



Policies and Procedures

Tarzana Treatment Centers, Inc.

Title: Charity Care

INTENT

The purpose of this policy is to ensure a consistent and uniform method among all Tarzana Treatment Centers, Inc. (TTC) facilities for compliance with the California "Voluntary Principles and Guidelines on Billing and Collection Practices for Services Provided to Low-income Uninsured Patients."

It is the intent of this policy to comply with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

PRINCIPLES

- This policy reflects a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.
- This policy balances a patient's need for financial assistance with TTC's broader fiscal responsibilities.
- Financial assistance provided by TTC is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay.
- TTC contracts with all levels of government to provide large variety of substance abuse, mental health, HIV/AIDS, primary care and other health and housing related services to the uninsured, low income and indigent members of our communities. Consistent with our commitment to reach out and service those most in need.

GUIDELINES

- TTC's financial assistance policies shall clearly state the eligibility criteria (i.e., income, assets) and the process used by the TTC to determine whether a patient is eligible for financial assistance. Such process shall take into account where and how far a particular patient falls relative to existing Federal Poverty Levels (FPL). (See Exhibit C for current FPL.)
- Any patient who believes that they are qualified may apply for financial assistance under TTC's charity care policy or discount payment policy.
- TTC staff shall use their best efforts to ensure all financial assistance policies are applied consistently.
- In determining a patient's eligibility for financial assistance, TTC staff shall assist the patient in determining if he/she is eligible for government-sponsored programs.

Communication of Financial Assistance Policies with Patients and the Public

- Each facility shall post notices regarding the availability of financial assistance to low-income uninsured patients. These notices shall be posted in visible locations such as admitting/registration and billing office.

- Every posted notice regarding financial assistance policies shall contain brief instructions on how to apply for charity care or a discounted payment.
- Directors shall ensure that appropriate staff members are knowledgeable about the existence of the Facility's financial assistance policies.
- When communicating to patients regarding the financial assistance policy, staff shall do so in the primary language of the patient, or his/her family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations.
- TTC shall share the financial assistance policy with appropriate community health and human services agencies and other organizations that assist such patients.

POLICY: COMPLIANCE – KEY ELEMENTS CHARITY CARE

Any self-pay, uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, any insured patient who indicates an inability to pay their liability after their insurance has paid may be screened for charity care. Screening shall include a review of the patient's eligibility for publicly funded programs operated by TTC. Screening for charity care will occur only after all other potential resources have been exhausted. The screening process will optimally occur at the time of service but may occur anytime during the collection process including post assignment to an outside collection agency.

At minimum, screening for charity care will include documentation of family size and gross family income.

Charity care will be granted based upon the following income levels:

<u>Income Level</u>	<u>Discount Amount</u>
Less than 200% of the Federal Poverty Level	100% Discount
200% to 300% of the Federal Poverty Level	75% Discount
301% to 350% of the Federal Poverty Level	50% Discount
350% to 400% of the Federal Poverty Level	25% Discount
Greater than 400% of Federal Poverty Level	Patient Pays Full charges

CATASTROPHIC CHARITY CARE

Based upon the patients' complete financial situation, when the patient liability amount exceeds 50% of the total annual family income, amounts greater than 50% of the income may be written off to charity care.

CLASSIFICATION AS STATUTORY OR NON STATUTORY

Charity care will be classified into two (2) categories: statutory and non-statutory.

Statutory Charity Care

Statutory charity care will be defined by facility participation in various federal, state, and/or county indigent care programs. Criteria must comply with governmental guidelines and/or state or county regulations.

Each patient who appears eligible for statutory charity care determination and who requests such determination must complete a Confidential Financial Statement (Exhibit A in English and Spanish). Additionally, he/she must provide supporting documentation to the financial counselor as required to verify his/her financial condition. Statutory charity care will generally be identified at the time of admission or while the patient is in-house by the facility financial counselor, however, it may also be identified after discharge or whenever a patient declares an inability to pay.

Non-Statutory Charity Care

Non-Statutory Charity Care is defined as charity care for patients known to meet the general charity care criteria. The determination of non-statutory charity care will be made at admission or while the patient is in-house; however, this determination could also be made after discharge or whenever patient declares an inability to pay.

