

## Charity Care/Discounted Payment Policy

### I. Policy:

Pursuant to this Policy, the Hospital will provide eligible patients Charity Care or Discounted Payment, together referred to as “financial assistance.” The Hospital shall provide this financial assistance to individuals who demonstrate an inability to pay for Medically Necessary Services. Eligibility guidelines and application procedures for Charity Care and Discounted Payment are detailed in this Policy.

### II. Purpose:

The purpose of the Charity Care and Discounted Payment Policy (the “**Policy**”) is to define the eligibility criteria and application process set forth by Dameron Hospital Association (the “**Hospital**”) to provide financial assistance to low-income, uninsured and underinsured patients.

This Policy is intended to comply with the Hospital’s mission and values as a nonprofit public benefit organization and with requirements set forth in California Health & Safety Code §§ 127400 *et seq* and with the requirements applicable to tax-exempt hospitals under § 501(r) of the Internal Revenue Code and the Department of Treasury regulations issued thereunder.

### III. Definitions:

**A. “Charity Care”** means Medically Necessary Services provided to a patient at no charge to the patient or his/her family.

**B. “Discounted Payment”** means that the Hospital shall limit the expected payment for Medically Necessary Services for Financially Qualified Patients to a discounted rate.

**C. “Emergency Medical Care”** means care provided for Emergency Medical Conditions.

**D. “Emergency Medical Condition”** is defined as:

1. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
  - a. Placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunctions of any bodily organ or part.
2. With respect to a pregnant woman who is having contractions:
  - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

**E. “Essential Living Expenses”** means expenses for any of the following: rent or house payment and maintenance; food and household supplies; utilities and telephone; clothing; medical and

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dental payments; insurance; school or child care; child or spousal support; transportation and auto expenses, including insurance, gas and repairs; installment payments; laundry and cleaning; and other extraordinary expenses.

**F. “Federal Poverty Level”** is defined in the chart set forth on **Attachment A**, based on the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.

**G. “Financially Qualified Patient”** means a patient who is both of the following:

1. A patient who is a Self-Pay Patient, as defined in Section III.L, or a Patient with High Medical Costs, as defined in Section III.J; and
2. A patient whose family income does not exceed 350 percent of the Federal Poverty Level.

**H. “Income”** includes, but is not limited to, wages, salaries, Social Security payments, public assistance, unemployment and workers’ compensation, veterans’ benefits, child support, alimony, pensions, regular insurance and annuity payments, income from estates and trusts, assets drawn down as withdrawals from a bank, sale of property or liquid assets and one-time insurance or compensation payments.

**I. “Medically Necessary Service”** means a service or treatment that is absolutely necessary to treat or diagnose a patient and could adversely affect the patient’s condition, illness or injury if it were omitted, and the service or treatment is not considered an elective or cosmetic surgery service or treatment.

**J. “Patient with High Medical Costs”** means a patient who meets *all* of the following requirements:

1. A patient with third-party coverage (*i.e.*, not a Self-Pay Patient);
2. A patient whose family income does not exceed 350 percent of the Federal Poverty Level, as set forth in Section III.F; and
3. A patient whose annual out-of-pocket costs incurred by the individual at the Hospital exceed 10 percent of the patient’s family income in the prior 12 months; *or* whose annual out-of-pocket expenses exceed 10 percent of the patient’s family income, if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

**K. “Patient’s family”** means the following:

1. For persons 18 years of age and older:
  - a. Spouse;
  - b. Domestic partner, as defined in Section 297 of the California Family Code; and
  - c. Dependent children under 21 years of age, whether living at home or not.
2. For persons under 18 years of age:

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- a. Parent;
- b. Caretaker relative; and
- c. Other children under 21 years of age of the parent or caretaker relative.

**L. “Self-Pay Patient”** means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers’ compensation, automobile insurance or other insurance, as determined and documented by the Hospital.

**M. “Reasonable Payment Plan”** means monthly payments that are not more than 10 percent of a patient’s family income for a month, excluding deductions for Essential Living Expenses.

### IV. Eligibility

#### A. Eligible Services

Financial assistance provided to Hospital patients pursuant to this Policy shall only apply to charges incurred for Emergency Medical Care and other Medically Necessary Services. If it is unclear whether a particular service is an Emergency Medical Care or other Medically Necessary Service, then the Chief Medical Officer or his/her designee shall determine whether services rendered to the patient were Medically Necessary Services.

Emergency physicians who provide emergency medical services in a hospital that provides emergency care are required by law to provide discounts to Self-Pay Patients and Patients with High Medical Costs who are at or below 350 percent of the Federal Poverty Level. Patients must contact the emergency physician’s billing office for further information regarding financial assistance programs for emergency services.

