, please initial here _____ and give a brief explanation of your financial situation: _____

Who is the primary wage earner? (check one) ☐ Patient

☐ Spouse/Other

Gross monthly salary/wages (before taxes)	\$ _____	\$ _____
Cash income (not including gifts)	\$ _____	\$ _____
Gross Social Security income	\$ _____	\$ _____
Other income: <input type="checkbox"/> Unemployment benefits	\$ _____	\$ _____
<input type="checkbox"/> State disability income	\$ _____	\$ _____
<input type="checkbox"/> Alimony or child support	\$ _____	\$ _____
<input type="checkbox"/> Pension income	\$ _____	\$ _____
<input type="checkbox"/> Rental property income	\$ _____	\$ _____
<input type="checkbox"/> Other sources (describe)	\$ _____	\$ _____
	\$ _____	\$ _____

Total monthly income: \$ _____ \$ _____

SECTION B: ASSETS (MARKET VALUE OF THINGS YOU OWN)

Checking Acct	Bank _____	Acct# _____	\$ _____
Savings Acct:	Bank _____	Acct# _____	\$ _____
Other Acct(s):	Bank _____	Acct# _____	\$ _____
Home Value:			\$ _____
Other Real Estate Value (explain):			\$ _____
Business Owned:			\$ _____
Franchise:			\$ _____
Other Assets:			\$ _____
Total Assets:			\$ _____

SECTION C: MEDICAL EXPENSES

(If your household income exceeds 350 percent of the Federal Poverty Guidelines (FPG) or if you're applying for special circumstances, you must complete this section. Copies of receipts and/or itemized invoices are required.)

Out-of-pocket medical expenses due or paid in the last 12 months:

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☐ Hospital or office visits: \$ _____
☐ Prescribed medications: \$ _____
☐ Other expenses (please describe): \$ _____

SECTION D: **MEDI-CAL SCREENING** (if you currently don't have Medi-Cal you must complete this section.)

If you've already applied for Medi-Cal and have a recent approval, denial, or pending letter, please submit it with your completed Financial Assistance application.

If you answer YES to any of the questions below, contact your local County Social Security Office.

- ☐ Are you younger than 21 or older than 65? ☐ Yes ☐ No
- ☐ Are you currently enrolled in Supplemental Security Income (SSI)/State Supplemental Payment (SSP) or Security Disability Insurance?..... ☐ Yes ☐ No
- ☐ Are you enrolled in CalWorks (AFDC), Entrant or Refugee Cash Assistance (ECA/RCA), Foster Care or Adoption Assistance Programs, or In-home Support Services (IHSS)? ☐ Yes ☐ No
- ☐ Are you legally blind? ☐ Yes ☐ No
- ☐ Are you permanently disabled? ☐ Yes ☐ No
- ☐ Are you pregnant or have you been pregnant in the last three months..... ☐ Yes ☐ No
- ☐ Have you been diagnosed with breast, cervical or prostate cancer?..... ☐ Yes ☐ No
- ☐ Are you being transferred to a skilled nursing facility or intermediate home care?... ☐ Yes ☐ No
- ☐ Do you have children younger than 21 (including unborn or adopted children) in the home? ☐ Yes ☐ No
 - ☐ If YES:
 - Is one of the child's parents absent or deceased? ☐ Yes ☐ No
 - Is one of the child's parents permanently disabled? ☐ Yes ☐ No
 - Is the primary wage earner unemployed or working less than 100 hours per month? ☐ Yes ☐ No

SECTION E: **MISSING INCOME DOCUMENTATION**

If you don't have income documentation, your signed attestation in this application **may** satisfy the income verification requirement if you meet any of the following criteria:

- ☐ I don't receive a formal pay stub from my employer.
- ☐ I receive no income. (If you check this box, you must provide a written explanation of your financial situation).
- ☐ I wasn't required to file a recent Federal or State Tax Return for the most recent tax year.

SECTION F: **FINANCIAL AGREEMENT AND CREDIT REPORT AUTHORIZATION**

I hereby declare under penalty of perjury that (i) all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents, or (ii) I am unable to provide documents relating to proof of income or other evidence of my income. I authorize employees and agents of Methodist Hospital of Southern California (MHSC) to investigate and verify that the information I have provided to it, including employment and credit

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METHODIST HOSPITAL FINANCIAL ASSISTANCE PROGRAM

history, for the purpose of determining my eligibility to participate in the Financial Assistance Program. I also acknowledge and agree that I am liable to MHSC for any and all amounts owing to MHSC for medical goods and services that are not covered by the Financial Assistance Program (the remaining amounts).|

Signature of Applicant/Guardian _____ Date _____

Signature of Spouse of Applicant/Guardian _____ Date _____