POLICY NUMBER: PFS.RI.1

SUBJECT: **PATIENT FINANCIAL ASSISTANCE PROGRAM**

REFERENCE(S): HealthCare Financial Management Association Principles and Practices Board Statement 15, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts
EMTALA, United States Code, Title 42
Patient Protection and Affordable Care Act
IRS Requirements for 501(c) (3)
Hospitals under the Affordable Care Act – Section 501(r)
Affordable Care Act Section 1557
California AB-774 Hospitals Fair Pricing Policies
California AB 1503
California AB 1276
California Health & Safety Code Section 127425
California AB 532

PURPOSE: To establish a Financial Assistance Program (FAP) and to ensure that patients and the community at large:

- Are aware that financial assistance is available
- Are provided adequate time to apply and submit required information and documentation; and
- Receive reasonable assistance with the application process

AFFECTED AREAS/DEPARTMENTS: This policy shall apply to Antelope Valley Medical Center, and any of its majority-owned not-for-profit entities (collectively referred to as "AVMC"). The policy shall also be provided to and apply to any contracted service that performs billing on behalf of AVMC or any of its majority-owned not-for-profit entities.

POLICY:

In accordance with federal and state laws and regulations, provide financial assistance to uninsured and under-insured patients who may not have sufficient financial resources to pay for services.

Definitions

•*AGB* - Amounts Generally Billed is the maximum amount that can be collected from patients that qualify for financial assistance or as otherwise allowed under this policy. This term is more fully defined under the Charge Limitation section below.
•*Application Period* – The period during which AVMC must accept and process an application for financial assistance u\under the FAP. The application period begins on the first post-discharge billing statement date and ends the 240th day after AVMC provides the first post discharge billing statement.

•*Essential Living Expenses* – Expenses for any of the following: rent or house payments and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

•*Extraordinary Collection Actions* - Actions taken by AVMC against an individual related to obtaining payment of a bill for health care services provided by AVMC that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer reporting credit agencies or credit bureaus. Specific guidelines related to wage garnishments and noticing or conducting the sale of a patient's primary residence are provided in California law. Filing a claim in a bankruptcy proceeding is not deemed to be an Extraordinary Collection Action.

•*FPL* – Federal Poverty Level for the current year can be obtained from the following website: https://aspe.hhs.gov/poverty-guidelines

• *Extended Payment Plan* or *EPP* – A plan negotiated between a patient and AVMC to allow payment of a discounted price over time.

•*Gross Charge* - An established price, listed on AVMC's charge master, for a service or item that is charged consistently and uniformly to all patients before applying any contractual allowances, discounts or deductions.

•*Household Unit* or *Family* - For patients 18 years of age and older, the Household Unit or Family includes the patient's spouse, registered domestic partner, and dependent children under 21 years of age whether living at home or not. For patients under 18 years of age, the family includes the patient's parent, caretaker relatives, and other children (under 21 years of age) of the parent or caretaker relative.

•*Income* - Income includes salary and wages, interest income, dividend income, workers compensation, disability payments, unemployment compensation, business income, farm income, rentals and royalties, inheritance, strike benefits, and alimony payments. Income is also defined as payments from the state for legal guardianship or custody.

•*Notification Period* –The notification period begins on the first episode of care and ends 120 days after AVMC provides the first post discharge billing statement.

•*Plain Language Summary* - A statement written in clear, concise and easy to understand language notifying individuals that AVMC offers a financial assistance program and describing the program.

•*Uninsured* - A patient who does not have third party coverage from a health insurance plan, Medicare or state funded Medicaid, or whose injury is not a compensated injury for purposes of workers compensation, automobile insurance or other insurance or other source as determined and documented by AVMC.

•*Under-insured* - Annual out-of-pocket costs incurred by the patient at AVMC that exceed 10 percent of the patient's Family income in the prior 12 months or 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 patient or the patient's Family in the prior 12 months.