Emergency Medical Care and other Medically Necessary Services provided by professionals or physicians, other than the hospital facility itself, are not covered by the Hospital’s financial assistance policies. Professional or physician services include:

- Ambulance Services
- Audiology
- Anesthesiology
- Cardiology
- Dentistry
- Dermatology
- Dialysis
- Emergency Physicians
- Endocrinology
- Gastroenterology
- Gynecology
- Hospitalists
- Internal Medicine
- Magnetic Resonance Imaging (MRI)
- Neonatology
- Nephrology
- Neurology
- Nuclear Medicine
- Obstetrics
- Otolaryngology ENT
- Ophthalmology
- Pathology
- Physician Assistants
- Podiatry
- Psychiatric Services
- Radiation Therapy
- Radiology
- Respiratory Care
- Surgeons
- Urology

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### B. General Eligibility

Consistent with the Hospital's mission as a nonprofit public benefit organization to operate and furnish care, treatment, hospitalization and other services, with or without compensation, the Hospital will, pursuant to this Policy, provide financial assistance to Financially Qualified Patients.

The Hospital shall determine eligibility for the Charity Care Program or Discounted Payment Program based upon an individual's financial need in accordance with this Policy. Patients seeking Charity Care or Discounted Payment are expected to make reasonable efforts to provide the Hospital with documentation of income and health benefits coverage. If a patient fails to provide the information specified in this Policy and the accompanying application form, the Hospital may consider such failure in making its determination.

Patients who are identified as homeless, or who are currently covered under another state Medicaid program may be deemed eligible for Charity Care.

In screening for the Charity Care Program or the Discounted Payment Program, all available resources should be reviewed, including, but not limited to, private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children's Services Program, or other state- or county-funded programs designed to provide health coverage.

Financial assistance under this Policy shall be provided to eligible patients without regard to race, religion, color, creed, age, gender, sexual orientation, national origin or immigration status.

### C. Specific Eligibility

Patients may apply for financial assistance under Section IV.C.1 or Section IV.C.2, as described below.

#### 1. Discounted Payment Program

Both Self-Pay Patients and Patients with High Medical Costs shall be eligible to apply for the Discounted Payment Program.

- a. **Self-Pay Patients:** The Hospital shall limit the expected payment for Emergency Medical Care and other Medically Necessary Services provided by Hospital to Self-Pay Patients whose documented income is between 150 percent and 350 percent, inclusive, of the Federal Poverty Level, to the "amount generally billed" ("AGB") for such services, which the Hospital determines to be the amount of payment the Hospital would expect in good faith to receive for providing services under Medicare as if such Self-Pay Patient had been a Medicare beneficiary. If the Hospital provides a service for which there is no established payment by Medicare, then the Hospital shall establish an appropriate Discounted Payment amount.

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- b. **Patients with High Medical Costs:** Patients with High Medical Costs whose documented income is between 150 percent and 350 percent, inclusive, of the Federal Poverty Level, shall be liable, taking into account any unreimbursed co-payments, co-insurance and deductibles, for the lesser of (i) the balance after any insurance payments are applied or (ii) the AGB.

Patients seeking a Discounted Payment must make reasonable efforts to provide the Hospital with documentation of income (limited to recent pay stubs or income tax returns) and health benefits coverage. Patients with High Medical Costs also must provide documentation of medical expenses paid by such patients or their families in the prior 12 months. For purposes of determining a patient's eligibility under this Policy, the Hospital may request the patient's consent to verify his/her employment status and credit history, as permitted by applicable law.

Patients that provide required documentation and qualify under the income requirements of this section may enter into an extended, interest free payment plan in accordance with the Hospital's Extended Payment Plan Policy & Procedure (No. 20-01-0035). The Hospital and the patient shall negotiate the terms of such extended payment plan, and shall take into consideration the patient's family income and Essential Living Expenses. If the Hospital and patient cannot agree on a payment plan, the Hospital shall create a Reasonable Payment Plan.

### 2. Charity Care Program

The Hospital also will provide its Charity Care Program to Financially Qualified Patients who are unable to pay, regardless of insurance status, provided that the patient's income falls below 150 percent of the Federal Poverty Level.

Patients seeking Charity Care must make reasonable efforts to provide the Hospital with documentation of income, monetary assets (including all liquid and non-liquid assets owned, less liabilities and claims against such assets) and health benefits coverage.

However, monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans. Also, the first \$10,000 of the patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first \$10,000 be counted in determining eligibility. The Hospital may, nonetheless, require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain verifying information from financial or commercial institutions, or other entities that hold or maintain the monetary assets. For purposes of determining a patient's eligibility under this Policy, the Hospital may request the patient's consent to verify his/her employment status and credit history, as permitted by applicable law.

### V. Application Procedures

When requesting financial assistance under the Policy, the patient, the patient's guarantor or the patient's legal representative is responsible for providing accurate information and using

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reasonable efforts to provide all documentation necessary. Below is a list of the responsibilities of the patient, the patient's guarantor or the patient's legal representative during the application process.

