



# Model Documents for Hospital Financial Assistance

Developed by the  
The Los Angeles County  
Hospital Financial Assistance Best Practices  
Committee

Updated 2/23/26



# Overview

In October 2023, the Los Angeles County Board of Supervisors passed a motion titled “Reducing Medical Debt in Los Angeles County Through Improved Data Collection and Innovative Strategies to Retire Medical Debt.” As part of this initiative, the Board directed Department of Public Health (DPH), the Chief Executive Office (CEO), the Department of Consumer and Business Affairs (DCBA), and County Counsel to partner with hospitals operating in the County to identify best practices related to debt collection and financial assistance activities, including data collection and systems change, and post this information publicly.

## Purpose

To address systemic barriers, the model financial assistance documents provide adaptable model materials that hospitals can use to strengthen their financial assistance programs. These model documents include the following:

- Committee Recommendations – Best practices summary with details
- Financial Assistance Application – Simplified for ease of patient and staff use.
- Financial Assistance Policy – Standardized language ensuring best practices and regulatory compliance.
- Plain Language Summary – Designed to improve accessibility and transparency.

## Development

Developed through rigorous research and stakeholder engagement, these documents were informed and reviewed by the Hospital Financial Assistance Best Practices Committee, including representatives from hospitals, the Southern California Hospital Association, legal aid, and policy groups. These materials have also been reviewed by the California Department of Health Care Access and Information (HCAI) and align with state reporting and transparency requirements. Facilities regulated by HCAI may find that adopting these standardized, patient-friendly documents not only eases compliance with HCAI’s financial assistance policy requirements but also enhance staff understanding and patient accessibility and satisfaction.

These materials are customizable, allowing hospitals to tailor them while adopting best practices and ensuring compliance with state regulations.

## How to Use the Materials

Hospitals are encouraged to adopt these materials in whole or in part to reduce patient barriers to financial assistance programs. The model documents can be integrated into existing workflows or used to inform updates to current policies and procedures.

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## Commitment to Healthy Communities

This initiative reflects the Coalition's efforts to ensure that patients do not forego essential medical care due to financial barriers. By providing clear, effective, and transparent financial assistance programs, the medical debt burden can be reduced in Los Angeles communities.

## Acknowledgements

These materials were developed through the collaborative efforts of the Hospital Financial Assistance Best Practices Committee. We are grateful for the time, expertise, and commitment of the following members:

Committee Members:

- Western Center on Law & Poverty (WCLP): Joy Dockter
- Neighborhood Legal Services of Los Angeles County (NLSLA): Bernadette Manigault, Eric Galson
- California Pan-Ethnic Health Network (CPHEN): Selene Betancourt
- Martin Luther King, Jr. Community Hospital: Bruce Pollack
- Hospital Association of Southern California (HASC): Paul Young, Adena Tessler
- Cedars-Sinai Medical Center: Lisa Maqueira, Susie Herrera

Los Angeles County Department of Public Health (DPH) served as the non-voting secretariat. We thank all members for their partnership and dedication to advancing financial assistance best practices that promote transparency, accessibility, and equity in care.

For more information, please contact the committee secretariat:

Email: [hccp@ph.lacounty.gov](mailto:hccp@ph.lacounty.gov) or [vshamamyam@ph.lacounty.gov](mailto:vshamamyam@ph.lacounty.gov)

# Best Practices for Hospital Financial Assistance Programs

## September 16, 2025

### Communication Recommendations

- **Leverage Digital Platforms:** Utilize patient portals to provide comprehensive financial assistance information.
- **Mobile Notifications:** Implement mobile-friendly systems to send texts or emails with billing and available financial resource details.
- **Culturally Sensitive Language:** Collaborate with community-based organizations to train staff in destigmatized, culturally sensitive communication when informing patients on facility financial assistance policy (e.g., “Your financial health matters”).
- **Accurate Translations:** Check that all materials are translated accurately, reflecting regional linguistic nuances, particularly for diverse Spanish-speaking communities.

### Awareness Recommendations

- **Community Partnerships:** Work with community health workers and promotoras to deliver personalized patient support.
- **Visibility Campaigns:** Launch prominent website banners, clear on-site banners, and regular social media posts to help patients find and use financial assistance resources.
- **Media Outreach:** Partnerships with hospitals and public health departments for billboard or PSA campaigns highlighting patient rights and available resources.
- **Policy Alignment:** Align facility practices with state financial assistance regulations, financial assistance is a requirement for all hospitals starting 1/1/2025 including both non-profit (publicly subsidized) hospitals and for-profit hospitals.

### Electronic Tools Recommendations

- **Presumptive Eligibility Tools:** Adopt and deploy electronic pre-screening to streamline financial eligibility and minimize manual review.
- **Coverage Finders:** Implement tools to locate active coverage and flag possible coverages for follow up using real time eligibility checks and periodic sweeps.
- **Pre-Service Screening:** Implement steps and processes to prescreen patients for financial assistance upstream at scheduling, preregistration, or registration so determinations may be made before care.
- **Bias-Free Systems:** Prohibit electronic propensity-to-pay scoring. Use electronic tools and systems solely for objective financial assistance eligibility determinations.
- **Means-Tested Programs:** Incorporate participation in means-tested programs to qualify patients as a form of non-electronic eligibility (e.g., Medicaid enrollment, SNAP, TANF...etc).

## Duration of Eligibility

- **Extended Coverage (paper application):** Approve financial assistance with a paper application and grant at least 12 months of continuous eligibility.
- **Re-Screening:** For facilities that use electronic tools to help review eligibility, recheck a patient's eligibility again six months after the first approval to make sure the patient continues to qualify.

## Eligibility Recommendations

- **Income Thresholds:** Provide no-cost or discounted care for patients with incomes below 400% of the Federal Poverty Level (FPL), regardless of insurance status.
- **Flexible Income Assessment:** Align with Medi-Cal guidelines by assessing eligibility based on current or past 12 months' income, whichever is more advantageous to the patient.
- **Non-Discrimination & Identification:** Immigration status will not be considered for eligibility, and a Social Security Number is not required to apply for or receive financial assistance (alternate identification or documentation may be used).
- **Comprehensive Coverage:** Recommend expanding financial assistance policies to include services like Anesthesia, Pathology, Emergency Department care, Radiology, Oncology and all credentialed medical staff. Staff that will not adhere to hospitals policy will have formally Opt-out during contracting.
- **Equitable Access & Medical Staff Compliance:** All credentialed medical staff must honor the hospital's Financial Assistance Program (FAP) decisions as a condition of their privileges, ensuring alignment with the hospital's mission and reducing medical debt-related harms.
- **Opt-Out & Public Disclosure:** Providers who refuse to comply with FAP determinations must submit an Opt-Out Declaration during credentialing or renewal. Their names will be publicly disclosed, and patients will be informed to help them make informed healthcare decisions.
- **Application Process:** Develop clear protocols to help patients apply for forgiveness of existing medical bills or debt, considering their updated financial circumstances. Ensure these protocols align with the requirements of California AB 2297, including the removal of application deadlines.

## Collection Practices

- **Clear Policies:** Publish transparent guidelines outlining the collections process.
- **Pre-Collection Checks:** Ensure financial assistance eligibility is assessed before initiating collections.
- **Debt Suspension:** Pause all collection activities while eligibility determination is ongoing.
- **Exemptions for Low-Income Patients:** Prohibit collection actions for patients earning less than 400% of Federal Poverty Level.

## Appeals Process

- **Re-Application Opportunities:** Allow patients to appeal or reapply for financial assistance following eligibility denials.
- **Transparent Appeals:** Provide clear, step-by-step instructions for the appeals process, including where and how to file appeals. Processes should include methods of appeal that are ADA compliant.

## Model Document Recommendations

- **Template Applications:** Dual acceptance or use of the collectively developed adaptable model application for financial assistance, in addition to their own forms.
- **Template Documents:** Use of the collectively developed model documents, including a plain language summary, policy, and application, that are adaptable to individual operations for facilities.