Unless the patient qualifies for the abbreviated screening procedure, every effort will be made to secure a signed application, but this may not be possible in all cases. Patients stating that they are homeless and without income, at the discretion of the PFS Director, do not need to complete a Confidential Financial Statement. Instead, charity care determination may be made by the financial counselor's completion of the eligibility worksheet. Non-statutory charity care shall be used for homeless patients that have no income or documentation to report.

MEDICAID/MEDI-CAL DENIALS

Patients who qualify for Medicaid are also presumed to qualify for full charity write-off. Any charges for services written off (excluding billing timeliness, medical records, missing invoices, or eligibility issues) as a result of a Medicaid denial (such as TAR denial) shall be written off to a specific code and booked as charity.

RESTRICTED MEDICAID/MEDI-CAL COVERAGE

Some Medicaid plans offer coverage for a limited or restricted list of services. If a patient is eligible for Medicaid, any charges for services not covered by the patient's coverage may be written off to charity without a completed Confidential Financial Statement. This does not include any Share of Cost (SOC) amounts, as SOC's are determined by the state to be an amount that the patient must pay before the patient is eligible for Medicaid.

DOCUMENTATION REQUIREMENTS

Application

In order to qualify for charity care, a Confidential Financial Statement shall be completed. The Confidential Financial Statement allows for the collection of information. Income and documentation requirements are defined below. Pending the completion of such application, the patient shall be treated as a pending charity care patient in accordance with the TTC's policies and the appropriate financial class recorded to reflect this status.

Family Members: Patients will be required to provide the number of family members in their household.

- **Adults:** In calculating the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all dependents.
- **Minors:** In calculating the number of family members in a minor patient's household, include the patient, the patient's mother and/or father and/or legal guardian and any other dependents.
- **Income Calculation:** Patients will be required to provide their household's yearly gross income.
- **Adults:** The term "yearly income" on the Confidential Financial Statement means the sum of the total yearly gross income of the patient and patient's spouse.
- **Minors:** If the patient is a minor, the term "yearly income" on the Confidential Financial Statement means income from the patient, the patient's mother and/or father and/or legal guardian and any other dependents.

Income Verification

Patients will be required to verify the income set forth in the Confidential Financial Statement in accordance with the documentation requirements identified below in cases where documentation is available. Any of the following documents is appropriate for verifying income:

- **Income Documentation:** Income documentation may include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, telephone verification by employer of the patient's income, bank statements, or other appropriate indicators of income.
- **Participation in a Public Benefit Program:** Documentation showing current participation in a public benefit program including Social Security, Workers' Compensation, Unemployment Insurance, General Relief, CALWORKS, Benefits, Medicaid, County Indigent Health, Food Stamps, WIC, or other similar indigence related programs.

Documentation Unavailable

In cases where the patient is unable to provide documentation verifying income, the following procedures shall be followed:

- **Obtain Patient's Written Attestation:** Have the patient sign the Financial Assistance Application attesting to the accuracy of the income information provided; or
- **Obtain Patient's Verbal Attestation:** The Financial Counselor who is completing the Confidential Financial Statement may provide written attestation that the patient verbally verified the income calculation. In all cases, at least two (2) attempts must be made and documented to attempt to obtain the appropriate income verification.
- **Expired Patients:** Expired patients may be deemed to have no income for purposes of the financial calculation. Although no documentation of income is required for expired patients, an asset verification process shall be completed to ensure that a charity care adjustment is appropriate.

Uncooperative Patients

Uncooperative patients are defined as unwilling to disclose any financial information as requested for Medicaid and/or charity care determination during the screening process. In these cases, the account will not be processed as charity care. The patient will be advised that unless they comply and provide the information, no further consideration will be given for charity care processing, and standard A/R follow-up will begin. Non-Compliant patients are defined as not meeting all required documentation for Medicaid/Medi-Cal screening, but qualifying for charity care. In these cases, the Financial Counselor may process the account for charity care, and the account will remain in the charity-pending financial class until the facility processes a charity write-off adjustment.