- A.** To establish eligibility, all patients requesting financial assistance under the Policy will be required to complete the Hospital's Financial Assistance Application form, attached to this Policy as **Attachment B**.
- B.** To be considered for the Charity Care Program or Discounted Payment Program under the Policy, the patient should cooperate with the Hospital to provide the information and documentation necessary to apply for other existing financial resources that may be available to cover (fully or partially) the charges for care rendered by the Hospital, including, but not limited to, private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children's Services Program, or other state- or county-funded programs designed to provide health coverage.
- C.** If a patient applies, or has a pending application, for another health coverage program at the same time s/he applies for a Hospital Charity Care or Discount Payment program, neither application shall preclude eligibility for the other program.
- D.** To be considered for Discounted Payment or Charity Care under the Policy, the patient should provide the Hospital with the financial and other information requested on the application needed to determine eligibility. This includes completing the required application forms and cooperating fully with the information-gathering and assessment processes.
- E.** A patient who qualifies for Discounted Payment shall cooperate with the Hospital in establishing an extended payment plan. If the Hospital and patient cannot agree on an extended payment plan, then the Hospital shall create a Reasonable Payment Plan.
- F.** A patient who qualifies for a Discounted Payment must make good-faith efforts to honor the payment plan. The patient must promptly notify the Hospital of any change in financial status so that his/her eligibility for financial assistance may be reevaluated by the Hospital pursuant to this Policy.
- G.** A patient's failure to mail or otherwise deliver to Hospital a complete Financial Assistance Application within 30 days of the final billing statement, which shall be sent at least 90 days from the date of the first post-discharge billing statement, shall result in the Hospital beginning collections actions as described in the Hospital's Collection of Past Due Accounts Policy.
- H.** In the event of a dispute, a patient may seek review from the Hospital's Patient Relations and Service Excellence Coordinator.
- I.** The following approvals are required for Financial Assistance Applications:

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Level	Charity Care/Discounted Care Payment Amount	Required Approvals
1	under \$50,000	Director of Patient Accounting
2	\$50,000 to \$249,999	Director of Patient Accounting and Chief Financial Officer
3	\$250,000 and above	Director of Patient Accounting, Chief Financial Officer and Chief Executive Officer

**VI. Collections Policies and Procedures for All Applicants**

The Patient Accounting and Credit and Collections Departments have the authority to advance a patient debt for collections, and will be responsible for determining an individual’s ability to pay, utilizing all or a portion of the factors outlined within this Policy. Collection activity will be conducted by the Hospital’s Credit and Collections Department or designated collection agency that has agreed to comply with this Policy and the collections procedures set forth in the Hospital’s Collection of Past Due Accounts Policy & Procedure (No. 20-01-0033).

- A.** To balance a patient’s need for financial assistance with the Hospital’s broader fiscal responsibility to the community of maintaining a financially healthy facility, the Hospital shall make all reasonable efforts to determine the patient’s ability to contribute to the cost of their care as set forth herein.
- B.** The Hospital shall determine the patient’s eligibility for financial assistance as close as possible to the rendering of Emergency Medical Care or other Medically Necessary Services.
- C.** The Hospital may declare an extended payment plan (including a Reasonable Payment Plan) inoperative if the patient fails to make all consecutive payments during a 90-day period. Before declaring an extended payment plan inoperative, the Hospital, collection agency or assignee shall make a reasonable attempt to contact the patient by telephone, give written notice that the extended payment plan may become inoperative, and inform the patient that s/he may renegotiate the terms of the payment plan.
- D.** If the Hospital determines that an individual is unable to pay for all or part of the payment due, and there are no other avenues available to collect on the account, then the uncollected amount will be written off as Charity Care. Otherwise, the account will be pursued as outlined in the Hospital’s Collection of Past Due Accounts Policy & Procedure. Any actions the Hospital may take in the event of nonpayment are set forth in the Hospital’s Collection of Past Due Accounts Policy, a copy of which is available and without charge, both by mail and at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings.
- E.** Under no circumstances will contractual write-offs, discounts or any other administrative or courtesy allowances be written off as Charity Care.

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- F.** Prior to commencing collection activities, the Hospital shall provide the patient with written notice containing a plain language summary of the patient's rights pursuant to California Health and Safety Code Section 127430(a), and a statement that nonprofit credit counseling services may be available in the area. Specific collection activities the Hospital may take and the time frames for pursuing collection actions are set forth in the Hospital's Collection of Past Due Accounts Policy, a copy of which is available and without charge, both by mail and at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings.
- G.** The Hospital or its assignee that is an affiliate or subsidiary of the Hospital shall not, in dealing with patients eligible under any portion of this Policy, use wage garnishments or liens on primary residences as a means of collecting unpaid Hospital bills.
- H.** In dealing with patients eligible under any portion of this Policy, a collection agency or other assignee that is not a subsidiary or affiliate of the Hospital shall not use a wage garnishment (except by court order) or notice or conduct a sale of the patient's primary residence as means of collecting unpaid Hospital bills.
- I.** Neither Section VI.G nor Section VI.H of this Policy shall preclude the Hospital, a collection agency or other assignee from pursuing reimbursement or any enforcement remedy or remedies from third-party liability settlements, tortfeasors or other legally responsible parties.
- J.** If a patient is attempting to qualify for eligibility under the Hospital's Charity Care Program or Discounted Payment Program and is attempting in good faith to settle an outstanding bill with the Hospital by negotiating an extended payment plan or by making regular partial payments of a reasonable amount, then the Hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with this Policy, and if the bill has already been sent to a collection agency the Hospital shall suspend such collection services.
- K.** The Hospital or the Hospital's assignee shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment at any time prior to 150 days after the first post-discharge billing statement. This period shall be extended if the patient has a pending appeal for coverage of the services until a final determination of the appeal is made.
- L.** No information collected by the Hospital for the purpose of determining eligibility for financial assistance shall be used for collections activities. However, the Hospital, collection agency or assignee may use information obtained independently of the eligibility process for the Charity Care Program or the Discounted Payment Program.



