

Sutter Health and Mills-Peninsula Health Services Administrative Policies and Procedures	
POLICY ON FINANCIAL ASSISTANCE FOR UNINSURED PATIENTS, INCLUDING CHARITY CARE	
Finance Policy Number: 14-294 Supersedes 14-285, 14-291,14-292, 14-293	Date: 10/90 Revised Date: 07/08 Next Review Date: - 07/09
Approved by: Bob Merwin, President & CEO	

POLICY

It is Sutter Health’s policy that all hospital affiliates shall provide Financial Assistance, consistent with this policy, in the form of free or discounted care to eligible:

- (1) **Low-income Uninsured Patients**
(Full Charity Care, Partial Charity Care, Special Circumstances Charity Care);
- (2) **Patients with high medical costs**
(Catastrophic Charity Care, High Medical Cost Charity Care); and
- (3) **Uninsured Patients**
(Uninsured Patient Discount, Prompt Payment Discount).

Further, Sutter Health's policy is to provide Uninsured Patients with information required by law regarding their estimated financial responsibility for services and the availability of Financial Assistance and discounts. *Any modification of this policy must be approved in writing by the Sutter Health Controller.*

PURPOSE

This policy is intended to:

- (1) Define the forms of available Financial Assistance and the associated eligibility criteria; and
- (2) Establish the processes that patients shall follow in applying for Financial Assistance and the process the hospital will follow in reviewing applications for Financial Assistance; and
- (3) Provide a means of review in the event of a dispute over a Financial Assistance determination; and
- (4) Provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance; and
- (5) Establish the process that patients shall follow to request an estimate of their financial responsibility for services, and the process the hospital shall follow to provide patients with these estimates.

GENERAL INFORMATION

A. Interaction with Other Policies.

This policy is intended to be read with the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227).*

B. Scope of Policy.

This policy does not create an obligation for hospital affiliates to pay for charges of physicians or other medical providers including anesthesiologists, radiologists, hospitalists, pathologists, etc. not included in the hospital bill.

DEFINITIONS AND ELIGIBILITY

*** Financial Assistance is available to eligible patients who receive Covered Services and who follow applicable procedures (such as completing applications and providing required information).**

- A. **Financial Assistance:** The term Financial Assistance refers to Full and Partial Charity Care, Special Circumstance Charity Care, Catastrophic Charity Care, High Medical Cost Charity Care, the Uninsured Patient Discount, and the Prompt Payment Discount. Guidelines for

determining when the Financial Assistance policy applies to particular circumstances that arise during the ordinary course of business are set forth in Attachment C.

1. **Full Charity Care:** Full Charity Care is a *complete* write-off of the hospital's undiscounted charges for Covered Services. Full Charity Care is available to patients:
 - a. Whose Family Incomes are at or below 350% of the most recent Federal Poverty Income Guidelines (Attachment B) (the 350% threshold represents the minimum required to be offered to low-income uninsured patients; hospital affiliates may adopt a higher income threshold); and
 - b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability.

2. **Partial Charity Care:** Partial Charity Care is a *partial* write-off of the hospital's undiscounted charges for Covered Services available to patients:
 - a. Whose Family Incomes are between 351% and 500% of the federal poverty level according to the most recent Family Federal Poverty Income Guidelines (Attachment B); and
 - b. Who have no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability.
 - c. For patients whose Family Incomes are between **351% and 500%** of the most recent Family Federal Poverty Income Guidelines (Attachment B) the expected payment shall not exceed 120% of the rates set forth in section 2c above.

3. **Special Circumstances Charity Care:** Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance criteria set forth in section 1 or 2, above, or who are unable to follow specified hospital procedures, to receive a complete or partial write-off of the hospital's undiscounted charges for Covered Services, with the approval of the affiliate hospital Chief Financial Officer, or designee. The hospital must document the decision, including the reasons why the patient did not meet the regular criteria. The following is a non-exhaustive list of some situations that may qualify for Special Circumstances Charity Care:
 - a. **Bankruptcy:** Patients who are in bankruptcy or recently completed bankruptcy;
 - b. **Homeless Patients:** Emergency room patients without a payment source if they do not have a job, mailing address, residence, or insurance.
 - c. **Deceased:** Deceased patients without insurance, an estate or third party coverage.
 - d. **Medicare:** Income-eligible Medicare patients may apply for Financial Assistance for denied stays, denied days of care, non-covered services and Medicare cost shares;
 - e. **Medi-Cal:** Income-eligible Medi-Cal patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services; however, patients may not receive Financial Assistance for the Medi-Cal share of cost. Persons eligible for programs such as Medi-Cal but whose eligibility status is not established for the period during which the medical services were rendered may apply for Financial Assistance.

