Financial Assistance Program (FAP)

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Review Date:	12/04/2019		
Approved by:	Ted Sirotta, Sr. VP, Chief Financial Officer		

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

This policy shall apply to Henry Mayo Newhall Hospital, and any of its majority-owned not-for-profit entities (collectively referred to as “HMNH” or “Hospital”). The policy shall also be provided to and apply to any contracted service that performs billing on behalf of HMNH or any of its majority-owned not-for-profit entities.

POLICY

In accordance with federal and state laws and regulations, provide financial assistance to 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 HMNH must accept and process an application for financial assistance under the FAP. The application period begins on the first post-discharge billing statement date and ends the 240th day after HMNH provides the first post discharge billing statement.

•*Community* – Patients whose primary residence is in the city of Santa Clarita including Acton, Agua Dulce, Canyon Country, Castaic, Newhall, Saugus, Stevenson Ranch, and Valencia.

•*Extraordinary Collection Actions* - Actions taken by the Hospital against an individual related to obtaining payment of a bill for health care services provided by the Hospital 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

•*Gross Charge* - An established price, listed on the Hospital'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* - For patients 18 years of age and older, the 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.

•*Plain Language Summary* - A statement written in clear, concise and easy to understand language notifying individuals that HMNH 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 HMNH.

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

Financial Assistance Program (FAP)

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), HMNH shall advise the patient of the availability of HMNH'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 the Hospital, including at a minimum, points of check-in/registration as well as patient waiting areas for the main Hospital building and all outpatient Hospital locations, 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. HMNH's full financial assistance policy, along with a Plain Language Summary (see Appendix A) shall be available on the Hospital's website and patient portal, 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 the Hospital 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 HMNH that can provide assistance with the financial assistance process. HMNH 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 the Hospital's patients. Documents shall use 12-point font.

Conspicuous notice of financial assistance availability shall be noted on every patient billing statement sent out from HMNH, 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 the Hospital 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 billing statement.

Written notice shall include a description of any Extraordinary Collection Actions that HMNH or its collection agencies intend to initiate. Efforts are deemed reasonable if HMNH 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.

Financial Assistance Program (FAP)

HMNH'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 the Hospital'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 HMNH's financial assistance program shall be displayed (in both English and Spanish) in a conspicuous public display of noticeable size throughout all HMNH locations where visitors are likely to see it. Written materials about our financial assistance program shall include non-discrimination language as appropriate.

Eligibility Requirements

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

- Individual or household unit income - up to 350% 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 as 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). 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 HMNH that exceed 10% of the patient's 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;

- HMNH deems 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) to be indigent. Therefore, such patients may be considered as eligible presumptively 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 Program (FAP)

Financial assistance is available to all individuals for emergency services regardless of where they live, and for all other medically necessary services provided by HMNH for patients who reside in our Community, except elective services such as teeth extractions, voluntary sterilizations, and cosmetic surgery. Guidelines for determining eligibility for financial assistance shall be applied consistently. HMNH 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, HMNH'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.

The Financial Assistance Application Form (see form in Appendix B) shall be completed for all requests for financial assistance (other than if a presumptive determination as described above 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, HMNH 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, tax returns and unemployment statements.

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

Financial assistance of $5,000 or more may include documentation supporting other financial obligations, such as living expenses, child support, and other health care bills. If a financial assistance application is received during the Application Period (as defined above) and 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. 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 HMNH 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. The Patient Financial Services and Patient Access departments will create a tracking document on the shared drive to monitor all applications received.

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 HMNH 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. Financial assistance may not be denied based on information that is not specifically listed as required in the Financial Assistance Application Form.

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 Services or Patient Access for amounts up to $9,999 and by either the Chief Executive Officer or Chief Financial Officer for any higher amounts. Documentation of receipt, review and approval of the Financial Assistance Application Form shall be made by the financial counselors or Patient Financial Services. 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 Hospital 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, HMNH 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 will be denied if Medi-Cal or other health and welfare eligibility application is refused by patient, if HMNH reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with HMNH 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 HMNH 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 (see appeal form in Appendix D).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 within thirty (30) days of being received. If the Director of Patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer 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, HMNH must accept and process a financial assistance application for a period up to 240 days after HMNH provides the first billing statement to the patient (defined as the Application Period). HMNH 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 HMNH 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.