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### VII. Notice Requirements

#### A. Website

This Policy, the Financial Assistance Application form, and a plain language summary of the Policy are made conspicuously available on the Hospital's website and are available for download and printing.

#### B. Hardcopies

Copies of this Policy, the Financial Assistance Application form, and a plain language summary of the Policy are available upon request and without charge, both by mail and at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings.

#### C. Notice to Patients

The Hospital shall offer a paper copy of a plain language summary of this Policy to patients as part of the intake or discharge process, including for individuals who received emergency or outpatient care and were never admitted as inpatients.

A conspicuous written notice on billing statements will notify and inform recipients about the availability of financial assistance under this Policy. Such notice shall provide the telephone number of the Hospital's department that can provide information about the Policy and the application process and the direct Website address where copies of the FAP, Financial Assistance Application form, and a plain language summary may be obtained.

Signage regarding the Policy, how to obtain more information about the Policy and how to obtain copies of the Policy, the Financial Assistance Application form, and a plain language summary, is posted at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings.

Prior to commencing collection activities, the Hospital or its designee shall provide the patient with written notice containing a plain language summary of the patient's rights pursuant to California Health and Safety Code Section 127430(a), and a statement that nonprofit credit counseling services may be available in the area.

#### D. Notice to Members of the Community

The Hospital will, in addition to informing patients about this Policy, notify and inform members of the community about the availability of financial assistance under this Policy as well as how or where to obtain more information about the Policy and the Financial Assistance Application process and to obtain copies of the FAP, Financial Assistance Application form, and a plain language summary of the Policy.

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### E. Translation

The Hospital will make this Policy, the Financial Assistance Application form, and a plain language summary of the Policy available in English and in any other language that the Hospital determines is spoken by populations in the community with limited English proficiency constituting the lesser of 1,000 individuals or 5 percent of the community served by the Hospital.

### F. Identification of Financially Qualified Inpatients

Hospital financial counselors will attempt to contact registered inpatients during their hospital stay to assess patients' needs and identify those patients that may be eligible for financial assistance. The Hospital may utilize internal staff or third party agents to assist patients in applying for medical assistance programs funded by city, county, state or federal programs.

### VIII. References:

California Health & Safety Code §§ 127400–127446 (Hospital Fair Pricing Policies) and §§ 127450–127462 (Emergency Physician Fair Pricing Policies)

California Family Code § 297 (Definition: Domestic Partner)

U.S. Department of Health and Human Services, Poverty Guidelines, available at <http://aspe.hhs.gov/poverty/>

Internal Revenue Code § 501(c) (3) (Tax-Exempt Organizations)

### X. Associated Documents:

DHA Financial Assistance Application Form – Attachment B (English)

DHA Financial Assistance Application Form – Attachment B (Spanish)

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ATTACHMENT A

FEDERAL POVERTY LEVEL

<b>2021 Federal Poverty Guidelines</b>			
<b>Family Size</b>	<b>Current Annual Federal Poverty Income Level</b>	<b>Family Gross Income is below 150% <i>Full Write Off</i></b>	<b>Family Gross Income is between 150% to 350% <i>Medicare Rate</i></b>
1	\$12,880	\$19,320	\$45,080
2	\$17,420	\$26,130	\$60,970
3	\$21,960	\$32,940	\$76,860
4	\$26,500	\$39,750	\$92,750
5	\$31,040	\$46,560	\$108,640
6	\$35,580	\$53,370	\$124,530
7	\$40,120	\$60,180	\$140,420
8	\$44,660	\$66,990	\$156,100
9	\$51,240	\$76,860	\$179,340
10	\$55,560	\$83,340	\$194,460
<i>Each Addtn'l</i>	\$4,540	\$6,810	\$15,890

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### ATTACHMENT B

#### Charity Care Discount Policy Applications (English & Spanish Versions\*)

**Presented on the following pages below**

## Charity Care and Discounted Payment Programs

Dameron Hospital (“the Hospital”) recognizes that many of the patients it serves may be unable to access quality health care services without financial assistance. The Charity Care and Discounted Payment Policy was developed to ensure that the Hospital continues to uphold its mission of providing quality health care to the community, while carefully taking into consideration the ability of the patient to pay.