4. **Catastrophic Charity Care:** Catastrophic Charity Care is a partial write-off of an Uninsured Patient's financial responsibility for Covered Services that is applied when an Uninsured Patient's financial responsibility exceeds 30% of their Family Income. Patients eligible for Catastrophic Charity Care will receive a full write-off of their undiscounted charges for Covered Services that exceed 30% of their Family Income. *[Uninsured Patient's financial responsibility for undiscounted charges for Covered Services] – [Family Income * 30%] = Catastrophic Charity Care write-off.*

5. **High Medical Cost Charity Care (for Insured Patients):** High Medical Cost Charity Care for Insured Patients ("High Medical Cost Charity Care") is a partial write-off of the hospital's undiscounted charges for Covered Services. High Medical Cost Charity Care is not available for patients receiving services that are already discounted (e.g., package discounts for cosmetic services). For inpatient services provided to patients who qualify for High Medical Cost Charity Care, affiliates shall limit expected payments to the Medicare inpatient DRG (or the highest rate the highest rate the hospital would expect in good faith to be paid by a government program in which the hospital participates). For outpatient services, affiliates shall limit expected payments to the Medicare fee schedule, or where there is no Medicare fee schedule rate, the hospital's undiscounted charges multiplied by the hospital's Medicare cost to charge ratio for outpatient services. This discount is available to insured patients who meet the following criteria:
 - a. The patient's Family Income is less than 351% of the Family Federal Poverty Income guidelines;
 - b. The patient's or the patient's family's medical expenses for Covered Services (incurred at the hospital affiliate or paid to other providers in the past 12 months) exceed 10% of the patient's Family Annual Income; and
 - c. The patient's insurer has not provided a discount off the patient's bill (i.e., the patient is responsible to pay undiscounted charges).

6. **Uninsured Patient Discount:** The Uninsured Patient Discount is a write-off of a portion of the hospital's undiscounted charges for Covered Services taken at the time an Uninsured Patient is billed for the hospital services rendered. The Uninsured Patient Discount does not apply to patients who qualify for charity care or receive services that are already discounted (i.e., package discounts for cosmetic services). Case rate and package rate pricing should not result in expected payment that is less than what the facility would expect had the Uninsured Patient Discount been applied to undiscounted charges for the services. Patients who are responsible for a hospital bill not covered or discounted by any type of insurance or governmental program, or whose benefits under insurance have been exhausted prior to admission are eligible for an Uninsured Discount if the patient or the patient's guarantor verifies that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill. Insurance in this case includes but is not limited to any HMO, PPO, indemnity coverage, or consumer-directed health plan.

7. **Prompt Payment Discount:** The Prompt Payment Discount is an additional partial write-off of the hospital's bill available to Uninsured Patients who pay promptly as described below. The Prompt Payment Discount is available only to patients receiving the Uninsured Patient Discount, as set forth in section 6, above and does not apply to insured patients' co-pays, deductibles, or cost shares. All affiliate hospitals must adopt the Post-Discharge Prompt Payment Discount as defined below. The Pre-Discharge Prompt Payment Discount is optional. If a hospital affiliate offers both discounts, patients may receive either the Uninsured Pre- or the Uninsured Post-Discharge Prompt Payment Discount, but not both.

- a. Post-Discharge Prompt Payment Discount: The Post-Discharge Prompt Payment Discount is a partial write-off of at least 10% of the amount owed by the patient that is applied after all other discounts are applied if the patient submits payment within 30 calendar days of the date the hospital affiliate mails the final bills and/or itemized statement.