[Hospital/system name/logo]

# Financial Assistance Application Form Instructions

Please use this form to apply for charity care (no-cost) or discounted care at [hospital or name]. Anyone can apply for financial assistance for free, regardless of their immigration status.

**California requires hospitals to provide financial assistance** to patients who meet certain income limits. You may qualify for free care or reduced-price care based on your household size and income, even if you have health insurance or another type of health coverage. The income limits for our hospital are shown in this table. **Note:** You may still qualify for financial help, even if your income is higher than the amounts listed. If you have a medical bill you can't afford, please reach out to our staff.

## Who Qualifies:

[insert hospital policy regarding eligibility and sliding scale FPL%] [link to FPL guidelines on hospital website].

	<b>NO-COST CARE</b> if gross yearly income is less than:	<b>DISCOUNTED CARE</b> if gross yearly income is less than:
Number in family/ household	[Insert Hospital Threshold] shown below is an example, based on the current average of 250% of Federal Poverty Level	[Insert Hospital Threshold] or mandated minimum 400% of Federal Poverty Level
1 person	\$39,900	\$63,840
2 people	\$54,100	\$86,560
3 people	\$75,130	\$109,280
4 people	\$82,500	\$132,000
5 people	\$96,700	\$154,720
6 people	\$110,900	\$177,440

Gross yearly income means the amount of income before tax.

For households of more than 6, add \$5,680 for each extra person.

To learn more about Federal Poverty Levels, visit <https://aspe.hhs.gov/poverty-guidelines>.

All information provided on this form will be kept confidential in accordance with California and federal law.

## How to get help with this application:

If you have questions or need help completing this form, please contact us at: [insert location and phone number and hours of the appropriate office or department.] If you're still in the facility, ask a billing staff member for assistance. We're here to help everyone, including those who need disability accommodations or want help in another language.

[Hospital/system name/logo]

## Financial Assistance Application Form Instructions (continued.)

You can also contact a free consumer advocacy group like the **Health Consumer Alliance** at 1-888-804-3536 or [healthconsumer.org](http://healthconsumer.org). They can help you understand the billing and payments system, apply for assistance, and appeal or reapply if your application is denied.

### How to submit your application:

You can submit the application by mail, phone, fax, online, email, or in person.

[Hospital Mailing Address]

[Phone #]

[Fax #]

[Email]

[Website URL] Scan the QR code with a mobile device to view the form online

Insert QR  
code here

### Location to submit your completed application in person:

[Department/office,

[Address]

[Hours]

[Phone #]

Make sure to include the required documents and keep a copy for your records. *There is no deadline to apply but the sooner you submit your application, the sooner we can offer discounted or free care.*

We will write to tell you if you are eligible for financial assistance within 30 calendar days after we receive your application and income documents. If we decide that you are not eligible, we will explain your rights and how you can appeal or reapply.

### On this form, family is defined as:

**If the patient is age 18 years of age or over:** family means the patient, their spouse or domestic partner, the patient's dependent children under 21 years of age or any age if disabled, and any other individual the patient claims as a tax dependent, whether or not living at home. A domestic partnership is a committed relationship between two adults who mutually care for each other; both must be at least 18 years old if of the same sex, or if of opposite sexes, both persons must be capable of consenting to the domestic partnership. "Disabled" has the meaning in Section 1614(a) of Part A of Title XVI of the Social Security Act.

**If the patient is under 18 years of age or a dependent child up to 20 years of age:** family means the patient, their parent(s) or other caretaker relative(s), and the parents' or caretaker relatives' other dependent children under 21 years of age, or any age if disabled.

### Financial Assistance / Charity Care Application Form

Please fill out as much information as possible. If it does not apply, write "NA."

#### Presumptive Eligibility

- Does the patient receive public benefits such as CalWORKs, CalFresh, WIC, or SSI?  Yes  No
- Does the patient receive any other public benefits?  Yes  No
- Has the patient applied for Medi-Cal or currently have Medi-Cal?  Yes  No
- Is the patient currently experiencing homelessness or lacks permanent housing?  Yes  No

#### Patient and Applicant Information

**Patient:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 First name      Middle name      Last name      Date of birth

**Person responsible for bill (if different from the patient):**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 First name      Middle name      Last name      Date of birth

**Address for Patient or Person responsible for bill (if different from the patient):**

\_\_\_\_\_  
 Street address      City      State      Zip code

\_\_\_\_\_  
 Email      (\_\_\_\_) \_\_\_\_\_ Phone      (\_\_\_\_) \_\_\_\_\_ Alternative phone

#### Other Identification Details (optional)

This information is optional but providing it may help your application to be processed faster.

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 Social security number\*      Hospital record number      Driver's license or ID number

\*A social security number is not required to apply for or receive financial assistance.

#### Household Size

**Enter the total number of people in the patient's family** Total  
 See form instructions for definition of family. \_\_\_\_\_

**Household Members**

**List all your family members. Include people who are also applying for financial assistance.** If the bill was from childbirth, please list both mother and baby’s information. If more than 5 other people are in your household, list them on a separate sheet.

Name	Date of Birth MM/DD/YY	Relationship to You
_____	_ / _ / _	_____
_____	_ / _ / _	_____
_____	_ / _ / _	_____
_____	_ / _ / _	_____
_____	_ / _ / _	_____

**Household Income**

**Check ALL types of income that you and your family members receive:**

- |  |  |
|--|--|
| <input type="checkbox"/> Employment Income/Wages         | <input type="checkbox"/> Alimony/Child Support             |
| <input type="checkbox"/> Business Income/Rental Property | <input type="checkbox"/> Income from Pension or Retirement |
| <input type="checkbox"/> Unemployment Benefits           | <input type="checkbox"/> Social Security                   |
| <input type="checkbox"/> Workers Comp/Disability Income  | <input type="checkbox"/> Veterans Benefits                 |
| <input type="checkbox"/> Income from Annuities           | <input type="checkbox"/> Other Income                      |

**Enter the total gross monthly income** for all family members. Gross income is the amount *before* taxes and other deductions Total  
\$ \_\_\_\_\_

**Proof of Income**

To be considered for financial assistance, you must provide information on the income of the patient and their family. To prove income, the hospital may only ask the patient for recent pay stubs or income tax returns. If the patient doesn't have these, other types of proof may be accepted, but are not required. If the patient has no proof of income, please explain why.

Examples of proof of income you can provide include:

- A “W-2” withholding statement OR
- Current pay stubs (2 *pay periods*) OR
- Most recent income tax return OR
- Written, signed statements from employers or others OR
- Approval/denial of eligibility for Medi-Cal and/or public benefit program OR
- Approval/denial of eligibility for unemployment compensation.

**If the patient has no income**, please explain how they pay their bills or support themselves. You can write the explanation on the back of this application or attach a separate page.

**Health Savings Accounts**

**Check the box if there is a Health Savings Account(s) that can be used for the patient's expenses.** *If you're not sure if you have a health savings account, please contact the hospital for help.*

Enter the balance in your Health Savings Account(s) Total  
\$ \_\_\_\_\_

**Healthcare Costs (optional)**

**Enter the total out-of-pocket expenses** you and your family members\* had at this hospital or to any other medical provider over the last 12-months. Include deposits, copays, co-insurance, share of cost payments, deductibles, and other payments for medical, dental, vision, hearing, pharmacy services, and medical equipment or supplies prescribed to you. Total  
\$ \_\_\_\_\_

**Enter the total amount** you and your family members currently owe to this hospital. Total  
\$ \_\_\_\_\_

**Agreement**

I understand that by submitting this financial assistance application, I am giving **[Hospital/system Name]'s**, permission to verify my information. This may include a credit check and/or other steps to determine if I qualify for financial assistance, such as charity care or discounted care. I understand that these inquiries should not affect my credit score.

I understand that giving false financial information may lead to my application being denied.

\_\_\_\_\_  
Name of person completing this form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of person completing this form

[ enter text: hospital name, hospital logo ]

## Plain Language Summary of the Financial Assistance Policy

Our goal is to provide caring, high-quality, and affordable healthcare to everyone who needs it.