The Hospital’s Charity Care and Discounted Payment Policy, the Financial Assistance Application form, and a plain language summary of the Policy are available on the Hospital’s website at <http://www.dameronhospital.org/> and are available for download and printing. Copies are also available upon request and without charge, both by mail and at all points of registration, including the emergency department, the billing office, the admissions office and other outpatient settings. The Charity Care and Discounted Payment Policy, the Financial Assistance Application form, and a plain language summary of the Policy are also available in Spanish.

## Eligible Services

Financial assistance provided to Hospital patients pursuant to the Charity Care and Discounted Payment Programs shall only apply to charges incurred for Emergency Medical Care and other Medically Necessary Services.

Emergency Medical Care and other Medically Necessary Services provided by professionals or physicians, other than the hospital facility itself, are not covered by the Hospital’s financial assistance policies. Professional or physician services include:

- Ambulance Services
- Audiology
- Anesthesiology
- Cardiology
- Dentistry
- Dermatology
- Dialysis
- Emergency Physicians
- Endocrinology
- Gastroenterology
- Gynecology
- Hospitalists
- Internal Medicine
- Magnetic Resonance Imaging (MRI)
- Neonatology
- Nephrology
- Neurology
- Nuclear Medicine
- Obstetrics
- Otolaryngology (ENT)
- Ophthalmology
- Pathology
- Physician Assistants
- Podiatry
- Psychiatric Services
- Radiation Therapy
- Radiology
- Respiratory Care
- Surgeons
- Urology

## General Eligibility

The Hospital shall determine eligibility for the Charity Care Program or Discounted Payment Program based upon an individual’s financial need in accordance with the Charity Care Program and Discounted Payment Policy. Patients seeking Charity Care or Discounted Payment must make reasonable efforts to provide the Hospital with documentation of income and health benefits coverage. If a patient fails to provide the information specified in the Charity Care Program and Discounted Payment Policy, the Hospital may consider such failure in making its determination.

Patients that meet certain low- and moderate-income requirements may qualify for discounted payment or charity care. Generally, “Financially Qualified Patients” are those patients (1) who are Self-Pay Patients (i.e., do not have third-party coverage) or Patients with High Medical Costs; and (2) whose family income does not exceed 350 percent of the current federal poverty level.

Before a patient can be eligible for the Charity Care Program or the Discounted Payment Program, all available resources must first be applied, including, but not limited to, private health insurance (including coverage offered through the California Health Benefit Exchange), Medicare, Medi-Cal, the Healthy Families Program, the California Children’s Services Program, or other state- or county-funded programs designed to provide health coverage.

Patients who are eligible for and/or receive financial assistance under the Charity Care Program or the Discounted Payment Program may not receive financial assistance pursuant to the Hospital's Uninsured Patient Discount Policy. Patients who are eligible for and/or receive financial assistance under the Charity Care Program or the Discounted Payment will not be charged more than the "amount generally billed" ("AGB") for such services.

Financial assistance under this Policy shall be provided to eligible patients without regard to race, religion, color, creed, age, gender, sexual orientation, national origin or immigration status.

### **Application Procedures**

Attached you will find a statement of financial conditions that must be filled out in its entirety. To be considered for Charity Care or Discounted Payment under the Policy, the patient must provide the Hospital with the financial and other information requested on the application needed to determine eligibility, which will be considered in accordance with the limitations set forth in the California Health and Safety Code Section 127405(e). This includes completing the required application forms and cooperating fully with the information gathering and assessment processes. If the Hospital determines the patient is eligible for the Charity Care Program, it may require waivers or releases from the patient or the patient's family authorizing the Hospital to obtain verifying information from financial or commercial institutions, or other entities that hold or maintain the monetary assets. If the Hospital determines the patient is eligible for financial assistance under the Discounted Payment Program, documentation of income will be limited to recent pay stubs and income tax returns.

A patient's failure to mail or otherwise deliver to Hospital a complete Financial Assistance Application within 30 days of the final billing statement, which shall be sent at least 90 days from the date of the first post-discharge billing statement, shall result in the Hospital beginning collections actions as described in the Hospital's Collection of Past Due Accounts Policy. Please return this application within 30 days, along with the following documents which support the data you entered on the application:

1. Proof of Identity – Provide one of the following:
  - Copy of state issued driver's license
  - Copy of Social Security card
  - Copy of Photo ID
2. Previous Year's Federal and State Income Taxes, including schedules as applicable. If not available please explain why and attach copy of 2 most recent pay stubs.
3. All Saving and Checking Account(s) Statements
4. Rent Receipts (if applicable)
5. Alimony (if applicable)

Mail completed application and required documentation to: Dameron Hospital Association  
Patient Accounting Department  
525 W. Acacia St.  
Stockton, CA 95203

Please contact the Dameron Hospital Credit and Collections Department at (209) 461-3147 between the hours of 7:00 a.m. to 3:30 pm if you have questions or need assistance in completing the attached Statement of Financial Condition application.

### **Emergency Physician Services**

An emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs. Please contact the emergency physicians billing office directly for further information regarding their financial assistance programs.