PROCEDURE:

Communication of Financial Assistance Policy to the Public

At each patient registration/admission interaction, and in all oral communications regarding the amount due that occurs during the Notification Period (as defined above and more fully discussed below), AVMC shall advise the patient of the availability of AVMC's FAP, where to obtain additional information about eligibility, and how to apply. Such communication shall be documented in the patient account. In addition, all public areas of AVMC, including at a minimum, points of check-in/registration, the admissions office, as well as patient waiting areas for the main AVMC building, the emergency department and all of AVMC's outpatient locations (including observation units), shall have written paper materials regarding the FAP and such information shall be included in every inpatient admission guide.

Applications shall be located in a conspicuous place easily viewable and accessible by patients. AVMC's full financial assistance policy, along with a Plain Language Summary (Appendix A) shall be available on AVMC's website with an ability to download and print the financial assistance application without any special hardware or software. The Plain Language Summary must include the physical location within AVMC where patients can obtain a copy of the financial assistance policy and application, as well as the contact information of the specific office or department of AVMC that can provide assistance with the financial assistance process. AVMC shall translate financial assistance program documents, including the full financial assistance policy and applications, into Spanish, as well as any other language that is the primary language of at least 5% of AVMC's patients.

Conspicuous notice of financial assistance availability shall be noted on every patient billing statement sent out from AVMC, which shall include notice about and how to get a copy of the financial assistance program policy. The Notification Period is defined as

the period during which AVMC must notify an individual about its financial assistance policy in order to have been deemed to have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Notification Period begins the first date that an episode of care is provided and ends the 120th day of the first post-discharge billing statement.

Written notice shall include a description of any Extraordinary Collection Actions that AVMC or its collection agencies intend to initiate and a statement that nonprofit credit counseling services may be available in the area. Efforts are deemed reasonable if AVMC notifies the patient about its financial assistance program as described above, and follows the requirements for incomplete and complete financial assistance applications described in the Review and Approval section below. Written notification shall be deemed to have been provided at the date when mailed.

AVMC's financial assistance program shall be widely publicized within the community in a manner that will reasonably reach those who are most likely to require financial assistance. This shall generally be accomplished by information about the program being posted on AVMC's web site, and at the local Federally Qualified Health Center and clinics within our community serving the uninsured/underinsured patients. In addition, information about AVMC's financial assistance program shall be displayed (in both English and Spanish) in a conspicuous public display of noticeable size throughout all AVMC locations where visitors are likely to see it. Written materials about our financial assistance program shall include non-discrimination language as appropriate.

Application Process

Once a patient initiates the application process, AVMC will be responsive to inquiries and offer the assistance of a financial counselor. If a patient provides AVMC with his or her contact information in connection with a financial assistance application, AVMC will follow up with the patient throughout the Application Period (as defined above) to encourage the patient to complete the application in full.

If a financial assistance application is received during the Application Period and deemed incomplete, a written notice to the patient (or guarantor) will be sent within 15 days of receipt of the incomplete application requesting that the missing information be returned within 30 days of the date of the notice. Such notice shall include contact information for the facility or department that can provide assistance with the financial assistance process, a copy of the Plain Language Summary, and information about potential Extraordinary Collection Actions AVMC or its credit agencies may initiate. Any Extraordinary Collection Actions in progress at the time an incomplete application is received must be suspended. Such collections may be initiated or resumed if a

completed application is not received or after a request for additional information is not received after 30 days of notification.

As discussed below in the Verification of Information Provided section, AVMC may waive the requirement to submit a complete application if AVMC obtains certain other information predictive of the patient's ability to pay and uses that information to determine that the patient is eligible for financial assistance. The basis for any predictive determination shall be documented in the billing system.

AVMC must accept and process a financial assistance application for a period up to 240 days after AVMC provides the first billing statement to the patient (defined as the Application Period).

Eligibility Requirements

Financial assistance is provided on a sliding scale basis (Appendix C), based on the following eligibility criteria:

- Individual or household unit income - up to 400% of the FPL. Employment status shall be considered when determining income levels. Prior income levels may not meet the established poverty level guidelines; however, recent unemployment should be considered when evaluating the current source of income.