Patient Financial Services and Patient Access will be responsible for maintaining the following data monthly:

- Number of applications for financial assistance received
- Number of individuals granted financial assistance
- Number of appeals received
- Percentage of appeals reviewed with a reversed decision; and
- Number of completed applications not processed within 30 days of receipt

Finance shall calculate the cost associated with the services approved for financial assistance for disclosure in the annual financial statements and tax return.

Frequency of Re-Evaluation of Eligibility:

Once a patient has been approved for financial assistance, Patient Financial Services will rely upon that approval for subsequent services rendered by HMNH 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 HMNH 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 HMNH'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 HMNH 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, HMNH 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, HMNH may bill the patient for the services rendered and advise the patient of their change in status.

Charge Limitation:

HMNH will utilize AGB via the Prospective Medicare methodology for inpatient and outpatient accounts when determining patient liability, for individuals who qualify for financial assistance. The billed amount will not exceed the AGB.

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

This policy is not required to be approved by the Board each year for updates to the AGB. The Director of Patient Financial Services is responsible for ensuring that the AGB is updated annually.

Medicaid Coverage:

Medicaid copays or Share of Cost not paid at the time of service will be billed to the patient. If unable to collect the copays by the end of the Application Period, the copays will be written off as a charity write-off. 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.

Financial Assistance Program (FAP)

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 financial assistance granted to patients with Medicare coverage meeting the IRS criteria, but not meeting CMS requirements for charity care, a transaction non-charge procedure code of "CMS IRS" shall be used in the billing system. For all other patient financial assistance granted, the code of "CMS CHAR" shall be used.

HMNH's separate Billing and Collections policy may be obtained on HMNH's website at: Billing and Collection Policy

As required by California State Law, HMNH provides the Office of Statewide Health Planning and Development (OSHPD) its Financial Assistance Program Policy and applications, when there is a significant change or every other year. If there has been no significant change, the Hospital notifies OSHPD of the lack of change.

Emergency physicians who provide emergency medical services in the hospital that provide emergency care are also required by law to provide discounts to uninsured patient or patients with high medical costs who are at or below 350% of the FPL. The HMNH FAP does not include professional services provided by our Medical Staff.

A list of hospital physicians is included in Appendix E: Financial Assistance Physician Listing 110519.xlsx and is updated no less frequently than annually.

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REFERENCES:

HealthCare Financial Management Association Principles and Practices Board Statement 15, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts
American Hospital Association Hospital Billing and Collection Practices Statement of Principles and Guidelines May 5, 2012
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
Also refer to the policy entitled "Billing and Collection Practices"

APPENDIX A

PLAIN LANGUAGE SUMMARY OF HMNH FINANCIAL ASSISTANCE POLICY

As a non-profit organization, Henry Mayo Newhall Hospital ("HMNH" or "Hospital") provides financial assistance to patients that may not have sufficient financial resources to pay for services.

Financial Assistance Eligibility Requirements

Eligibility for financial assistance is both income and asset based, using a sliding scale. Income level eligibility is up to 350% 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).

Financial assistance is available to all individuals for emergency services regardless of where they live, and for all other services provided by HMNH for patients who reside in our community, except elective services such as teeth extractions, voluntary sterilizations, and cosmetic surgery.

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, HMNH'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 Patient Access Services, Main Admitting, (2) by phone at (661)200-1050 or (661)200-1110, (3) on the web: **English:** https://www.henrymayo.com/images/FINANCIAL-ASSISTANCE-PROGRAM-APPLICATION-ENGLISH.pdf
Spanish: https:www.henrymayo.com/documents/Applicacion-en-espanol[1].pdf or (4) by mail to Henry Mayo Newhall Hospital, 23845 McBean Pkwy, Valencia, CA 91355: Attn: Patient Financial Services. The Financial Assistance Policy ("FAP") may be obtained at: https://www.henrymayo.com/documents/POLICY-with-Eng-application[1].pdf

The application specifies certain information that is required to be submitted with the application. This information may be independently verified by HMNH to ensure its completeness and accuracy. If a financial assistance application is received within 240 days of HMNH's initial billing for a service and is deemed incomplete, a written notice to the patient/ guarantor will be

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 HMNH reasonably believes that the patient could qualify. In addition, the patient is expected to cooperate with HMNH 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 HMNH 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 within thirty (30) days of being received. If the Director of patient Financial Services feels additional input is needed in making a determination, the Chief Financial Officer 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 HMNH 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 HMNH'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 HMNH, 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, HMNH will not reverse the amount of financial assistance granted.