**STATEMENT OF FINANCIAL CONDITION  
SCHEDULE OF CURRENT INCOME AND EXPENDITURES**

Your Name: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
 Your SS# \_\_\_\_\_ Spouse SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**A. FAMILY STATUS**

1. List all dependents that you support (other than your spouse)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**B. EMPLOYMENT AND OCCUPATION**

- You are employed by: \_\_\_\_\_ Position \_\_\_\_\_  
 If self employed, give name of business \_\_\_\_\_
- Your spouse is employed by: \_\_\_\_\_ Position \_\_\_\_\_  
 If self employed, give name of business \_\_\_\_\_

**C. CURRENT INCOME**

	<u>You</u>	<u>Spouse</u>
1. Gross pay (wages, salary, commissions, tips)	\$ _____	_____
2. Income from operating a business	\$ _____	_____
3. Other income:		
a. Interest and dividends	\$ _____	_____
b. From real estate or personal property	\$ _____	_____
c. Social Security	\$ _____	_____
d. Pension or other retirement income	\$ _____	_____
e. Other (specify) _____	\$ _____	_____
_____	\$ _____	_____
4. Alimony, maintenance or support payments	\$ _____	_____
<b>TOTAL MONTHLY INCOME (total all above)</b>	<b>\$ _____</b>	_____

**(PLEASE TURN OVER AND COMPLETE OTHER SIDE)**

**D. SCHEDULE OF CURRENT EXPENDITURES**

- 1. Home expenses:
  - a. Rent or house payment and maintenance cost \$ \_\_\_\_\_
  - b. Household supplies \$ \_\_\_\_\_
  - c. Real estate taxes \$ \_\_\_\_\_
  - d. Utilities
    - Electric and gas \$ \_\_\_\_\_
    - Water \$ \_\_\_\_\_
    - Telephone \$ \_\_\_\_\_
    - Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_
  - Total Utilities \$ \_\_\_\_\_
- 2. Other Expenses:
  - a. Spousal or child support \$ \_\_\_\_\_
  - b. Insurance (only if not deducted from wages)
    - Health \$ \_\_\_\_\_
    - Auto \$ \_\_\_\_\_
    - Homeowners or renters \$ \_\_\_\_\_
    - Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_
  - Total Insurance Expenses \$ \_\_\_\_\_
  - c. Installment Expenses:
    - Auto \$ \_\_\_\_\_
    - Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_
    - Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_
  - Total Installment Expenses \$ \_\_\_\_\_
  - d. Transportation (including gas & repairs) \$ \_\_\_\_\_
  - e. Education or child care \$ \_\_\_\_\_
  - f. Food \$ \_\_\_\_\_
  - g. Clothing (including laundry or cleaning) \$ \_\_\_\_\_
  - h. Medical, dental, and medicines \$ \_\_\_\_\_
  - i. Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_
  - Other (specify) \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL CURRENT MONTHLY EXPENSES (Total all above) \$ \_\_\_\_\_**

By my signature, I declare under the penalty of perjury that the above schedule of income and expenditures is a true reflection of my monthly income and expenses. I agree to allow Dameron Hospital Association to verify employment status and credit history for the purpose of determining my qualification for financial assistance, as permitted by law.

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Signature of Patient or Guarantor)



## Programas de Cuidado de Caridad y Pago con Descuento

Dameron Hospital ("el Hospital") reconoce que muchos de los pacientes que atiende quizá no pueden tener acceso a los servicios de atención de salud de alta calidad sin asistencia financiera. La Política de Cuidado de Caridad y Pago con Descuento fue desarrollada para asegurar que el Hospital mantenga su misión de brindar atención médica de calidad a la comunidad, teniendo muy en cuenta la capacidad de pago del paciente.

Están disponibles en la página web del Hospital <http://www.dameronhospital.org/> la Política de Cuidado de Caridad y de Pago con Descuento, la Solicitud de Aplicación de Asistencia Financiera y un resumen en lenguaje simple, y están disponibles para su descarga e impresión. También hay copias disponibles bajo petición y sin gastos, tanto por correo y en todos los puntos de registro, incluyendo el servicio de urgencias, la oficina de facturación, la oficina de admisiones y otros entornos ambulatorios. El Cuidado de Caridad y Política de Pago con Descuento, el formulario de Solicitud de Asistencia Financiera, y un resumen en lenguaje simple de la política también están disponibles en español.

## Servicios Elegibles

La asistencia financiera prestada a los pacientes del hospital de conformidad con los Programas de Cuidado de Caridad y de Pago con Descuento solo se aplicará a los gastos generados por la atención médica de emergencia y otros servicios médicamente necesarios.