### What is financial assistance?

Hospital financial assistance is healthcare that is provided at no-cost (free) or low cost for people who are uninsured, underinsured, and who are unable to pay for their care. At our hospital:

- **No-Cost Care** is for people whose income is [Insert Hospital Threshold]% of the Federal Poverty Level (FPL) or less. The patient does not have to pay anything for their healthcare.
- **Discounted Care** is for people whose income is more than [Insert Hospital Threshold]% but less than or equal to [Insert Hospital Threshold] or mandated minimum 400% of the FPL. The patient will only pay a reduced amount of their original bill.

*See next page for information about Federal Poverty Levels (FPL)*

### Am I eligible for financial assistance?

You can get financial assistance if your income (before tax) is up to [Insert Hospital Threshold] or mandated minimum 400% of Federal Poverty Level (FPL) when you got treatment or got your first bill if you:

- Don't have health insurance and can't join a government healthcare program, *OR*
- Have insurance or a government healthcare program but it doesn't cover all of your bills, *OR*
- Can't pay for your bill because of your financial situation.

Note: If you make more than [Insert Hospital Threshold] or mandated minimum 400% of the Federal Poverty Level (FPL) but have large medical bills, you may still qualify for help. Talk to someone from our billing staff for assistance.

You can get financial assistance regardless of your immigration status.

*We will look at your application to see if you can get help from a government program.*

If you are given discounted care, you will never be charged more for emergency or medically necessary care than what hospitals usually get paid from Medicare, Medi-Cal, or other insurance plans, this is known as the "amounts generally billed" (AGB).

### How do I apply for financial assistance?

- Fill out an application and provide some papers to show your income.
- You can submit an application by mail, email, fax, online, or in person at the hospital. If you are still in the facility, ask for a member of our billing staff to assist.
- You can apply for financial assistance at any time, but it is best to apply as soon as possible.

[ enter text: hospital name, hospital logo ]

## Where can I get the application for financial assistance?

The application, this plain language summary and the full policy are available to everyone for free, in English and other language(s).

- Online at [enter weblink],
- At the hospital's emergency room, [enter hospital office or department], [enter street address], [enter city, state, zip code]
- By mail - to request a form and financial assistance policy:
  - Call the financial assistance office [enter phone number]. You can also call the main hospital number at [enter phone number] and ask to speak with a financial counselor.
  - Write to the hospital at the address above [edit if different address]
- The hospital will send you application in the mail for free if you ask for one.

## How can I get help?

- If you have questions or need help completing this form, please contact us at: [insert location and phone number and hours of the appropriate office or department.] If you are still in the facility, ask for a member of our billing staff to help. We can help anyone for any reason, including people who need accommodation for a disability or people who use a different language.
- You can also contact a free consumer advocacy group like the Health Consumer Alliance .They can help you understand the billing and payments system, apply for assistance, appeal or reapply if your application is denied. Call the *Health Consumer Alliance* at 1-888-804-3536 or visit <https://healthconsumer.org/>.

**What percentage of the Federal Poverty Level (FPL) is my income?** See the table below or visit <https://aspe.hhs.gov/poverty-guidelines>. For additional help contact the Health Consumer Alliance (see above).

**The figures provided for 100%, 250%, and 400% of FPL are intended as reference points. Facilities may establish their own thresholds as appropriate.**

Examples of Federal Poverty Levels (FPLs) in 2026			
Number in family/household*	Gross income (before tax) in a year		
	100% of FPL	250% of FPL	400% of FPL
1 person	\$15,960	\$39,900	\$63,840
2 people	\$21,640	\$54,100	\$86,560
3 people	\$27,320	\$68,300	\$109,280
4 people	\$33,000	\$82,500	\$132,000
5 people	\$38,680	\$96,700	\$154,720
6 people	\$44,360	\$110,900	\$177,440

*\*For households of more than 6, add \$5,680 for each extra person\**

<b>Financial Assistance Charity and Discounted Care Policy</b>	<b>Policy #:</b> LAC-0124
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**Template/Model POLICY**

<p><b>Financial Assistance Charity Care Policy</b>  <b>Financial Assistance Discounted Care Policy</b></p>	<p><i>Policy Number:</i>  LAC-0124</p>
<p><b>Policy Review Schedule:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Biennial <input type="checkbox"/> Triennial</p> <p><b><u>For Help with Financial Assistance Call</u></b></p> <p>[ Enter Department Name ] at: [ enter phone number ]</p>	<p><b>Originated:</b>  MM/DD/YY</p> <p><b>Reviewed/Revised:</b> MM/DD/YY</p> <p><b>Effective:</b> MM/DD/YY</p>

**I. Purpose**

The purpose of this policy is to ensure a fair, non-discriminatory, effective, and uniform method for the provision of financial assistance, no-cost, and discounted care to eligible individuals who are unable to pay in full or part for medical services and other hospital services provided. This Financial Assistance Policy complies with all federal, state, and local laws.

**II. SCOPE & COVERAGE**

**A.** The scope of this policy and the financial assistance programs herein constitutes the official Financial Assistance Policy for each hospital owned, leased, or operated by [ enter hospital organization ] and facilities. *See list below.* For a complete list of affiliated physician practices, clinics, and providers *See Appendix C*

- [ enter facility name ]
- [ enter facility name ]
- [ enter facility name ]
- [ enter facility name ]
- [ enter facility name ]

**III. DEFINITIONS / ACRONYMS**

**Amount Generally Billed (AGB):** The average amount allowed for reimbursement by Medicare, Medi-Cal, and/or other third-party payers, including both the amount the insurer will pay and the amount (if any) the patient is personally responsible for paying in the form of co-payments, co-insurance, and deductibles. This is usually expressed as a percent of gross

**Financial Assistance Charity and Discounted Care Policy**Policy #: **LAC-0124**

charges. Pursuant to federal law, hospital organizations that are described by 501(c)(3) may not charge individuals eligible for financial assistance more than AGB. Pursuant to state law, in California, AGB applies to all hospitals regardless of ownership status and is based on the amount of payment the hospital would expect to receive for providing services from Medicare or Medi-Cal, whichever is greater.

**Application Period:** The period during which the facility must accept and process an application for financial assistance submitted by an individual in order to determine whether the individual is eligible for financial assistance under this policy. **In California there is no deadline to apply for financial assistance.** The Application Period usually begins on or before the date that the first post-discharge statement for the care provided and does not have a deadline.

**Charity Care (no-cost):** Charity Care (no-cost) is a program offering a full 100% discount on eligible medical services for patients who meet certain financial need criteria, making these services free for them and their guarantor. Charity Care (no-cost) does not reduce the amount, if any, that a third-party health coverage may be required to pay for eligible services provided to the patient.

**Debt Collection:** Debt Collection means any act or practice in connection with the collection of medical debt from a patient, including but not limited to the following:

- Any attempt to contact a patient regarding a debt more than 90 days past-due, including, but not limited to the following communication methods: mail, email, text, phone calls, and in-person.
- The sale or assignment of a patient's debt to a third party for collections purposes.
- Reporting adverse information about the patient to a consumer reporting agency.
- Any civil actions undertaken to collect a medical debt, including but not limited to placing a lien on a patient's property, attaching, or seizing a patient's bank account or any other personal property, obtaining an order for examination pursuant to California Code of Civil Procedure Section 708.120, or garnishing a patient's wages.
- Delaying or denying care because a patient has an unpaid medical debt.
- Engaging in any other Extraordinary Collection Action not mentioned above.

**Discounted Care:** Discounted Care is a program that offers partial financial assistance to qualifying patients based on financial need, reducing the amount they and their guarantor owe for eligible medical services. This assistance doesn't affect payments from health insurance or other third-party payers for these services. The amount paid by patients who are eligible for Discounted Care cannot exceed the AGB.