Abbreviated Application Process

TTC may establish an abbreviated application and verification process for those service areas in which they have determined that the typical level of charges are not high such as clinics, and outpatient areas. In these service areas, admissions staff or the financial counselor must at minimum document the family size and the total family gross income in order to determine the level of charity discount if any. TTC may require income verification if there are discrepancies in income reported by the client. For example, if the patient reports \$1,000 of gross income per month but is making a large mortgage payment along with several credit card payments TTC may require further income verification such as a credit report. If a credit report is not available, document that fact in the patient notes. No further effort is required.

Communication

Facilities are required to post signs in their admitting and registration areas that inform patients about their financial assistance policies. Additionally, patient statements shall have standard language informing patients that they may request financial screening to determine eligibility for charity care. To the extent possible, these communications shall be in the primary language of the patient.

Once a charity determination has been made, the outcome must be communicated to the patient. That communication may be accomplished by sending the patient Exhibit B

EXHIBIT A

Patient Name		Facility:		DOS:	
Patient Number		Confidential Financial Statement (Application)			
RESPONSIBLE PARTY					
Name		Marital Status		Social Security Number	
Street Address, City, State, Zip		How long at this address		Home Phone	
Employers Name and Address (If Unemployed –How Long)					Business Phone
Position / Title	Monthly income – Gross	Monthly income - Net		Length of current employment	
SPOUSE					
Name		Social Security Number			
Employer Name and Address					Business Phone
Position / Title	Monthly income – Gross	Monthly income – Net		Length of current employment	
DEPENDENTS					
Name & Year of Birth of all dependents in household		Total Number of dependents in household		Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount	
INCOME PER MONTH & ASSETS					
Dividends, Interest	\$	Child Support / Alimony		\$	
Public Assistance / Food Stamps	\$	Rental Income		\$	
Social Security	\$	Grants		\$	
Unemployment Compensation	\$	IRA		\$	
Workers' Compensation	\$	Other		\$	
Savings	\$				
EXPENSES PER MONTH					
Mortgage / Rent Payment:	\$	Balance:	\$	Medical / Dental	\$
Own Home? (Yes/No)				Doctor – Name	\$
Food	\$			Doctor – Name	\$
Utilities:	\$			Doctor – Name	\$
Electric	\$			Credit Cards:	\$
Gas	\$			Visa Limit	\$
Water / Sewer	\$			Mastercard Limit	\$
Trash	\$			Discover Limit	\$
Phone	\$			Other Limit	\$
Cable	\$			Installment Loans	\$
Auto Payments	\$			Child Support	\$
Auto Expenses	\$			Miscellaneous Expenses	\$
Insurance:					
Auto Premium	\$				
Life Insurance	\$				
Health Insurance	\$				
OFFICE USE ONLY		To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Tarzana or its agent to verify my financial standing.			
Gross income					
Net income					
Total Expenses					
Total Net income(loss)					
PATIENT/GUARANTOR				SIGNATURE	
DATE					