Atención médica de emergencia y otros servicios médicamente necesarios prestados por profesionales o médicos, aparte de aquellos brindados por el hospital, no están cubiertos por las políticas de asistencia financiera del Hospital. Los servicios profesionales o médicos incluyen:

- Servicios de Ambulancia
- Audiología
- Anestesia
- Cardiología
- Odontología
- Dermatología
- Diálisis
- Médicos de Emergencia
- Endocrinología
- Gastroenterología
- Ginecología
- Hospitalistas
- Medicina Interna
- Imagen de resonancia magnética (MRI)
- Neonatología
- Nefrología
- Neurología
- Medicina Nuclear
- Obstetricia
- Otorrinolaringología
- Oftalmología
- Patología
- Podiatra
- Asistente Médico
- Servicios Psiquiátricos
- Terapia de Radiación
- Radiología
- Cuidado Respiratorio
- Cirujanos
- Urología

## Elegibilidad General

El Hospital determina la elegibilidad para el Programa de Cuidado de Caridad y de Pagos con Descuento basado en las necesidades financieras del individuo de acuerdo con su política escrita de Cuidado de Caridad y Pago con Descuento. Los pacientes que deseen ser considerados para el Programa de Cuidado de Caridad o el Programa de Pago con Descuento deben hacer esfuerzos razonables para proporcionar al Hospital con la documentación de ingresos y cobertura de beneficios para la salud. Si un paciente no puede proporcionar la información prevista en el Programa de Cuidado de Caridad y Política de Pago con Descuento, el Hospital puede considerar dicho incumplimiento al formular su determinación.

Los pacientes que cumplen con ciertos requisitos de bajos y moderados ingresos pueden calificar para el pago con descuento o atención caritativa. En general, "los pacientes financieramente calificados" son aquellos pacientes (1) que son auto-Pay pacientes (es decir, no tienen cobertura de terceros) o pacientes con altos costos médicos; y (2), cuyo ingreso familiar no exceda 350 por ciento del nivel de pobreza federal actual.

Antes de que un paciente puede ser elegible para el Programa de Cuidado de Caridad o el Programa de Pago con Descuento, todos los recursos disponibles primero deben aplicarse, incluyendo, pero no limitado a, el seguro de salud privado (incluyendo la cobertura ofrecida a través del Intercambio de Beneficios de Salud de California), Medicare, Medi-Cal, el Programa de Familias Saludables, Programa de Servicios para Niños de California, u otros programas financiados por el estado o el condado diseñados para proporcionar cobertura de salud.

Los pacientes que son elegibles para y/o reciben asistencia financiera bajo el Programa de Cuidado de Caridad o el Programa de Pago con Descuento no pueden recibir asistencia financiera en virtud de la Política de Descuento para Pacientes No Asegurados del Hospital. Los pacientes que son elegibles para y/o reciben ayuda financiera con cargo al Programa de Cuidado de Caridad o el Pago con Descuento no se les cobrará más que la “cantidad generalmente facturada” (“AGB”) para tales servicios.

### **Información de Factura**

La ayuda financiera en virtud de esta Política, se brindará a los pacientes elegibles sin importar su raza, religión, color, credo, edad, género, orientación sexual, origen nacional o estatus migratorio.

### **Procedimientos de Aplicación**

La declaración de las condiciones financieras debe ser llenada en su totalidad. Para ser considerado para el Cuidado de Caridad o Pago con Descuento en virtud de la política, el paciente debe proporcionar al Hospital con la información financiera y otra solicitada en la aplicación necesaria para determinar la elegibilidad, que será considerado de acuerdo con las limitaciones establecidas en la Sección del Código de Salud y Seguridad de California 127.405 (e). Esto incluye completar los formularios de solicitud necesarios y cooperar plenamente con la recopilación de información y los procesos de evaluación. Si el Hospital determina que el paciente es elegible para el Programa de Cuidado de Caridad, puede requerir exenciones o liberaciones del paciente o la familia del paciente autorizando al hospital para obtener la verificación de información de las instituciones financieras o comerciales, u otras entidades que mantienen los activos monetarios. Si el Hospital determina que el paciente es elegible para recibir asistencia financiera bajo el Programa de Pago con Descuento, la documentación de los ingresos se limitará a los talones de pago recientes y declaraciones de impuestos.

La falta de un paciente de enviar por correo o entregar al hospital una Solicitud de Asistencia Financiera completa dentro de los 30 días de la factura final, que se enviará al menos 90 días desde la fecha de la primera factura después del alta, dará lugar a que el Hospital de inicie acciones de cobranza como se describe en la Política de Cobranza de Cuentas Morosas del Hospital. Por favor devuelva esta solicitud dentro de los 30 días, junto con los siguientes documentos que apoyan los datos introducidos en la aplicación:

1. Prueba de identidad – Proporcionar una de las siguientes:
  - Copia de la licencia de conducir emitida por el estado
  - Copia de la tarjeta de la Seguro Social
  - Copia de identificación con foto
2. Impuestos sobre la renta federal y estatal del Año Anterior, incluyendo anexos según corresponda. Si no está disponible por favor explique por qué y adjunte copia de 2 talones de pago másrecientes.
3. Todos los estados de cuenta(s) de ahorro y de cheque.
4. Recibos de renta/alquiler (si es que aplica)
5. Pension Alimenticia (si es que aplica)

Envíe la solicitud completa y la documentación requerida a:

Dameron Hospital Association  
Patient Accounting Department  
525 W. Acacia Street  
Stockton, CA 95203

Por favor, póngase en contacto con el Departamento de Crédito y Cobranza del Hospital Dameron al (209) 461-3147 entre las horas de 7:00 am a 3:30 pm, si desea obtener más información o ayuda para solicitar cualquiera de estos programas.