**Financial Assistance Charity and Discounted Care Policy**Policy #: **LAC-0124**

**Extraordinary Collection Action (ECA):** Per the IRS Extraordinary Collection Actions are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's Financial Assistance Policy (FAP). These actions include, but are not limited to:

- Selling an individual's debt to another party,
- Reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"),
- Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP.
- Any actions that require a legal or judicial process

**Essential Living Expenses (ELE):** Expenses that may include, but are not limited to, the following: rent or house payments and maintenance; food and household supplies; utilities and telephone; clothing; medical and dental payments; insurance; school or childcare costs; child or spousal support; transportation and auto-related expenses (including insurance, gas, and repairs); installment payments; laundry and cleaning; and other extraordinary expenses.

**Federal Poverty Level (FPL) (at the time the patient was first billed):** Dollar amount cut-off of income set by the U.S. Department of Health and Human Services to define poverty. Federal Poverty Level for the current year can be obtained from the following website:

<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

**High Medical Costs:** (1) Annual out-of-pocket medical expenses incurred by the patient at the hospital that exceed the lesser of 10 percent of the patient's current family income or family income in the prior 12 months; (2) annual out-of-pocket medical expenses that 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 Members (or Household) as defined above; or (3) a lower level determined by the hospital in accordance with the hospital's charity care policy. Out-of-pocket costs means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing

**Household Income (at the time of first billing):** All income of all family members who live in the same household, defined as the home address the patient uses on income tax returns, or on other government documents. This may include the following: gross wages, salaries, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, interest, dividends, income from rental properties, estates and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources.

**Financial Assistance Charity and Discounted Care Policy**Policy #: **LAC-0124**

**Limited English Proficiency (LEP) Group:** A group of people who either do not speak English, or who are unable to effectively communicate in English because it is not their native language. The size of the group is the lesser of either 1,000 individuals, or five percent (5%) of the community served by the facility, or the non-English speaking populations likely to be, affected or encountered, by the facility. The facility may use any reasonable method to determine the number, or percentage, of LEP patients that may be affected, encountered, or are served by the facility.

**Medically Necessary:** Refers to inpatient or outpatient health care services provided to evaluate, diagnose, or treat an injury, illness, disease, or its symptoms, where without treatment the patient's health would be at risk. For individuals 21 years of age or older, a service is medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (Welf. & Inst. Code § 14059.5). For individuals under 21 years of age, medically necessary services include those needed to treat, correct, or ameliorate conditions identified by screening services, consistent with the EPSDT standard at 42 U.S.C. § 1396d(r)(5). All medically necessary services are eligible for the Discount Payment Program. Hospitals may, but are not required to, provide discount payment for non-emergency services provided to patients with high medical costs for out-of-network care not covered by a third-party payer if the patient declines transfer to an in-network facility. For purposes of patient complaint investigations, services performed within the hospital are presumed to be medically necessary unless the hospital provides the Department an attestation that the hospital services at issue in the complaint were not medically necessary; an attestation is valid if it is signed by the provider who referred the patient for the hospital services at issue in the complaint or by the supervising health care provider for the hospital services at issue; the hospital must obtain the required attestation before denying a patient's eligibility for the Discount Payment Program on the basis that the services at issue were not medically necessary.

**Medi-Cal Presumptive Eligibility:** Provides qualified individuals immediate access to temporary, no-cost Medi-Cal while applying for permanent Medi-Cal coverage or other health coverage.

**Patients Family (Family Members or Household):** A Household is a single individual aged 18 years and older, the patient, spouse, domestic partner, and dependent children under 21 years of age whether living at home or not, or any age if disabled, plus any other individual for whom the patient bears financial responsibility and claims as a tax dependent regardless of residence; a domestic partnership is a committed relationship between two adults who mutually care for each other, with both at least 18 years old if of the same sex, or if of opposite sexes, both persons capable of consenting to the domestic partnership; for patients under 18 years of age or for dependent children 18 to 20 years of age, the household includes parents, caretaker relatives, and the parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled; use the definition of "disabled" from Section 1614(a) of Part A of Title XVI of the Social Security Act.

**Presumptive Financial Assistance Eligibility:** Eligibility determined or assumed through means other than patient-provided information in an application. This may include utilizing a

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scoring tool or leveraging existing means-tested qualifications for government or FQHC services designed for lower-income individuals. Additionally, financial assistance qualification may be assumed based on certain criteria, such as currently unhoused or suffering housing instability, current Medicaid/Medi-Cal program status, or credit-based financial assessments. Hospitals may employ an automated scoring tool to assess patients' eligibility for financial assistance, utilizing publicly available data sources to predict the likelihood of qualification. This tool offers estimates of the patient's financial status and household income, thereby streamlining the assessment process. Scoring tools may be used to qualify a patient for assistance but will not be used to disqualify a patient from applying for financial assistance.

**Reasonable Payment Plan:** Monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "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 dental payments; insurance; school or childcare; child or spousal support; transportation and auto expenses, including insurance, gas, and repairs; installment payments; laundry and cleaning; and other extraordinary expenses. Payment plans shall be interest free and include no additional fees.

**Self-Pay Patient:** A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medi-Cal, or whose health insurance does not cover all services provided during a hospital stay, 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.

**Uninsured Patient:** A patient with no level of health coverage or insurance to help pay their medical bills.

**Underinsured Patient:** A patient who has some amount of insurance or health coverage but still has out-of-pocket expenses that exceed their ability to pay.

#### IV. POLICY

**A. Objective.** [ enter hospital name ] is committed to helping people who need medical care but can't afford it. This includes those who don't have insurance, have limited insurance, can't get help from the government, or just can't pay for emergency or necessary medical care. This goal fits with our mission to provide caring, high-quality, and affordable healthcare while supporting those in need. We work hard to make sure money problems don't stop people from getting the care they need. We aim to use our resources wisely to help as many patients as possible and have set up guidelines for offering financial assistance.

**B. Emergency Medical Conditions.** The facility will provide, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay, eligibility for financial assistance under this Financial Assistance Policy and regardless of their eligibility for government assistance.

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**C. Services Eligible Under This Policy.** The following healthcare services provided are eligible for financial assistance:

1. Emergency medical services provided in an emergency room setting.
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
4. All medically necessary services provided by the hospital facility are eligible for the Discount Payment Program. Services performed within the hospital are presumed medically necessary unless the hospital obtains a valid attestation from the referring provider or the supervising health care provider that the services at issue were not medically necessary, and the hospital must obtain that attestation before denying eligibility on that basis. Patients may apply for financial assistance for services that are not medically necessary, and the hospital may approve such assistance on a case-by-case basis under the hospital's Discretionary Financial Assistance policy.
5. Financial assistance approvals apply to the patient's current bill and to any outstanding balances for medically necessary services. If a patient has already made payments and is later determined eligible for financial assistance, the hospital will reimburse any amount paid more than what is owed under this policy, with interest at the statutory rate set by Code of Civil Procedure § 685.010, accruing from the date the hospital received the payment; reimbursement will be issued within 30 days. The hospital is not required to reimburse or pay interest when the total due is less than \$5. If the hospital, or the Department, determines that the patient qualified for financial assistance at the time of first billing and either (i) five or more years have passed since the last payment to the hospital, its assignee, or a debt buyer, or (ii) the patient debt was sold to a debt buyer before January 1, 2022 in accordance with state law, the hospital may, but is not required to, provide reimbursement.

**D. Non-Medically Necessary Care.** Financial assistance is provided under this policy only for emergency and medically necessary care. A non-medically necessary procedure is not emergency or medically necessary care and is not covered under this policy. The facility may grant financial assistance for non-medically necessary services in particular situations at its discretion.

**E. Who Qualifies and How Much You Can Be Billed.**

1. **Scope.** Eligibility for charity care or discounted care will be considered for individuals who are uninsured, underinsured, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy.
2. **Non-Discrimination.** We decide on financial help based only on your financial need. We do not consider your age, gender, marital status, race, color, beliefs, ethnicity, social or immigration status, country of origin, sexual orientation, gender identity or expression, religion, disability, or veteran or military status. We also do not consider any other factor that

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federal, state, or local law forbids.