B. **Other Definitions:**

1. **Covered Services:**

- a. Covered Services for **Full Charity Care** or **Catastrophic Charity Care** are all services that are required to be covered by a Knox-Keene licensed Health Care Service Plan, except that services requiring prior administrative approval as defined below are not Covered Services.

- b. Covered Services for **Partial Charity Care** and **High Medical Cost Charity Care**, are all services provided by the hospital, except that

services requiring prior administrative approval, as defined below, are not Covered Services.

- c. Covered Services for the **Uninsured Patient Discount** and the **Prompt Payment Discount** are all services provided by the hospital to Uninsured Patients.
 - d. Services Requiring Prior Administrative Approval: Due to their unique nature, certain non-emergency services require administrative approval prior to admission and the provision of service. Generally, patients who seek complex, specialized, or high-cost services (e.g. experimental procedures, transplants) must receive administrative approval prior to the provision of services. Patients seeking to receive such services are **not** eligible for Full Charity Care, Partial Charity Care, Catastrophic Charity Care, or High Medical Cost Charity Care unless hospital administration makes an exception. Affiliate hospitals shall develop a process for patients to seek prior administrative approval for services that require such approval. If a patient receives a service that requires prior administrative approval without obtaining prior approval, the patient shall receive Partial Charity Care or High Medical Cost Charity Care if they are eligible under this policy, or if they are not eligible, they shall receive an Uninsured Patient Discount and a Prompt Payment Discount if payment is submitted promptly in accordance with this policy.
2. **Uninsured Patient:** An Uninsured Patient is a patient who has no source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs or third party liability, or whose benefits under insurance have been exhausted prior to the admission. Guidelines for determining when the Financial Assistance policy applies to Uninsured Patients under particular circumstances that arise during the ordinary course of business are set forth in the Uninsured policy.
 3. **Primary Language of Affiliate's Service Area:** A language is a primary language of the affiliate's service area if 5% or more of the affiliate's local population speaks the language.
 4. **Family Income:** Family Income is annual family earnings from the prior 12 months or prior tax year as shown by recent pay stubs or income tax returns, less payments made for alimony and child support. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates. For patients over 18 years of age, the patient's family includes their spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For patients under 18 years of age, the patient's family includes their parents, caretaker relatives, and other children under 21 years of age of the parents or caretaker relatives.

PROCEDURES

A. **Applying for Financial Assistance:**

1. An Uninsured Patient who indicates the financial inability to pay a bill for Covered Service shall be evaluated for Financial Assistance. In order to qualify as an Uninsured Patient, the patient or the patient's guarantor must verify that he or she is not aware of any right to insurance or government program benefits that would cover or discount the bill.
2. The Sutter Health standardized application form, "Statement of Financial Condition", Attachment A, will be used to document each patient's overall financial situation. This application shall be available in the primary language(s) of the affiliate service area.
3. A sample of the "Charity Care Calculation Worksheet" (Attachment C) is provided to aid hospital affiliates in determining the amount and type of charity care for which the patient may be eligible.

4. If an Uninsured Patient does not complete the application form within 30 days of delivery, the hospital will notify the patient that the application has not been received and will provide the patient an additional 60 days to complete the application. Failure to complete and return the application within 60 days may result in the Uninsured Patient being denied Financial Assistance.

B. Financial Assistance Determination and Notice:

1. **Determination:**

- a. The affiliate hospital will consider each applicant's Financial Assistance Application and grant Financial Assistance where the patient meets eligibility requirements and has received (or will receive) Covered Service(s).
- b. An affiliate may make Financial Assistance approval contingent upon a patient applying for governmental program assistance, which may be prudent if the particular patient requires ongoing services.
- c. In determining whether each individual qualifies for Financial Assistance, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, the Healthy Families Program, Victims of Crime, or California Children Services
- d. The affiliate should assist the individual in determining if they are eligible for any governmental or other assistance.
- e. Where administrative approval is required, the hospital will consider the request for service in a timely fashion and provide a response to the request in writing.