Note: The Financial Statement (Application) is available in Spanish

Nombre del	OFICINA	DOS
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Número del		DECLARACION CONFIDENCIAL DE ESTADO FINANCIERO	
PERSONA RESPONSABLE			
Nombre	Estado Civil	Número de Seguro Social	
Dirección, ciudad, estado, código postal dirección?	¿Cuánto tiempo ha vivido en esta	Teléfono de su domicilio	
Nombre y dirección de su empleador (Si está desempleado, ¿por cuánto tiempo?)		Teléfono de su trabajo	
Empleo/Puesto Neto	Ingreso mensual-Bruto	Ingreso mensual-	Tiempo en su empleo actual
ESPOSA/ESPOSO			
Nombre		Número de Seguro Social	
Nombre y dirección del empleador		Teléfono de su trabajo	
Empleo/Cargo	Ingreso mensual-Bruto	Ingreso mensual-Neto	
Tiempo en su empleo actual			
DEPENDIENTES			
Nombre y año de nacimiento de todos		Número total de dependientes	¿Alguna otra persona contribuye? Si la respuesta
los dependientes que viven en su casa que viven en su casa: _____		es sí, ¿con qué cantidad? :	
		Sí/No	Cantidad
INGRESO MENSUAL Y ACTIVOS			
Dividendos, Intereses	\$	Manutención para hijos menores/esposa	\$
Ayuda pública/Cupones de alimentos	\$	Ingreso por alquileres	\$
Seguro social	\$	Acciones, bonos	\$
Compensación por desempleo	\$	Subvenciones (<i>grants</i>)	\$
Compensación por accidente de trabajo	\$	Cuenta de jubilación individual (<i>IRA</i>)	\$
Ahorros	\$	Otros inmuebles, sin incluir a su vivienda	\$
GASTOS MENSUALES			
Pagos de hipoteca/alquiler	\$	Gastos médicos/dentales	\$
¿Es propietario de su vivienda?			
Alimentos	\$	Doctor-Nombre	
Servicios públicos:	\$	Doctor-Nombre	
Electricidad	\$	Doctor-Nombre	
Gas	\$	Tarjetas de crédito:	
Agua-Alcantarillado	\$	Visa	\$ Límite \$
Recolección de basura	\$	Mastercard	\$ Límite \$
Teléfono	\$	Discover	\$ Límite \$
Cable	\$	Otras	\$ Límite \$
Pago de vehículos	\$	Préstamos a plazo	\$
Gasto de vehículos	\$	Manutención para hijos menores	\$
Seguro :	\$	Gastos misceláneos	\$
Prima de vehículos	\$		
Seguro de vida	\$		
Seguro médico	\$		
SOLO PARA USO DE LA OFICINA Ingresos brutos		Hasta donde me es posible saber, la información arriba proporcionada es correcta. Autorizo al Tarzana o a su representante, para que obtengan un reporte de crédito para la verificación de mi situación financiera.	
Ingresos netos			
Total de gastos			
Ingreso neto total (pérdida)			
FIRMA DEL PACIENTE/GARANTE		FECHA	

EXHIBIT B

Tarzana Name Date

Tarzana Address

Tarzana Phone

Guarantor Name Guarantor Address

RE: Account Number:

Patient Name:

Dates of Service: Account Balance:

Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do meet eligibility guidelines for full charity assistance on this account.

Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you do not meet eligibility guidelines for full charity assistance on this account.

Your account has been reviewed for possible charity assistance. After review of all of your submitted financial documentation it has been determined you meet eligibility guidelines for partial charity assistance on this account. "Account balance" is the remaining portion, which is your responsibility to pay.

If you have any questions, please feel free to contact us at 818.996.1051 during normal business hours.

Patient Financial Services Department

Tarzana Name

Tarzana Phone Number

Tarzana Name Date

Tarzana Address

Tarzana Phone

Guarantor Name

Guarantor Address

RE: Número de Cuenta:

Nombre del Paciente: Fechas

de Servicio: Balance de la

Cuenta:

- u Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted satisface las normas de elegibilidad para la asistencia de caridad por completo en esta cuenta.
- u Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted no satisface las normas de elegibilidad para la asistencia de caridad por completo en esta cuenta.
- u Su cuenta ha sido revisada para una posible asistencia de caridad. Después de revisar toda su documentación financiera se ha determinado que usted satisface las normas de elegibilidad para la asistencia de caridad parcial en esta cuenta.
- u \$(account balance) es la porción remanente, la cual es su responsabilidad de pagar.

Si tiene alguna pregunta, por favor siéntase libre de llamarnos al (Tarzana phone) durante horas normales de oficina.

Departamento de Servicios Financieros del Cliente Tarzana Name
Tarzana Phone Number

**2014 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES
AND THE DISTRICT OF COLUMBIA**

Persons in Family/Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$11,670	\$14,580	\$13,420
2	15,730	19,660	18,090
3	19,790	24,740	22,760
4	23,850	29,820	27,430
5	27,910	34,900	32,100
6	31,970	39,980	36,770
7	36,030	45,060	41,440
8	40,090	50,140	46,110
For households with more than 8 persons, add	\$4,060 for each additional person.	\$5,080 for each additional person.	\$4,670 for each additional person.

Source: Federal Register on January 22, 2014.

<http://www.aspe.hhs.gov/poverty/14poverty.cfm>