3. **Evaluation of Need.** This hospital uses one application for both free-care, also called charity care, and discounted payment. You may apply yourself or ask an outside representative, someone who is not employed by the hospital, to apply for you, such as DollarFor, a nonprofit, or a legal aid group. If an outside representative applies, they must include all required information and show they have your permission, for example with a signed HIPAA release or an authorized representative form. We ask only for the information we need to decide if you qualify, and we use it only to check for government programs and for help under this policy, so you receive the most assistance you qualify for.

4. **Financial Need.**

a. **No-Cost (charity care):** Uninsured and underinsured patients whose family gross income is between 0% and 250% of FPL at the time the patient is first billed, are eligible for charity care (i.e., free care). An application may be submitted by the patient or patient representative(s), including third-party non-profit organizations assisting patients. See **Appendices A and B**, for recent FPL amounts based on family size.

b. **Discounted Care:** Uninsured patients and underinsured patient with High Medical Cost whose gross income is above 250% of FPL and up to and including 400% of FPL at the time the patient is first billed are eligible to receive discounted care. An application may be submitted by the patient or patient representative(s), including third-party non-profit organizations assisting patients. See **Appendices A and B**, for recent FPL amounts based on family size.

c. **Individual Financial Circumstances:**

Patients who fall outside the standard charity care and discounted care guidelines may still qualify for financial assistance. [insert hospital name] may grant discounted or charity care at its discretion for patients facing catastrophic medical expenses or based on an assessment of the patient's individual financial situation, including income, assets, and expenses. If you have a medical bill you cannot afford, please reach out to our staff for help.

5. **Limit on what you can be billed.**

a. **All hospitals.** If you qualify for discounted care, you will not be billed more than what we expect to receive from Medicare or from Medi Cal for the same service, whichever is higher.

b. **Tax-exempt non-profit hospitals.** If this facility is a tax-exempt non-profit hospital, we also follow the federal Amount Generally Billed rule for emergency or other medically necessary care. We use the Prospective Medicare method to set that amount. If both rules apply, we will bill the lower of the two amounts.

c. **Insurance payments.** If your insurer has already paid the Amount Generally Billed or the Medicare rate for a bill, you will not owe a copayment or any other remaining balance for

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that bill.

d. **Patient responsibility.** If you qualify for discounted care and your insurer has already paid the AGB or the Medicare rate for that bill, you will not owe any copayments or any remaining balance.

6. **Exceptions.** We may approve financial assistance outside the usual rules on a case-by-case basis. We can be more generous than the required limits. Your charge will still be at or below the required AGB caps.

7. **Third Parties.** Your financial assistance does not reduce what an insurer or any other payer must pay. We will seek payment from them first.

**F. Effective Period.** Financial assistance eligibility determinations remain in effect for **365** days, unless additional information is obtained, impacting the determination the hospital previously made. The hospital may only request further information from an individual if it is to offer charity care rather than discounted care.

**G. Patient responsibilities.** Please give complete and accurate information and work with us on the steps to review your request for financial help. You may be asked to pay what you can based on your ability to pay. For charity care, we may require you to apply for other coverage. For discount payment, we will not require you to apply for Medicare, Medi Cal, or other coverage before we screen you for, or provide, a discount. During the discount payment screening, we may require you to take part in a Medi Cal eligibility screening. We may also suggest that you explore health coverage for future care, but this is not a condition for receiving a discount now. *(CA H&SC 127405(b)(2))*

## V. PROCEDURE

### A. Determination of Financial Need.

1. **Our promise.** We are committed to fairness, compassion, and accountability in how we offer financial help. This includes the application, the review of financial need, and the final decision.

2. **Making patients aware of financial assistance.** We will make every reasonable effort to tell patients that financial help is available and to find out if a patient qualifies.

3. **How we decide if you qualify.** We may use one or more of the following steps:

a. **Presumptive screening.** We check each bill to see if the patient appears to qualify for financial help. We do this before we set up a payment plan or send an account to a third-party debt collector. This helps make sure eligible patients receive help.

b. **Application review.** You or your guarantor may be asked to complete an application and provide information and documents we need to decide financial need.

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c. **What assets we look at.** When we decide eligibility for financial help, we will limit our review of assets to a health savings account held by the patient or the patient's family.

d. **Money assets.** We may also ask about money assets only for two reasons:

- To waive or reduce Medi Cal and Medicare cost sharing amounts as part of our charity care or discount payment programs.
- For Medicare cost sharing, we may consider money assets only as needed to follow Medicare rules for bad debt and reimbursement. "Money assets" means things that can be turned into cash. It does not include retirement plans, deferred compensation plans, or assets that are protected for a spouse under federal Medicaid rules.

e. **Documentation.** To decide if you qualify for free care or discounted care based on financial need, you are required to provide only one of these to show your income: recent pay stubs or recent income tax returns.

- **Recent income tax returns** mean returns that show your family income for the year you were first billed, or for the twelve months before you were first billed.
- **Recent pay stubs** mean pay stubs dated within six months before or after the date you were first billed. For care that has not yet been provided, pay stubs within six months of the date you submit the application.
- If you cannot provide pay stubs or tax returns, we may ask for other proof, such as a signed employer letter, a letter showing approval or denial from a government program, a written declaration, or a verbal statement. You are not required to provide these other items, but we will accept them if you choose to provide them

f. **Public data and electronic tools.** We may use public data and electronic tools, such as credit checks and income verification, to understand your ability to pay or your eligibility for government programs. We use these tools to confirm that you qualify for help, not to deny help. You can still apply based on your own situation, including financial hardship or a very large medical bill.

g. **Past bills and quick checks.** We may look at our records of your past hospital bills and payments to help prequalify you and speed up our decision. We will also prescreen you for free care or a discount if any of these apply: you are uninsured; you are enrolled in Medi Cal or you qualify under the Hospital Presumptive Eligibility program; you have a Covered California plan and your household income is at or below 400 percent of the federal poverty level; you are enrolled in CalFresh, CalWORKs, Tribal Temporary Assistance for Needy Families, Women Infants and Children, California Alternate Rates for Energy, the Low Income Home Energy Assistance Program, the Housing Choice Voucher program, or another similar program named by the Department or by the hospital; you are experiencing homelessness; or after insurance and other payments you would still owe the hospital 500 dollars or more. If you have proof that you were income tested for a public program in the last twelve months, bring it and we will accept it to fast track your application. You can still apply without these items.

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4. **Gather information to review eligibility.** A financial counselor may ask for the items listed below to help decide if you qualify for free care or discounted care. Only the items in d and e can be required to show income. All other items are optional. Information collected for financial assistance will not be used for collections unless we obtained it separately and not as part of this review. We will not deny financial assistance because you did not provide optional items. We may still approve help based on other proof or on your attestation. (CA H&SC 127405(e))

- a. Financial assistance application.
- b. Credit Bureau Reports (including the lack thereof).
- c. Bank statements showing payroll deposits.
- d. Payroll stubs.
- e. IRS tax returns.
- f. Written Declarations.
- g. Verbal attestations.
- h. Reports from electronic tools to qualify patient for presumptive financial assistance or public assistance.
- i. Any other documents that may be used to substantiate the need for financial assistance.

5. **If you cannot complete the form.** If you are not able to fill out the written application, you may give a signed statement or tell us the facts and we will write them down. This statement, sometimes called an attestation, is acceptable. With your permission, staff can also fill out the application for you. When we receive information from you or others, we may check it to make sure it is correct. If anything is missing or unclear, a financial counselor will contact you as soon as possible and give you a chance to correct or add to your application.

6. **Review of your application.** A financial counselor will check your application to make sure it is complete and correct and will keep your documents safe. We ask only for the information needed to decide if you qualify. What we need may vary based on what you or your family can provide. If anything is missing, we will tell you and give you a chance to add it.

