

INSTRUCTIONS FOR FINANCIAL ASSISTANCE FOR UNINSURED PATIENTS INCLUDING CHARITY CARE

It is the policy that this surgery center provides Financial Assistance, consistent with the following conditions, in the form of free care to eligible Low-income Uninsured Patients. This information is intended to:

- A. Define the forms of available Financial Assistance and the associated eligibility criteria; and
- B. Establish the processes that patients shall follow in applying for Financial Assistance and the process the surgery center will follow in reviewing applications for Financial Assistance; and
- C. Not create an obligation to pay for charges of physicians or other medical providers including anesthesiologists, radiologists, pathologists, etc. not included in the surgery center bill.

DEFINITIONS AND ELIGIBILITY

**** Financial Assistance is available to eligible patients who receive Covered Services and who follow applicable procedures, completing the application and providing required information.***

Financial Assistance: The term Financial Assistance refers to Full Charity Care and Special Circumstance Charity Care.

Full Charity Care: Full Charity Care is a *complete* write-off of the surgery center's undiscounted charges for Covered Services. Full Charity Care is available to patients:

-Whose Family Incomes are at or below 200% of the most recent "Federal Poverty Income Guidelines" (Attachment A) (the 200% threshold represents the minimum required to be offered to low-income uninsured patients; surgery center affiliates may adopt a higher income threshold); and

-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.

Special Circumstances Charity Care: Special Circumstances Charity Care allows Uninsured Patients who do not meet the Financial Assistance criteria set forth in section 1 above, or who are unable to follow specified

surgery center procedures, to receive a complete write-off of the surgery center's undiscounted charges for Covered Services, with the approval of the affiliate surgery center Administrator, or designee.

The following is a non-exhaustive list of some situations that may qualify for Special Circumstances Charity Care:

-Bankruptcy: Patients who are in bankruptcy or recently completed bankruptcy.

-Homeless Patients: Patients without a payment source if they do not have a job, mailing address, residence, or insurance.

-Deceased: Deceased patients without insurance, an estate or third party coverage.

-Medicare: Income-eligible Medicare patients may apply for Financial Assistance for denied stays, non-covered services and Medicare cost shares.

-MediCal: Income-eligible MediCal patients may apply for Financial Assistance for denied stays and non-covered services; however, patients may not receive Financial Assistance for the MediCal share of cost. Persons eligible for programs such as MediCal but whose eligibility status is not established for the period during which the medical services were rendered may apply for Financial Assistance.

Covered Services: Covered Services for Financial Assistance are all services that are required to be covered by a Knox-Keene licensed Health Care Service Plan.

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.

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.

Applying 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.

The standardized application form below, "Statement of Financial Condition" will be used to document each patient's overall financial situation. Failure to complete and return the application within 90 days of original delivery may result in the Uninsured Patient being denied Financial Assistance. Please attach copies of the following documentation:

- Copy of last pay check stub
- Copy of W-2 from last year's income tax
- Copies of documentation of Social Security benefits
- Copies of documentation from local welfare agencies representing your financial situation
- Copies of documentation related to health care insurance applied for or denied such as Medicare, MediCal or employer insurance program

Please return completed application and documentation to the surgery center billing department. If you have any questions regarding this policy, you will find the center's address and phone number in Contact Us.

FEDERAL POVERTY GUIDELINES

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add \$3,740 for each additional person.

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME:

SPOUSE NAME:

PARENT(S) NAME(S):

ADDRESS:

PHONE: _____

ACCOUNT#: _____

SSN: Patient: _____ Family Member: _____

FAMILY STATUS: List all dependents supported by Patient or Parent(s)

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

FAMILY SIZE

Total Family Members (add patient, spouse, parent(s) and dependents): _____

Do you have Health insurance? Yes _____ No _____

Do you have other Insurance that may apply (such as an auto policy)? Yes _____ No _____

EMPLOYMENT AND OCCUPATION

Patient/Family Member Name:

Employer:

Position:

Contact Person & Telephone:

If Self-Employed, Name of Business:

Patient/Family Member Name:

Employer:

Position:

Contact Person & Telephone:

If Self-Employed, Name of Business:

CURRENT MONTHLY INCOME

	Patient/Family Member	Patient/Family Member
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> Payments		
• Alimony		
• Child Support	_____	_____
<i>Equals:</i> Current Monthly Income		

Total Family Current Monthly Income \$ _____

By signing this form, I agree to allow _____ Surgery Center to check employment and credit history for the purpose of determining my eligibility for Financial Assistance. 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) (Date)