### **Servicios de Médicos de Emergencia**

Un médico de urgencias que presta servicios médicos de emergencia en un hospital que brinda atención de emergencia también está obligado por ley a ofrecer descuentos a los pacientes sin seguro médico o los pacientes con altos costos médicos. Por favor, póngase en contacto con la oficina de facturación del médico de emergencia directamente para obtener más información sobre sus programas de asistencia financiera.

**ESTADO DE SITUACIÓN FINANCIERA  
INGRESOS ACTUALES PLANEADOS**

Su nombre: \_\_\_\_\_ Nombre de esposo/a: \_\_\_\_\_

Su SS# \_\_\_\_\_ SS# de esposo/a: \_\_\_\_\_

Dirección: \_\_\_\_\_

Ciudad/Estado/Cód. Postal: \_\_\_\_\_ Teléfono: \_\_\_\_\_

**A. CONFORMACIÓN DE LA FAMILIA**

1. Enumere todos los dependientes que usted mantiene (que no sean su esposo/a)

<u>Nombre</u>	<u>Edad</u>	<u>Relación</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**B. EMPLEO Y OCUPACIÓN**

1. Su empleador es: \_\_\_\_\_ Posición \_\_\_\_\_

Si es trabajador independiente, dé el nombre del negocio \_\_\_\_\_

2. El empleador de su esposo/a es: \_\_\_\_\_ Posición \_\_\_\_\_

Si es trabajador independiente, dé el nombre del negocio \_\_\_\_\_

**C. INGRESO ACTUAL**

	<u>Usted</u>	<u>Esposo/a</u>
1. Pago bruto (sueldos, salarios, comisiones, propinas)	\$ _____	_____
2. Ingresos por operar un negocio	\$ _____	_____
3. Otros ingresos:		
a. Intereses y dividendos	\$ _____	_____
b. De inmuebles o propiedad personal	\$ _____	_____
c. Seguro Social	\$ _____	_____
d. Pensión u otros ingresos de jubilación	\$ _____	_____
e. Otros (especifique) _____	\$ _____	_____
_____	\$ _____	_____
4. Pensión alimenticia, pagos por mantenimiento o ayuda	\$ _____	_____
<b>INGRESO MENSUAL TOTAL (total de arriba)</b>	\$ _____	_____

**(POR FAVOR COMPLETAR EL OTRO LADO)**

**D. PROGRAMA DE GASTO CORRIENTE**

1. Gastos de Casero:
  - a. Alquiler o hipoteca y mantenimiento costaron \$ \_\_\_\_\_
  - b. Hogar suministra \$ \_\_\_\_\_
  - c. Inmobiliaria impuestos \$ \_\_\_\_\_
  - d. Utilidades
    - Eléctrico y gas \$ \_\_\_\_\_
    - Agua \$ \_\_\_\_\_
    - Teléfono \$ \_\_\_\_\_
    - Otros (especificar) \_\_\_\_\_ \$ \_\_\_\_\_
    - Utilidades Total \$ \_\_\_\_\_
  
2. Otros Gastos:
  - a. Cónyuge o hijo apoyo \$ \_\_\_\_\_
  - b. Seguro (sólo si no descontados de sus salarios).
    - Salud \$ \_\_\_\_\_
    - Auto \$ \_\_\_\_\_
    - Los propietarios o inquilinos \$ \_\_\_\_\_
    - Otros (especifique) \_\_\_\_\_ \$ \_\_\_\_\_
    - Total Gastos de Seguros \$ \_\_\_\_\_
  - c. Gastos en Cuotas:
    - Auto \$ \_\_\_\_\_
    - Otros (especifique) \_\_\_\_\_ \$ \_\_\_\_\_
    - Otros (especifique) \_\_\_\_\_ \$ \_\_\_\_\_
    - Gastos totales a Plazos \$ \_\_\_\_\_
  - d. Transporte (incluyendo gas & reparaciones) \$ \_\_\_\_\_
  - e. Educación o cuidado de niño \$ \_\_\_\_\_
  - f. Comida \$ \_\_\_\_\_
  - g. Ropa (incluyendo lavado o limpieza) \$ \_\_\_\_\_
  - h. Médica, dental y medicamentos \$ \_\_\_\_\_
  - i. Otros (especifique) \_\_\_\_\_ \$ \_\_\_\_\_
  - j. Otros (especifique) \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL DE GASTOS MENSUALES ACTUALES (Total todo arriba) \$ \_\_\_\_\_**

Con mi firma, declaro que el programa de ingresos y gastos de arriba es un reflejo real de mis ingresos mensuales. Consiento que Dameron Hospital Association verifique mis datos de empleo e historia de crédito con el fin de determinar si califico para asistencia financiera, según lo permitido por la ley.

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
(Firma del Paciente o Fiador)