7. **Rechecking your eligibility.** We will check your eligibility again each time you receive care if your last review was more than **one year** or **365 days**, ago. We will also recheck if we learn new information that could change your eligibility. You do not need a new application when we can decide using our presumptive screening methods described in this policy.

8. **Program based eligibility.** We will consider you for no cost care or a discount, and we will prescreen you, if you are enrolled in, recently applied for, or were found eligible for any of the following, or if any of these situations apply: Covered California with a household income at or

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below 400 percent of the federal poverty level, California Alternate Rates for Energy (CARE), Low Income Home Energy Assistance Program (LIHEAP), experiencing homelessness, Medi Cal or Medicaid, Ability to Pay (ATP), CalFresh, CalWORKs, Women, Infants, and Children (WIC), Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF) or Tribal TANF, Cash Assistance Program for Immigrants (CAPI), State Children’s Health Insurance Program (SCHIP), Head Start, Housing Choice Voucher Program, Public Housing Program, Federal Pell Grant Program, and the Food Stamp Program.

9. **Denial.** We may deny financial assistance if:

- a. You do not meet the eligibility rules in this policy.
- b. You do not provide the required proof of income or an attestation after we ask, and there is not enough information to decide using our presumptive screening tools.

10. **Denial Procedure:** If you do not qualify for financial assistance, we will do the following:

- a. We will keep a record that shows why your application was denied and how we made the decision.
- b. We will send you a written notice of the denial by mail, email, your patient portal, or another usual way we contact you.
- c. The notice will explain your right to appeal and will include clear instructions on how to appeal, what to send, and where to send it. If you need help or another language, ask us and we will assist you:

**Help Paying Your Bill**

There are free consumer advocacy organizations that will help you understand the billing and payment process and can help you apply for assistance or help appeal or reapply if your application is denied. You may call the Health Consumer Alliance at 888-804-3536 or go to [healthconsumer.org/](http://healthconsumer.org/) for more information.

**Hospital Bill Complaint Program**

The Hospital Bill Complaint Program is a State of California program. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to [HospitalBillComplaintProgram.hcai.ca.gov](http://HospitalBillComplaintProgram.hcai.ca.gov) for more information and to file a complaint.

- d. If you do not qualify for financial assistance and do not set up a payment plan, we may start our collection process as allowed by law.

11. **Appeal process.** If you disagree with our decision about financial assistance, including the discount amount or a denial, you can appeal. Send a written appeal to [office or department name] by mail, email, or our online form. In your appeal, include your full name, date of birth, account or medical record number, what decision you disagree with, and any new information or documents you want us to consider. We will review your appeal and any new information and send you a written decision within [number] days. If we need more information, we will

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contact you and give you time to provide it. You may also reapply if your situation changes. If you need help or another language, we will assist you at no cost.

- a. **When you can appeal.** You may appeal after you receive our financial assistance decision. You can appeal a denial or appeal if you believe the discount is too low.
- b. **How to appeal.** Send your appeal to [office or department name] by mail, email, or our online form. Include your name, date of birth, account or medical record number, what part of the decision you disagree with, and any new information or documents.
- c. **Our timeline.** We will send you a written decision within 45 days of when we receive your appeal.
- d. **While an appeal is pending.** If you have an appeal with your insurer or an Independent Medical Review about coverage for the services, we will not sell your debt until that appeal is resolved. If we assign or sell an account for billing, the company must follow the Hospital Fair Pricing Act. By law we will not report hospital debt to credit bureaus or start a court case for nonpayment for at least 180 days after the first bill.

**B. How to Apply for Financial Assistance.**

1. **Getting help with financial assistance.** [enter hospital name and office or department] can explain this policy and help you fill out the application. You can get help in person at the hospital, by phone, by fax, by mail, or online. We can also help you look for insurance or public programs that might cover your care and check your eligibility under this policy. There is no deadline for patients to apply for financial assistance.
2. **Checking for coverage.** We will ask you, or your outside representative, if you have any insurance or public coverage that could pay part of your bill. This may include Medicare, Medi Cal, Covered California, California Children’s Services, or other state or county programs. We will help you find and apply for these programs, and we can refer you to agencies such as the Los Angeles County Department of Public Social Services. For discount payment, we will not require you to apply for Medicare, Medi Cal, or other coverage before we screen you for, or provide, a discount. For charity care, we may require you to apply for other coverage. (CA H&SC 127420(a))
3. **How to get the application and policy.**  
The financial assistance application, the plain language summary, and this full policy are free in English and other languages. You can get them:
  - a. **Online:** [ enter weblink],
  - b. **In person:** Free paper copies are available at the hospital at [name or location of office within hospital].
  - c. **By phone:** Call [enter phone number] or call the main hospital number at [enter phone number] and ask for a financial counselor. We return calls about financial assistance within one business day.
  - d. **By mail:** We will mail free copies to you on request.

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4. **Decision timeline.** We will send you a written notice within **30** days after we receive your completed application. The notice may come by mail, email, or your patient portal.
5. **Who can refer you for financial assistance.** Any member of our staff or medical staff can refer you, including physicians, nurses, financial counselors, social workers, case managers, chaplains, religious leaders, and other staff.
6. **Who can request financial assistance.** You can ask for financial assistance. With your permission, a family member, a close friend, or another person acting for you may also ask. We will follow privacy laws, including HIPAA.

**C. Presumptive Financial Assistance Eligibility.**

1. We will make reasonable efforts to prescreen patients for free care or a discount before starting any collection activity and whenever we have information that suggests a patient may qualify. We will also prescreen in the situations listed in the “Program based eligibility” section above. You can still apply even if none of these apply. We may use information from public sources, electronic screening tools, other hospitals, nonprofit groups, or government agencies, as allowed by law. We use these tools to confirm eligibility, not to deny help. Examples of information or circumstances we may rely on include, but are not limited to:
  - a. Participation in state-funded prescription programs.
  - b. Unhoused, or having received care from a clinic for the unhoused.
  - c. Participation in Women, Infants and Children programs (WIC).
  - d. Food stamp eligibility.
  - e. Means-tested subsidized school lunch program eligibility.
  - f. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid Spend-down, Share of Cost).
  - g. Low income/subsidized housing is provided as a valid address.
  - h. Low income/subsidized housing vouchers.
  - i. Credit based electronic screening tools for FPL (i.e., FinThrive, Experian, etc.)
  - j. The patient is deceased with no known assets.
  - k. The patient has been declared bankrupt by a federal bankruptcy court order within the past twelve (12) months.
2. **Presumptive financial assistance.** Presumptive financial assistance can be free care or discounted care. If we find you presumptively eligible for a discount rather than free care, we will tell you that you can apply for additional financial assistance.
3. **Automatic qualification for free care.** If you are enrolled in any of the following, you qualify for free care: CalFresh,, Medi-Cal for Adults, Medi-Cal Program for Pregnant Women, Food Stamp Program, Head Start, Extremely Low Housing Choice Voucher Program (Section 8), CHIP, WIC, SSI, and TANF & Tribal TANF.

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4. **Using prior decisions.** If we previously decided that you qualified for financial assistance, we may use that prior decision to presumptively approve you again for no cost care or a discount when current information shows similar circumstances, such as experiencing homelessness, recent bankruptcy, or enrollment in one of the programs listed above. You can still send new information or ask for a fresh review at any time.
5. **Propensity to pay scores.** We do not use propensity to pay scores to decide if you qualify for financial assistance. These scores are predictions from electronic tools about whether someone might pay a bill. They are not used to approve or deny help.
6. **Written notice of presumptive eligibility.** If we find you presumptively eligible for financial assistance, we will make reasonable efforts to send you a written notice that explains the decision and the help you qualify for. We may send this by mail, email, or your patient portal.

**D. Prohibited Charges.** After we decide you qualify for financial assistance, we will not bill you full (undiscounted) charges. We also will not bill you more than the Amount Generally Billed for emergency or other medically necessary care while you are eligible, as required by federal rules.