2. **Notice:**

- a. While it is desirable to determine the amount of Financial Assistance for which a patient is eligible as close to the time of service as possible, there is no rigid limit on the time when the determination is made. In some cases, eligibility is readily apparent while in other cases further investigation is required to determine eligibility. In some cases, a patient eligible for Financial Assistance may not have been identified prior to initiating external collection action. Each hospital affiliate's collection agency shall be made aware of this policy so that the agency knows to refer back to the hospital patient accounts that may be eligible for Charity Care.
- b. Once a Full or Partial Charity Care, Catastrophic Charity Care, or High Medical Cost Charity Care determination has been made a "Notification Form" (Attachment D) will be sent to each applicant advising them of the hospital affiliate's decision.

C. Dispute Resolution:

In the event of a dispute over the application of this policy, a patient may seek review from the hospital by notifying the affiliate's Chief Financial Officer (CFO), or designee, of the basis of any dispute and the desired relief. Written communication should be submitted within thirty (30) days of the patient's their notice of the circumstances giving rise to the dispute. The CFO or designee shall review the concerns and inform the patient of any decision in writing.

- D. Administrative and Accounting Guidelines:** To allow the affiliate to track and monitor the amount and type of charity care and discounts being granted, each affiliate will account for Financial Assistance.

E. Recordkeeping:

Records relating to Financial Assistance must be readily accessible. Affiliates must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied and the reasons for denial. In addition, notes relating to Financial Assistance application and approval or denial should be entered on the patient's account.

F. **Third-Party Liens:**

Sutter Health hospital affiliates may lien the tort recoveries of Uninsured Patients in a manner consistent with the *Management of Patient Accounts Receivable, Collection Practices, Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227)*. Hospital affiliates may not lien tort recoveries for amounts actually paid by patients or for any amount other than the discounted amount owed by the Uninsured Patient.

G. **Billing for Uninsured Patients:** For special rules related to billing for Uninsured Patients, see the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227)*.

H. **No Misrepresentation:** Hospital affiliates or their agents shall not misrepresent this policy to patients or patients' guarantors' in any way.

I. **Submission to OSHPD:**

Beginning January 1, 2008, and biennially thereafter (every two years), affiliates shall forward copies of their Financial Assistance policy to the Office of Statewide Health Planning and Development ("OSHPD"). Submission of the policy shall be done consistent with the manner prescribed by OSHPD.

COMMUNICATION OF FINANCIAL ASSISTANCE AVAILABILITY

A. **Information Provided to Patients:**

1. **Preadmission or Registration:** During preadmission or registration (or as soon thereafter as practicable) hospital affiliates shall provide:
 - a. **All patients** with information regarding the availability of Financial Assistance and their right to request an estimate of their financial responsibility for services (Important Billing Information for Uninsured Patients).
 - b. **Patients who the hospital identifies may be uninsured** with a Financial Assistance application substantially similar to the Sutter Health standardized Financial Assistance application, "Statement of Financial Condition", Attachment A.
2. **Emergency Services:** In the case of emergency services, hospital affiliates shall provide the above information as soon as practicable after stabilization of the patient's emergency medical condition or upon discharge.
3. **All other times:** Upon request, hospital affiliates shall provide patients with information about their right to request an estimate of their financial responsibility for services, the Sutter Health standardized Financial Assistance application form, "Statement of Financial Condition", Attachment A, and/or the Important Billing Information for Uninsured Patients.

B. **Postings and Other Notices:**

Information about Financial Assistance shall also be provided as follows:

1. By posting notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration, including but not limited to the emergency department, billing offices, admitting office, and other hospital outpatient service settings.
2. By posting information about Financial Assistance on the Sutter Health website and each hospital affiliate website, if any.
3. By including information about Financial Assistance in bills that are sent to Uninsured Patients.
4. By including language on bills sent to uninsured patients as specifically set forth in the *Management of Patient Accounts Receivable, Collection Practices, Hospital Affiliate Third-Party Liens, and Affiliate Dispute Initiation Policy (Finance Policy 14-227)*.

C. **Applications Provided at Discharge:**

If not previously provided, hospital affiliates shall provide Uninsured Patients with applications for Medi-Cal, Healthy Families, California Children's Services, or any other potentially applicable government program at the time of discharge.

D. **Languages:**

All notices/communications provided in this section shall be available in the Primary Language(s) of the affiliate's service area and in a manner consistent with all applicable federal and state laws and regulations.