- Individual or household unit net worth - up to $250,000 (excluding net worth in primary homes of up to $500,000 and retirement or deferred compensation plans; disregard the first $10,000 of a person's monetary assets (i.e., cash and investments) and half of monetary assets thereafter). When reviewing net worth, other financial obligations such as high medical bills should be considered. Patients with high net worth that would otherwise disqualify them for financial assistance may be considered for eligibility if they have, for example, uninsured catastrophic health care costs that would significantly reduce their net worth. High medical costs shall mean:

    1. Annual out-of-pocket costs incurred by a patient at AVMC that exceed the lesser of 10% 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% 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;

- Self-pay patients admitted through the Emergency Department with insufficient information provided to fully evaluate financial assistance and eligibility tests, for whom the ability to pay cannot be reliably determined, will be classified as charity. If information becomes available later that would disqualify the patient from meeting the financial assistance criteria, then the patient account will be reclassified to the appropriate payer class.

- Patients who presumptively qualify for Medi-Cal, but where AVMC does not receive payment for their entire stay are eligible for charity care for denied stays, denied days of care, and non-covered services. These denials and any lack of payment for non-covered services provided to Medi-Cal patients are to be classified as charity. These patients are receiving the service, and they presumptively do not have the ability to pay for it. In addition, Medicare patients who have Medi-Cal or Medi-Cal Managed Care coverage for their co-insurance/deductibles, for which Medi-Cal or Medi-Cal Managed Care does not make payment, and Medicare does not ultimately provide bad debt reimbursement will also be included as charity. These patients are receiving a service for which a portion of the resulting bill is not being reimbursed.

- Trauma services rendered to patient medical conditions meeting the definition of billable trauma care, per our trauma care agreements with the County of Los Angeles and the State of California, will be classified as charity care. These patients will not be billed for their services.

- Patients who are eligible for government sponsored, low-income assistance programs (i.e., Medi-Cal, out of state Medicaid, California Children's Services and any other applicable Federal, State or local low-income program) are presumed to be indigent. Therefore, such patients may be considered as presumptively eligible under the FAP when payment is not made by the governmental program. Rationale for such presumptive determination shall be documented in the patient account.

Financial assistance is available to all individuals regardless of where they live for medically necessary services; this does not include cosmetic surgery or other cosmetic services. Guidelines for determining eligibility for financial assistance shall be applied consistently. AVMC shall not discriminate against patients applying for financial assistance based on race, color, creed, national origin, sex, age, or disability. In determining a patient's eligibility for financial assistance, AVMC's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange. Patients can also obtain information for the Covered California Health Insurance Exchange through their website at coveredca.com and can obtain

further health consumer assistance from Health Consumer Alliance whose website is healthconsumer.org.

The Financial Assistance Application Form (Appendix B) shall be completed for all requests for financial assistance (other than if a presumptive determination as described in this policy is made), and be submitted to a financial counselor. All requests for financial assistance must be signed by either the patient or authorized patient representative attesting that the information provided on the application is true and accurate. When possible, AVMC shall screen each uninsured patient for eligibility for financial assistance.

Partial financial assistance provided under this policy is considered partial charity care.

Verification of Information Provided

Data used to determine eligibility for financial assistance should be verified to the extent practical in relation to the amount of financial assistance involved and the significance of an element of information in the overall determination. In all cases, the minimum verification shall include:

- Income, by reviewing sources such as a W-2, recent pay stub showing year-to-date totals and/or income tax returns as well as unemployment statements, if applicable.

- An individual's net worth, by reviewing applicable supporting documentation (bank statements, investment statements, loan documents).

Except for patients with Medicare coverage, submission of a Financial Assistance Application Form and related required supporting documentation described above may be waived in lieu of information AVMC obtains through use of technology tools or other methods of presumptive assumptions as predictive measures of a patient's ability to pay and financial status. See discussion in the Eligibility Requirements section above. Financial assistance may not be denied based on information that is not specifically listed as required in the Financial Assistance Application Form.