**E. Widely Publicizing Financial Assistance.** We will share information about financial assistance in our community as required by California law and federal rules. This will include, but not be limited to: *(CA H&SC 127400)*

1. **Website posting.** We will post the full, current policy on our website, along with translations for patients with limited English proficiency, the plain language summary, and the financial assistance application. These materials will be easy to find and free to access, as required by federal and California law.
2. **Notice to patients.** All patients who receive services will get a written notice about this Financial Assistance Policy. The notice explains who may qualify, how to apply, other payment programs, and how to get help. It includes contact information for our financial assistance office:

- **Phone:** [insert phone number]
- **Email:** [insert email address]
- **Office location:** [name or location of office within hospital]

For emergency department visits, we will give you a paper copy at the time of service or before discharge, as required by California law. Patients who receive emergency or outpatient care and are not admitted will also receive the notice. The notice and any other letters we send will be in the language you speak, as required by state and federal law. Free copies are available on request, and we can mail them to you at no charge. *(CA H&SC 127410)*

3. **Notices in key locations.** We post clear notices in the emergency department, admissions or registration areas, and the billing office that explain our Financial Assistance Policy, who

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may qualify, and how to get help, an application, or a copy of the policy. Free paper copies of the plain language summary, the application, and the full policy are available on request, and we can mail them to you at no cost. Materials are available in English and in other languages for patients with limited English proficiency. During intake or discharge, we will offer you a paper copy of the plain language summary. (*Treas. Reg. §1.501(r)-4(b)(5)(i)(D)*)

4. **Help Paying Your Bill webpage.** We will keep a webpage titled “**Help Paying Your Bill.**” It will include, at a minimum but not be limited to.

- a. Who may qualify for free care or a discount.
- b. How to apply.
- c. Links to this policy, the plain language summary, and the application.
- d. How to reach the office for more information, including phone, email, location, and hours.
- e. Information about the State of California’s Hospital Bill Complaint Program.

5. **Finding the page.** A link called “**Help Paying Your Bill**” will be easy to find on our website and will appear:

- a. In the website footer.
- b. On any page with information about paying a bill.
- c. In the website header or within one click in a drop-down menu from the header.

6. **Notices in public areas.** We will place clear signs in public areas of the hospital, at least in the emergency department and in admissions or registration areas. The signs will tell patients that financial assistance is available and where to get:

- a. More information about this policy and how to apply.
- b. Free copies of this policy and translations for patients with limited English proficiency.
- c. The financial assistance application and translations for patients with limited English proficiency.
- d. The plain language summary of this policy and translations for patients with limited English proficiency.

7. **Billing statements.** Every bill will include a clear notice that financial assistance is available. The notice will list the phone number for our financial assistance office [insert phone number] and the direct web address [enter weblink] where you can get this policy, the application, and the plain language summary.

8. **Community notice.** We will share information about financial assistance with the community we serve in ways that are likely to reach people who need it most. The notice will explain that help is available and how to get:

- a. More information about this policy.
- b. Help with the application process.

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- c. Free copies of this policy, the application, and the plain language summary.
- d. We may share this information through community groups, events, clinics, social service agencies, and social media, etc.

**9. Translations.** We will provide free translations of this policy, the application, and the plain language summary in the main languages in our community. We will translate into any language spoken by at least five percent of the community we serve or one thousand people, whichever is smaller, and for groups we are likely to serve. We will also provide qualified interpreters at no cost for any conversations about financial assistance.

**F. External Providers.** Some care at our hospital is provided by doctors and other health care professionals who are not employed by or affiliated with [enter organization name]. They bill for their own services, and their bills are not covered by this financial assistance policy. If you are approved for help under our policy, you may share your approval letter with their billing office in case they offer their own financial assistance. This policy covers care provided at our hospital's facilities and including all locations that fall under hospital's licenses.

1. If you are determined to be eligible for free care under this policy, you will not be billed by these external vendors. Patients for whom an eligibility determination is pending may receive bills from these healthcare providers.

2. We contract with and allow some outside doctors to treat patients at our hospital. These doctors must follow this policy. They agree to honor our financial assistance decisions for their professional charges for care given at our hospital. This is a condition of getting and keeping permission to treat patients here.

a. To support fair access to care and our mission to serve patients regardless of ability to pay, all credentialed medical staff agree to honor our Financial Assistance Program (FAP) decisions for care provided at our hospital. This is a condition of getting and keeping privileges. Aligning their bills with our decisions helps reduce harms from medical debt, including missed follow up care, trouble paying for prescriptions, housing instability, and food insecurity.

**3. Opt-out and Public Notice.** If a doctor chooses not to follow our financial assistance decisions for their own charges, they must submit an opt out statement during credentialing or renewal. We will post the names of providers who opt out on our website and in other public materials. We will also tell you if your provider has opted out so you can make an informed choice and avoid unexpected costs. *See Appendix D.*

**4. Emergency physicians.** Under California law, emergency physicians who provide care in our hospital must follow this policy and offer free care or discounted care to eligible patients. This includes uninsured patients and patients with high medical costs whose household income is at or below 400 percent of the federal poverty level, as set out in California Codes. *(CA H&SC 127450(a) and (b))*

**G. Collection Efforts.** This section does not include extraordinary collection actions. The hospital may take only the actions listed below, and only within the time frames listed:

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1. **Before we start collections.** We will send you a notice that includes:
  - a. A plain language summary of your rights under the California Hospital Fair Pricing Act and the federal Fair Debt Collection Practices Act, and
  - b. A statement that non-profit credit counseling services may be available in your area.
2. **At discharge.** If you have insurance, we may ask you to pay your share (copay, coinsurance, or deductible) if you are able. You do not have to pay these out-of-pocket costs to qualify for charity care or discounted care.
3. **Outreach calls and statements.** We will try to reach you by phone up to three times to schedule an appointment to help you apply for financial assistance under this policy. We may also send you billing statements.
4. **Presumptive screening before collections.** Before we start any collection activity, we will check if you qualify for financial assistance using presumptive screening. This may include public records and credit based electronic tools. We use these tools to confirm eligibility, not to deny help. We may repeat these checks if new information comes up.
5. **Presumptive results and billing.** If we find that you qualify for free care, we will stop all collection efforts. If the screening does not show free care but your household income is below 400 percent of the federal poverty level, we will treat you as eligible for a discount under this policy. We will then send you statements about paying the discounted amount or setting up a payment plan about every 30 days, for up to eight statements over about 240 days.
6. **Sending to a collection agency.** If you do not respond to our bills within 240 days, or if we decide you are not eligible for financial assistance, your unpaid bill may be sent to a collection agency. Any agency working for us must follow California law and this policy and may not use extraordinary collection actions against patients who qualify for financial assistance (explained below). Any exception to this rule must be approved by [enter applicable staff or department] and must comply with California Health and Safety Code, and applicable policies. [enter applicable staff or department] has the authority to approve exceptions to this provision.
7. **When collections stop after assignment.** The collection agency will stop all collection efforts if the account is still unpaid 180 days after we assigned it to them. We will not take any further collection steps on that account. With approval from [enter staff title or department], we may stop collection efforts earlier, after 120 days from the date of assignment.
8. **Applying during billing or collections.** You can ask for free care or a discount at any time during billing or collections. We will not deny your application because it was late. When you apply, we will pause collections while we review it.
9. **Payment plans for discounted bills.** If you qualify for financial assistance and receive a discounted bill, we will offer a reasonable, extended payment plan based on your ability to pay. While you are making payments as agreed or working with us in good faith to set up or

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adjust a plan, we will not send your account to a collection agency, and we will not start extraordinary collection actions. Before sending any remaining balance to collections, we consider the amount of assistance you received and your good faith efforts to pay on time. You do not have to apply for government programs to be eligible for discounted care or for a payment plan.

**10. Appeals about coverage.** If you are appealing your insurance coverage for these services and you keep us updated on the status, we will extend the state timelines that bar suing you or reporting to credit bureaus until the appeal is decided. We may still assign or sell the account while your appeal is pending only if we first meet all legal requirements and any company that gets the account must follow this policy and state law.