E. **Notification to Uninsured Patients of Estimated Financial Responsibility:**

By law, Uninsured Patients are entitled to receive an estimate of their financial responsibility for hospital services. Except in the case of emergency services, hospital affiliates shall notify patients who the hospital identifies may be Uninsured Patients that they may obtain an estimate of their financial responsibility for hospital services, and provide estimates to those patients upon request. Estimates shall be written, and be provided during normal business hours. Estimates shall provide the patient with an estimate of the amount the hospital affiliate will require the patient to pay for the health care services, procedures, and supplies that are reasonably expected to be provided to the patient by the hospital, based upon the average length of stay and services provided for the patient's diagnosis. A sample estimate form is found in Attachment E.

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____	SPOUSE _____
ADDRESS _____	PHONE _____
ACCOUNT # _____	SSN _____
	(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
 Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

Spouse Employer: _____ Position: _____
 Contact Person & Telephone: _____
 If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

	Patient	Spouse
<i>Add:</i> Gross Pay (before deductions)	_____	_____
<i>Add:</i> Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
<i>Subtract:</i> Alimony, Support Payments Paid	_____	_____
<i>Equals:</i> Current Monthly Income	_____	_____
Total Current Monthly Income (add Patient + Spouse Income from above)	_____	_____

FAMILY SIZE

Total Family Members _____
 (add patient, spouse and dependents from above)

Do you have Health Insurance?	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other Insurance that may apply (such as an auto policy)?	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	<input type="checkbox"/>	<input type="checkbox"/>

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financing discount. I understand that I may be required to provide proof of the information I am providing.

_____ (Signature of Patient or Guarantor)	_____ (Date)
_____ (Signature of Spouse)	_____

Attachment A

Federal Poverty Guidelines as of January 23rd, 2009

Family size	Period	FPG	Full,if income is 100% below 351%	Partial,if income is 351% to 500%
1	Annual	\$ 10,830.00	\$ 37,905.00	\$ 54,150.00
	Monthly	\$ 903.00	\$ 3,160.50	\$ 4,515.00
2	Annual	\$ 14,570.00	\$ 50,995.00	\$ 72,850.00
	Monthly	\$ 1,214.00	\$ 4,249.00	\$ 6,070.00
3	Annual	\$ 18,310.00	\$ 64,085.00	\$ 91,550.00
	Monthly	\$ 1,526.00	\$ 5,341.00	\$ 7,630.00
4	Annual	\$ 22,050.00	\$ 77,175.00	\$ 110,250.00
	Monthly	\$ 1,838.00	\$ 6,433.00	\$ 9,190.00
5	Annual	\$ 25,790.00	\$ 90,265.00	\$ 128,950.00
	Monthly	\$ 2,149.00	\$ 7,521.50	\$ 10,745.00
6	Annual	\$ 29,530.00	\$ 103,355.00	\$ 147,650.00
	Monthly	\$ 2,461.00	\$ 8,613.50	\$ 12,305.00
7	Annual	\$ 33,270.00	\$ 116,445.00	\$ 166,350.00
	Monthly	\$ 2,773.00	\$ 9,705.50	\$ 13,865.00
8	Annual	\$ 37,010.00	\$ 129,535.00	\$ 185,050.00
	Monthly	\$ 3,084.00	\$ 10,794.00	\$ 15,420.00
Each			\$ -	\$ -
Additional Family Member	Annual	\$ 3,740.00	\$ 13,090.00	\$ 18,700.00
	Monthly	\$ 312.00	\$ 1,092.00	\$ 1,560.00

Charity Care Calculation Worksheet

Patient Name _____ Patient Account _____
 Affiliate _____ DOS _____ LOS _____
 Special Circumstances _____
 _____ To Code _____

	YES	NO
Does patient have insurance?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is patient eligible for Medicare?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is patient eligible for Medi-Cal?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is patient eligible for other Government Program s(i.e. Crime victims, etc.)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
If eligibility exists for above programs, patient will not generally be eligible for Charity Care.		
Does the patient have other insurance (i.e. auto med pay)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Was the patient injured by a third party?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the patient self-pay?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Charity/Financial Assistance Calculation:

Total combined current monthly income
 (from statement of financial condition) \$ _____
 Family size (from statement of financial condition) _____
 Qualification for Charity Care/Financial assistance **Full** Partial
 (identify using eligibility guide) Catastrophic No eligibility

Partial Charity Write-off Calculation (complete only if patient qualifies for partial charity care)

A. Total Charges \$ _____
 B. Medicare 120% Net Cost/Charge ratio for a facility _____ 24% _____
 C. Patient liability (Line A times Line B) \$ _____
 D. Discount Amount (Line A minus Line C) \$ _____

Catastrophic Charity Write-off Calculation (complete only for Catastrophic charity care)

A. Patient liability (total charges unless another discount
 Has been applied) \$ _____
 B. Annual income \$ _____
 C. Patient liability as percent of annual income _____
 D. Is Line A divided by Line B greater than .10%? YES NO
 E. If no, patient is not eligible for this write-off
 F. If yes, multiply Line B by 10% for patient balance. \$ _____
 G. If yes, subtract Line F from Line A to get write off amount \$ _____

Total Amount of Recommended Charity Write-off: \$ _____

Worksheet completed by _____ Phone: **(650) 652-3058**

Approved by: _____ Date: _____

Attachment C

**NOTIFICATION FORM
SUTTER HEALTH
ELIGIBILITY DETERMINATION FOR CHARITY CARE**

Sutter Health has conducted an eligibility determination for charity care for:

PATIENT'S NAME ACCOUNT NUMBER DATE (S) OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _____.
This determination was completed on:_____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for charity care has been approved for services rendered on_____
After applying the charity care reduction, the amount owed is \$_____.

_____ Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____ Your request for charity care has been denied because:

REASON:_____

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided incomplete or inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold the you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact:

Mills-Peninsula Health Services
(650) 652-3058

Attachment D

Policy 14-294

ESTIMATE OF FINANCIAL RESPONSIBILITY FOR HOSPITAL SERVICES

IMPORTANT -- PLEASE READ BEFORE SIGNING. This estimate is the hospital's best effort to calculate your financial responsibility for hospital services. It is based on the average length of stay and level of service of other patients with your condition(s). Your financial responsibility may be more or less than this estimate based on the hospital services you actually receive.

This estimate is not a promise to provide services at a fixed cost. It is an estimate of the amount of services you will require based on the hospital's past experiences with patients with your diagnosis.

This estimate does not create a contract between you and the hospital. It is provided to you as required by California Health & Safety Code section 1339.585.

This estimate is not intended to result in the sale or lease of goods or services to you or anyone.

You should also be aware that there may be additional charges for services that will be provided by physicians during your stay in the hospital, such as bills from your personal physician, and any anesthesiologist, pathologist, radiologist, or other medical professionals who are not employees of the hospital. **You will receive a separate bill for their services.**

This hospital offers discounts to uninsured patients who submit payment for their services prior to being discharged by the hospital. You can receive further information regarding this discount from the business office.

This hospital offers free or discounted charity care to eligible low-income/uninsured patients. Your eligibility for charity care depends on your financial circumstances. You can receive information regarding charity care, and an application for charity care determination, from the business office.

This hospital also offers discounted care to eligible uninsured patients. Your eligibility for the uninsured discount depends upon your insurance status. You can receive further information regarding this discount from the Business Office.

THIS ESTIMATE IS BASED ON THE FOLLOWING INFORMATION:

Patient Name: _____ Account No: _____

Expected Admit Date: _____

Date of Estimate: _____ Estimate completed by: _____
Attachment E

Diagnosis _____

Average Length of Stay for Patients with this diagnosis _____

Estimated charges for patients with this diagnosis _____

YOUR ESTIMATED FINANCIAL RESPONSIBILITY: \$ _____

Deposit of \$ _____ must be collected prior to admission.

Patient/Guarantor has been notified. N/A. Notified by: _____

Charity care and uninsured patient discount information provided

Comments:

By my signature below, I signify that I have read and understand the information above concerning my estimated financial responsibility for hospital services.

Patient/Guarantor Signature

Date

Hospital Use Only	
CPT Code used	
ICD-9 Code used	

Copies: Original to Patient Financial Services
 Patient

Attachment E