Extended Payment Plans:

If a patient qualifies for financial assistance under this policy, the patient may elect to pay any amounts the patient is financially responsible for, after any financial assistance discounts and charge limitations have been applied, in accordance with this policy based on the payment plan program offered by AVMC. In the event that such program does not meet the patient’s needs, AVMC will discuss with the patient other payment

options, taking into consideration the patient's family income and essential living expenses. If AVMC and the patient cannot agree on a payment plan, the patient's monthly payments will be limited to no more than 10% of the patient's Household Unit income for a month, excluding deductions for Essential Living Expenses. AVMC cannot undertake any Extraordinary Collection Actions while it is in the process of establishing an extended payment plan or to settle an outstanding bill, or if the patient is making regular partial payments of a reasonable amount as solely determined by AVMC.

Extended payment plans can occur in person or over the phone at any point in the revenue cycle, during pre-registration, registration, discharge, billing and follow-up.

In the event that a patient that qualifies for financial assistance defaults on an amount due under a payment plan (patient fails to make all consecutive payments due during a 90-day period), the patient has one opportunity to renegotiate their extended payment plan before AVMC may declare the payment plan inoperative and begin collection activities. More specifically, AVMC must make a reasonable attempt to contact the patient by telephone and, to give notice in writing, that the payment plan may become inoperative, and of the opportunity to renegotiate the payment plan.

Review and Approval:

Financial assistance must be documented on the Financial Assistance Application Form and shall be approved by the Director or Manager of Patient Financial Service (PFS) per policy guidelines. Documentation of receipt, review and approval of the Financial Assistance Application Form shall be made by PFS.

At the time a decision is made for the approval or denial of an account for financial assistance, a letter shall be sent to the patient or responsible party as notification of the decision made. The letter, which generally shall be sent within 30 days of receiving the Financial Assistance Application Form, should be typewritten and should include the following information:

- Patient name
- Account number(s) for AVMC account
- Current outstanding balance of the account(s)
- Any balance which will be due on the account (if only a portion of the account is covered by financial assistance)
- Detail of arrangements to pay for any remaining balance on the account after financial assistance is provided; and
- Appeal process if request for financial assistance was denied

Upon approval of a financial assistance request, AVMC shall:

- If any amount is due from patient, provide a billing statement to the patient showing the amount due, how the AGB was determined, and how the amount due was arrived at;
- Include all patient due amounts covered by the FAP in the approval.
- Refund any patient payments; with interest in accordance with the separate patient refund policy once financial assistance is granted; and
- Take reasonable measures to vacate or reverse any Extraordinary Collection Actions, such as lifting a lien and removing adverse information on credit reports.

Approval of financial assistance and application of any AGB charge limitation will be denied if Medi-Cal or other health and welfare eligibility application is refused by patient, if AVMC reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with AVMC in reviewing affordable insurance coverage options offered through the Covered California Health Insurance Exchange. If the patient chooses not to purchase insurance coverage through the Covered California Health Insurance Exchange and does not qualify for Medi-Cal, then the patient will be required to submit a Financial Assistance Application Form. Assignment to AVMC of all insurance payments, including liability settlements, is required, up to the amount of Gross Charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting reevaluation. The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred to and reviewed by the Director of Patient Financial Services or designee within thirty (30) days of being received. If the Director of Patient Financial Services or designee feels additional input is needed in making a determination, the Vice President of Revenue Cycle will be asked to review and assist with the determination.

If subsequent to review and determination of financial assistance, it is found that the information relied on was in error, the following shall occur:

- If the corrected information in a prior denial of financial assistance now *qualifies* the patient for financial assistance, the patient will be notified that they are now eligible for financial assistance and the account(s) will be processed as described above.

- If the corrected information in a prior granting of financial assistance now *disqualifies* the patient for financial assistance, the patient will be notified that they

are not eligible for financial assistance and payment is expected on their account(s).

The completed Financial Assistance Application Form and all related supporting documentation will be scanned into the patient's accounts in the patient billing system. Notwithstanding the above, AVMC must accept and process a financial assistance application for a period up to 240 days after AVMC provides the first billing statement to the patient (defined as the Application Period).

Extraordinary Collection Actions:

AVMC shall not undertake an Extraordinary Collection Action at any time prior to 180 days after AVMC provides the first post discharge billing statement if AVMC is aware that the patient lacks coverage or if the patient has provided information that indicates that he or she may be a patient with high medical costs.