**11. Assets.** We do not use your assets, such as your home, car, savings, or other property, to decide if you qualify for free care or a discount. Eligibility is based on income only. We do not place liens on your home or other real estate, and neither will any collection agency working for us; your assets are not used as collateral for hospital bills. We will not ask you to use or sell your assets to qualify. We follow California law for all billing and collections.

**H. Extraordinary Collection Actions.** We may use extraordinary collection actions (ECAs) only when the law allows it and only after we complete all steps required by federal rules at Treasury Regulation 1.501(r)-6(b).

**1. When extraordinary collection actions may be used.**

We consider extraordinary collection actions only after at least 180 days with no response to our bills or to our offers of financial assistance, or after we send you a written decision that you are not eligible, and you do not appeal. The 180 days starts over any time you contact us about the bill, send new information or an application, or make a payment. Before any extraordinary collection action, we will send all required notices, screen you for financial assistance, and offer a reasonable payment plan.

- a. We made reasonable efforts to learn whether you qualify for financial assistance. This may include the presumptive screening tools described in this policy.
- b. We made reasonable efforts to determine that you are not at or below 400 percent of the federal poverty level.
- c. Based on those efforts, you were not found eligible for financial assistance, are not at or below 400 percent of the federal poverty level, and you have not been approved for financial assistance.

**2. When we will not use extraordinary collection actions.** If you are at or below 400 percent of the federal poverty level, or you have been approved for financial assistance, we will not use extraordinary collection actions. We may sell or assign a bill only to a nonprofit whose sole purpose is to cancel medical debt.

If you are approved for a discount and we set a reasonable payment plan, but you miss payments for 90 days and we tell you the plan is no longer in effect, and you then do not

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respond to billing or our offers of help for 180 days, we may resume the limited collection actions the law allows

**3. When we will not use extraordinary collection actions.** We will not use extraordinary collection actions against patients who are at or below 400 percent of the federal poverty level or who have been approved for financial assistance. We may sell or assign an account only to a nonprofit whose sole purpose is to cancel medical debt. If you are approved for a discount and we set a reasonable payment plan, but you miss payments for 90 days and we notify you that the plan is no longer in effect, and then you do not respond to our bills or our offers of help for 180 days, we may resume the limited collection actions that the law allows. See the list of allowed extraordinary collection actions in this policy:

- a. Selling a patient's hospital bill to another company that will collect the debt.
- b. Actions that require a legal or judicial process, including but not limited to:
  - Placing a lien on an individual's property (***but not including*** a lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or their representative) as a result of personal injuries for which the hospital facility provided care).
  - Your assets, such as your home, car, savings, or other property are excluded from use during collection activities and excluded from being the subject of liens by a healthcare facility or its designated collection agency(s).
  - Foreclosing on an individual's real property.
  - Attaching or seizing an individual's bank account or any other personal property.
  - Commencing a civil action against an individual.
  - Causing an individual's arrest.
  - Causing an individual to be subject to a writ of body attachment (court order summoning a person to court).
  - Garnishing an individual's wages. This is allowed only if a judge approves it after a noticed court hearing. Before asking the judge, we must show that you can afford payments under a garnishment. The judge must consider the size of the bill and your ability to pay, including other obligations and likely future medical costs. If you are approved for a discount and on a reasonable payment plan, we cannot seek garnishment unless you miss payments for 90 days, we notify you and offer to renegotiate, and the plan is declared not in effect. We also must follow the timing rules, including waiting at least 180 days with no response to our bills or offers of help before using court actions.

**4. Prohibited Extraordinary Collection Actions**

- a. We will not delay care, deny care, or require payment before providing medically necessary care because you owe money for earlier care covered by this policy.
- b. We will not report your hospital bill to credit reporting agencies or credit bureaus in compliance with CA Senate Bill 1061.

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**I. Payment plans.** If you qualify for discounted care, we will offer an interest free payment plan so you can pay the discounted amount over time. We will work with you to set a monthly payment you can afford after your essential living expenses. If we cannot agree, we will use a simple rule: your monthly payment will not be more than 10 percent of your monthly income after essential living expenses. We do not charge interest or late fees on these plans, and you can ask to change the plan if your income or expenses change.

**J. Authority and Documentation.** Approvals and records. We review each application, get the needed approvals, and apply any approved discount to your account. We keep records of financial assistance decisions for at least seven years

**K. Regulatory Requirements.** We will follow all applicable federal, state, and local laws and regulations when carrying out this policy.

**L. Debt collectors and other companies.** This policy applies to any company that buys your hospital bill or works on our behalf to collect it. They must follow this policy and all applicable laws.

**VI. AMENDMENTS**

**A.** The Board of Directors, or a board committee with authority, must approve this policy when it is first adopted and whenever it is changed.

**B.** Material or substantive amendments to this policy require review by legal counsel and/or accounting firm with expertise in compliance with Internal Revenue Code Section 501(r) for 501(c)(3) hospitals prior to approval by the Board of Directors of the facility.

**VII. CONTACT INFORMATION**

**A. Financial assistance help:** [ enter office or department ] [ enter phone number ]

**B. Main hospital:** [ enter phone number ]

**C. Help Paying Your Bill:** There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to <https://healthconsumer.org/> for more information.

**D. The Hospital Bill Complaint Program** is a State of California program. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to [Hospital Bill Complaint hcai.ca.gov](https://hospitalbillcomplaint.hcai.ca.gov) for more information and to file a complaint.

**APPENDIX A**

**Federal Poverty Levels**

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Under the facility's Financial Assistance Policy, eligibility for free charity care is based on having family income at or below **250%** of the Federal Poverty Levels (FPL) and eligibility for discounted care is based on having family income above **251%** of FPL and no greater than **400%** of FPL. FPL amounts are updated periodically in the Federal Register by the United States Department of Health and Human Services. Current FPL amounts are available at: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

As of January 17, 2026, FPL amounts were as follows. ***These amounts are subject to change.***

Size of Family Unit*	100% of FPL*	400% of FPL
<b>1 person</b>	\$15,960	\$63,840
<b>2 persons</b>	\$21,640	\$86,560
<b>3 persons</b>	\$27,320	\$109,280
<b>4 persons</b>	\$33,000	\$132,000
<b>5 persons</b>	\$38,680	\$154,720
<b>6 persons</b>	\$44,360	\$177,440
<b>7 persons</b>	\$50,040	\$200,160
<b>8 persons</b>	\$55,720	\$222,880

The Size of Family Unit includes the patient's family. **Patients Family (Family Members or Household):** A Household is a single individual aged 18 years and older, the patient, spouse, domestic partner, and dependent children under 21 years of age whether living at home or not, or any age if disabled, plus any other individual for whom the patient bears financial responsibility and claims as a tax dependent regardless of residence; a domestic partnership is a committed relationship between two adults who mutually care for each other, with both at least 18 years old if of the same sex, or if of opposite sexes, both persons capable of consenting to the domestic partnership; for patients under 18 years of age or for dependent children 18 to 20 years of age, the household includes parents, caretaker relatives, and the parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled; use the definition of "disabled" from Section 1614(a) of Part A of Title XVI of the Social Security Act.

\*\*For families/households with more than 8 persons, add \$5,680 for each additional person.\*\*

**APPENDIX B****Sliding Scale for Financial Assistance**

Family Income as a Percentage of Federal Poverty Guidelines	Percentage of Discount (write-off)	Balance Billed to Patient or Guarantor
0%- <b>250%</b>	100%	0%
<b>251%-350%</b>	<b>75%</b>	<b>25%</b>

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<b>Family Income as a Percentage of Federal Poverty Guidelines</b>	<b>Percentage of Discount (write-off)</b>	<b>Balance Billed to Patient or Guarantor</b>
<b>351%-400%</b>	<b>50%</b>	<b>50%</b>

**APPENDIX C**

**Affiliated Physician Practices, Clinics, and Providers**

**APPENDIX D**

**Excluded (Opted Out) Services, Providers, Physician Practices and Clinics**