Charge Limitation

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Individuals who are eligible for financial assistance based on the guidelines herein and have applied for financial assistance, but do not qualify will not be charged more than the Average Generally Billed (AGB) amounts. HMNH uses Medicare allowable rates for AGB.

This document (The Plain Language Summary) summarizes the HMNH 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) 200-1050 and are available to assist patients with the financial assistance application process.

APPENDIX B

HENRY MAYO NEWHALL HOSPITAL
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date:

Patient Name
Patient Address
City, State, Zip

Patient Name:
Patient Account:
Date of Service:

Financial Assistance Program

Dear _____:

Thank you for choosing Henry Mayo Newhall Hospital (HMNH) for your health care needs, where we strive to improve the health of our community through compassion and excellence in health care services. You may be eligible for financial assistance to assist you in paying health care services you will or have received at HMNH. This financial assistance applies to your hospital bill only, and does NOT apply to bills you may receive from your physicians or surgeons, although if this application is approved, some providers may extend a full or partial courtesy discount based upon the hospital acceptance determination letter.

Enclosed, please find an application for financial assistance which must be filled out in its entirety, proper documentation enclosed, signed and dated so that the review process may commence.

The application and required information is provided below. Please submit the requested documents to Patient Access Services in person or by mail to:

Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy
Valencia, CA 91355.
Attn: Patient Access Financial Counselors

You will receive a determination of Eligibility for Financial Assistance letter within thirty days after we receive a completed application with appropriate supporting documents.

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Completion of this application is not a guarantee of eligibility or qualification for financial assistance or any other program. Financial assistance is considered after all possible sources of potential payment (for example, health insurance, Medicare, Medicaid, liability insurance) have been exhausted. Failure to provide requested documents may result in denial of the application.

If you need any further information or assistance in completing the application, please make an appointment to come to the hospital at Patient Access Services, Main Admitting, or call 661-200-1050, Monday through Friday, 7:00 AM through 5:00 PM and a representative will assist you. For more information about the Financial Assistance Program, you may visit our website at: https://www.henrymayo.com/documents/POLICY-with-Eng-application[1].pdf

_____

(signature line)

(printed name of financial counselor)
Financial Counselor

Financial Assistance Program (FAP)

Physician: Medical Record #: Date(s) Of Service:

PATIENT INFORMATION:
Patient Account:
Patient Name:
Patient Home Address:

Social Security#: Phone#: Birthdate:

Third party coverage (i.e., Medi-Cal, Medicare, private insurance, etc.), which may partially or fully cover the cost of health insurance received on the above date(s). Yes_____ No_____

Place of Birth
City: _____ State: _____
Mother's Maiden Name _____

If you were born outside the United States, have you applied to or received Amnesty under Federal law? Yes_____ No_____ Amnesty #_____

Name(s) and age(s) of dependents living with you for whom you are responsible:

_____

_____

_____

_____

_____

_____

_____

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Total Household Monthly Income

$: _____

INCOME: List income for family from:

	Monthly	Annually
Wages (self).....	$_____	$_____
(Spouse)	$_____	$_____
(Other family member).....	$_____	$_____
Farm/self-employment.....	$_____	$_____
Public Assistance.....	$_____	$_____
Unemployment Compensation...	$_____	$_____
Workman's Compensation.....	$_____	$_____
Strike Benefits.....	$_____	$_____
Alimony.....	$_____	$_____
Child Support.....	$_____	$_____
Military family allotment.....	$_____	$_____
Pension(s).....	$_____	$_____
Income from rent, interest,	$_____	$_____
dividends	$_____	$_____
Social Security Income	$_____	$_____
Income from Interest/Rental	$_____	$_____
TOTAL	$_____	$_____

EXPENSES (MONTHLY)	$_____
Mortgage/Rent	$_____
Medical Insurance:	$_____
Utilities:	$_____
	$_____
Electricity	$_____
	$_____
Gas	$_____
	$_____
Water	$_____
Home/Renter's Insurance	$_____

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Auto Insurance:	$_____
	$_____
Telephone:	$_____
Medical Bills	$_____
Food/Groceries:	$_____
Hospital:	$_____
Credit Cards	$_____
Physicians:	$_____
Credits Union:	$_____
Prescriptions:	$_____
Auto loans:	$_____
Life Insurance:	$_____
Auto gasoline:	$_____
Health Insurance:	$_____
TV/Cable:	$_____
Medical Bills:	$_____
Child Care:	$_____
School expense:	$_____
School Expense:	$_____
TOTAL EXPENSES:	$_____

Do you own your own home?	Yes____ No____Estimated Value $_____
Do you own other property?	Yes____ No____Estimated Value $_____
Do you own an automobile?	Yes____ No____
Stocks, Bond, Mutual Funds	Yes____ No____Estimated Value $_____
401K and Annuities	Yes____ No____Estimated Value $_____
Savings Account 1	Yes____ No____Estimated Value $_____
Savings Account 2	Yes____ No____Estimated Value $_____
Checking Account	Yes____ No____Estimated Value $_____

The following information is required to be submitted with your application:

Proof of income (for each household member, provide all documents that exist or apply).