AVMC may initiate or resume Extraordinary Collection Actions against an individual who has submitted an incomplete financial assistance application and who has not provided the missing information necessary to complete the application any earlier than the later of:

- 30 days after AVMC provides written notice that the additional information is required, or
- The last day of the Application Period

Accounting for and Tracking Financial Assistance Data:

Approved financial assistance, along with any write-offs as a result of applying AGB amounts, shall be classified and recorded as charity care, because, by definition, charity care is "demonstrated inability to pay". The amount of charity care provided will be reported separately in the monthly financial statements.

Frequency of Re-Evaluation of Eligibility:

Once a patient has been approved for financial assistance, PFS will rely upon that approval for subsequent services rendered by AVMC from initial approval date for up to six months, except as follows:

- There is a change in patient financial status as described below. It is the responsibility of the patient/guarantor to advise AVMC of such change. After six months, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.

- In AVMC's reasonable estimation, patient can afford to purchase insurance coverage through the Covered California Health Insurance Exchange and the period for which such coverage can be obtained is in less than six months from the time financial assistance is granted by AVMC and it is during an open enrollment period.

If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, AVMC will not reverse the amount of financial assistance granted.

Changes in Patient Financial Status:

Patients may have unexpected changes to their ability to pay that occur after the time service is rendered and after either a payment plan or financial assistance has been granted. If a patient agreed to a payment plan (see separate Patient Payment Plans policy) that was reasonable in relation to his or her circumstances at the time, but the patient subsequently lost his or her job or had some other financial hardship occur and became unable to pay under the plan, the patient may apply for financial assistance under the guidelines of this policy.

Alternatively, if a patient who was granted financial assistance but subsequently experiences a positive change to his or her ability to pay for the services rendered, AVMC may bill the patient for the services rendered and advise the patient of their change in status.

Charge Limitation:

AVMC will utilize AGB via the Prospective Medicare methodology for inpatient and outpatient accounts when determining patient liability, for individuals who qualify for financial assistance. Specifically, AVMC will limit charges for a particular service to the AGB, which will be equal to the amount that would be paid for the services if the patient were Medicare-eligible. The billed amount will not exceed the AGB or gross charges.

The billing statement to a patient may state AVMC’s standard Gross Charges but must show a write-off to get to the AGB. The difference between AVMC’s standard Gross Charges and the AGB or financial assistance discount amounts, will be accounted for as a charity care write-off.

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Medi-Cal and Medicaid Coverage:

Medi-Cal Share of Cost or Medicaid copays not paid at the time of service will be billed to the patient. If unable to collect the copays, the copays will be written off as a charity write-off based on presumptive eligibility. Patients who have Medicaid coverage and have balances due for service dates up to six months prior to the effective date of their coverage, will be granted 100% financial assistance on such balances without further review or documentation from the patient based on presumptive inability to pay.

Other:

Generally, the determination that a patient stay qualifies for financial assistance will be made upon pre-admission, admission or as soon as possible thereafter. A financial counselor is available to assist patients with settlement of their accounts including applications for financial assistance, government- sponsored programs and referral to outside resources. However, in some cases qualification for financial assistance may be made after rendering services and in some circumstances, even after rendering of the bill. Collection efforts, including the use of a collection agency, are part of the information collection process and can appropriately result in identification of eligibility for financial assistance.

For partial financial assistance granted to patients meeting criteria for charity care, a transaction code of “30060” shall be used in the billing system. Until additional transaction codes are created, all other patient financial assistance granted, the code of “30070” shall be used.

As required by California State Law, AVMC provides the Department of Health Care Access (formerly the Office of Statewide Health Planning and Development (OSHPD)) its Financial Assistance Program Policy and application forms, as well as its debt collection policy at least bi-annually on January 1, or when there is a significant change. If there has been no significant change since the information was previously provided, AVMC notifies the Department of Health Care Access of the lack of change.

Emergency physicians who provide emergency medical services in AVMC are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the FPL. The AVMC FAP does not include professional services provided by our emergency physicians or any other medical staff.

APPENDIX A

Antelope Valley Medical Center

Plain Language Summary Financial Assistance Policy

Antelope Valley Medical Center (AVMC) provides financial assistance to patients that may not have sufficient financial resources to pay for services.

Financial Assistance Eligibility Requirements

Financial assistance is available to uninsured or under-insured patients for emergency and medically necessary related care who meet eligibility and qualification requirements contained in our Patient Financial Assistance policy.

Eligibility for financial assistance may include family size and family income at or below 400% of the Federal Poverty Levels (FPL), using a sliding scale.

For information on poverty guidelines, visit the U.S. Department of Health & Human Services website at: http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, AVMC's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange. You may also apply directly for these programs by accessing the below websites directly:

Medi-Cal: http://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx

Affordable Care Act: www.HealthCare.gov, to apply by phone call 1-800-318-2596

Find AVMC's policy:
https://www.avmc.org/images/PFS-RI.1-PATIENT-FINANCIAL-ASSISTANCE-POLICY.pdf

Application Process

Financial Assistance Applications may be requested:

1. In person at Patient Access Services, Main Admitting
2. By phone at (661) 949-5781
3. On our website:
   English: https://www.avmc.org/images/AVMC-Financial-Assistance-App_English_2022.pdf
   Spanish: https://www.avmc.org/images/AVMC-Financial-Assistance-App_Spanish_2022.pdf
4. By mail to: Antelope Valley Medical Center
   Attn: Business Office
   1600 West Avenue J
   Lancaster, CA 93534

The application specifies certain information that is required to be submitted with the application. This information may be independently verified by AVMC for completeness and accuracy. If you need assistance completing your application, please contact our Patient Financial Counselors at 661-949-5635.

There are organizations that will help patients understand the billing and payment process. For more information visit: https://healthconsumer.org/

Financial Assistance Eligibility Requirements

Eligibility for financial assistance is both income and asset based, using a sliding scale. Income level eligibility is up to 400% of the federal poverty level. Asset level eligibility is up to $250,000 (excluding net worth in primary homes of up to $500,000 and retirement or deferred compensation plans).

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, AVMC's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange.

Application Process

Financial Assistance Applications may be requested:

(1) In person at Main Admitting
(2) By phone at (661) 949-5781
(3) https://www.avmc.org/images/AVMC-English-Financial-Assistance-App-11.1.22.pdf
(4) https://www.avmc.org/images/AVMC-Spanish-Financial-Assistance-App-11.1.22.pdf

The Financial Assistance Policy ("FAP") may be obtained at:
https://www.avmc.org/images/PFS-RI.1-PATIENT-FINANCIAL-ASSISTANCE-POLICY.pdf

The application specifies certain information that is required to be submitted with the application. This information may be independently verified by AVMC to ensure its completeness and accuracy. If a financial assistance application is received within 240 days of AVMC's initial billing for a service and is deemed incomplete, a written notice to the patient/guarantor will be sent within 15 days of receipt of the incomplete application requesting the missing information be returned within 30 days of the date of the notice. Notice of approval or denial of an application shall generally be sent to the patient within 30 days of receipt of application.

Approval of financial assistance will be denied if Medicaid or other health and welfare eligibility application is refused by the patient, if AVMC reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with AVMC in reviewing affordable insurance coverage options offered through Covered California Health Insurance Exchange. If the patient chooses not to purchase insurance coverage through the Covered California Health Insurance Exchange and does not qualify for

Medicaid, then the patient will be required to submit a Financial Assistance Application Form. Assignment to AVMC of all insurance payments, including liability settlements, is required up to the amount of gross charges on a patient's bill.

Denials of financial assistance may be appealed. Appeals must include an appeal letter from the patient or party with financial responsibility requesting re-evaluation. The appeal must also include any supporting documents that may prove inability to pay that were not part of the initial consideration. Appeals will be referred and reviewed by the Director of Patient Financial Services or designee within thirty (30) days of being received. If the Director of Patient Financial Services feels additional input is needed in making a determination, the Vice President of Revenue Cycle will be asked to review and assist with the determination.

Period that Approved Financial Assistance Will Be Provided

Once a patient has been approved for financial assistance, the patient will be deemed to have approval for services rendered by AVMC for six months subsequent to initial approval date, except as follows:

- There is a change in financial status. After six months, the patient will be required to re-apply for financial assistance, and the appropriate verifications of information will need to be made.