- Copy of the three most recent paystubs. If paid in cash, a notarized letter from each employer indicating terms of employment including wages, salary, dates of employment, current employment status, the availability of any health care benefits, etc.

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- If self-employed, the latest tax returns.
- Copies of checks or award letters from unemployment, Social Security.
- Copies of checks for child or spousal support.
- Proof of other income (for example, interest income, pension, or rental income).
- Copy of the most recently filed income tax return.
- Photo ID/Proof of Identification
- Current Driver License, or
- Current State ID, or
- Current Passport

DISCLOSURE OF ASSETS (for each household member, provide all documents that apply)

- Past three months of detailed statements from Checking and Savings accounts, Certificates of Deposit, Money Market Fund, Brokerage Statement, Retirement Plan, and/or title of Vehicle(s) owned.

EXPENSES

- Copy of rent lease (for the last 6 months)/mortgage agreement, most recent statements for all monthly expenses such as utility bills, credit card statements, car payments and/or any other that may apply.

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION.

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

_____ _____/_____/_____
Patient/Responsible Relative(s) Signature Date

_____ _____/_____/_____
Hospital Reviewer Date

Financial Assistance Program (FAP)

APPENDIX C

SLIDING SCALE FINANCIAL ASSISTANCE

Income / Net Asset Levels	Discount from Total Charges							
	< $1,000	$1,000 - $2,500	$2,591 - $10,000	$2,501 - $5,000	$10,001 - $25,000	$25,001 - $50,000	$50,001 - $100,000	>$100,000
0 - 200% FPL Net assets:								
<$100,000	100%	100%	100%	100%	100%	100%	100%	100%
$100,000 -$150,000	85%	85%	85%	85%	100%	100%	100%	100%
$150,001 - 250,000	75%	75%	75%	75%	75%	100%	100%	100%
201 - 350% FPL Net assets:								
<$100,000	75%	75%	75%	100%	100%	100%	100%	100%
$100,000 -$150,000	75%	75%	75%	75%	75%	75%	75%	75%
$150,001 - 250,000	50%	50%	50%	50%	50%	50%	50%	50%

NOTE: The AGB is the maximum amount that can be collected from patients that qualify for financial assistance or as otherwise allowed under this policy, regardless of the percentages shown above.

The FPL for the current year can be obtained from the following website:

https://aspe.hhs.gov/poverty-guidelines

The total charges to be used for purposes of determining the initial level of financial assistance to be provided shall be the total charges outstanding and due from the patient at the time the application for financial assistance is received. This could include more than one bill.

APPENDIX D

Financial Assistance Program (FAP)

HENRY MAYO NEWHALL HOSPITAL
FINANCIAL ASSITANCE APPEAL FORM
REQUEST FOR RE-EVALUATION ON FINANCIAL ASSISTANCE DENIAL

General Information
Date:
Name of Patient:
Date of Birth:
Address:
City, State, Zip Code:
Phone Number:

Guarantor Name (if different than patient): Relationship:
Date of Birth:
Guarantor Address:
City, State, zip Code:
Phone Number:

Please list reason of your request to appeal your Financial Assistance Denial (Appeal letter must include supporting documents that may prove inability to pay that was not part of the initial consideration):

Please submit your appeal letter and supporting documents in person or by mail
Henry Mayo Newhall Hospital
23845 Mc Bean Pkwy
Valencia, CA 91355
Attn: Patient Financial Services

You will receive a determination of your request to re-evaluate the denial decision of your financial assistance application within thirty days after receiving your appeal letter with appropriate supporting documents.

If you have any questions please contact one of our Patient Financial Services representatives at (661) 200-1112 or our Director of Patient Financial Services at (661) 200-1111.Thank you for choosing HMNH as your health care provider.

APPENDIX E

Financial Assistance Program (FAP)

Financial Assistance Physician Listing 110519.xlsx