- In AVMC's reasonable estimation, patient can afford to purchase insurance coverage through the Covered California Health Insurance Exchange and the period for which such coverage can be obtained is less than six months from the time financial assistance is granted by AVMC, only the timeframe that is non-covered will be approved.

If a patient is granted financial assistance on a portion of their bill, and the patient subsequently does not pay their remaining portion of the bill, AVMC will not reverse the amount of financial assistance granted.

Charge Limitation

AVMC will utilize the Prospective Medicare methodology to determine the Amounts General Billed (AGB) for inpatient and outpatient accounts when determining patient liability for individuals who qualify for financial assistance. The billed amount will not exceed the AGB.

This document (The Plain Language Summary) summarizes the AVMC financial assistance policy (FAP) and is not intended to represent a complete explanation of the

FAP. Our financial counselors can be reached Monday through Friday from 8:00 am to 5:00 pm at (661) 949-5000 and are available to assist patients with the financial assistance application process.

APPENDIX B

Antelope Valley Medical Center
1600 West Avenue J • Lancaster, CA 93534 • (661) 949-5000
www.avmc.org

Financial Assistance Application

Antelope Valley Medical Center's Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Account Number_____
Address_____ Phone number_____
_____ Social Security _____
Date of Birth ___/___/___ Sex____ M=Male F=Female Do you own a home? Yes ( ) No ( )
Number of dependents filed on tax return: _____ Do you own other property? Yes ( ) No ( )
List Dependents: Do you own automobiles? Yes ( ) No ( )

Name	Relationship	Age	Gender

Household Banking Information **Name**_____ **Balance**_____
Business Banking Information **Name**_____ **Balance**_____

Wages/Income	**Monthly**	**Annual**
Self-Wages		
Spouse Wages		
Other Family Member Wages		
Social Security		
Unemployment Benefits		
Retirement / Pensions		
Alimony / Child Support		
Military Family Allotments		
Pensions		
Income from Rent, Dividends, Interest		
Expenses	**Monthly**	**Annual**
Mortgage / Rent		
Utilities		
Auto Loans		
Hospital Bills		
Telephone		
Food		
Credit Cards		
Gasoline		
Child Care		
Other		

Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 4 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____
Print Name **Signature** **Date**

SUBJECT: PATIENT FINANCIAL ASSISTANCE PROGRAM

APPENDIX C

Maximum Charity Care		Partial Discount Charity Care			
Federal Poverty Level	**200% or Below**	**201-250%**	**251-300%**	**301-325%**	**326-400%**
Persons	Gross Mo income	Gross Mo. Income	Gross Mo. Income	Gross Mo. Income	Gross Mo. Income
1	$2,265	$2,831	$3,398	$3,681	$4,530
2	$3,052	$3,815	$4,578	$4,959	$6,103
3	$3,838	$4,798	$5,758	$6,237	$7,677
4	$4,625	$5,781	$6,938	$7,516	$9,250
5	$5,412	$6,765	$8,118	$8,794	$10,823
6	$6,198	$7,748	$9,298	$10,072	$12,397
7	$6,985	$8,731	$10,478	$11,351	$13,970
8	$7,772	$9,715	$11,658	$12,629	$15,543
Uninsured Amount to Pay	0%	30% of AGB	45% of AGB	60% of AGB	80% of AGB
Underinsured Amount to Pay	**20% of Balance**	**40% of Balance**	**60% of Balance**	**80% of Balance**	**80% of Balance**

POLICY NUMBER: PFS.RI.1

SUBJECT: PATIENT FINANCIAL ASSISTANCE PROGRAM

RESPONSIBILITY FOR REVIEW AND MAINTENANCE OF THIS POLICY IS ASSIGNED TO: Vice President, Revenue Cycle or designee

REVIEWED AND APPROVED:

Finance Committee of the Board of Directors	**DATE: 11/30/22**
Board of Directors	**DATE: 11/30/22**

EFFECTIVE DATE: 11/30/22
REVISED DATES:
REVIEW DATES: See Policy Manager

CROSS REFERENCE(S):

ATTACHMENT(S):