CARSON VALLEY MEDICAL CENTER	Section/Number	Reviewed/Revision Date:
Department: **Admitting**	ADT 550.01	10/03/2013, 11/11/2015, 06/21/2016, 04/18/2017, 09/8/2017
	New Date:	
Title: **Financial Assistance Policy**	9/8/17	Page 1 of 15 Pages

POLICY:

Financial assistance if provided only when care is deemed medically necessary and after patients have been found to meet all financial criteria. Carson Valley Medical Center offers both free care and discounted care, depending on individuals' family size and income.

Patients seeking assistance may first be asked to apply for other external programs as appropriate before eligibility under this policy is determined. Additionally, any uninsured patients who are believed to have the financial ability to purchase health insurance may be encouraged to do so to help ensure healthcare accessibility and overall well-being.

PURPOSE:

Consistent with our Vision to, strengthen our community by providing accessible, affordable, high quality healthcare to all. Carson Valley Medical Center is committed to providing financial assistance to uninsured or underinsured individuals who are need of emergency or medically necessary treatment.

DEFINITIONS:

1. Community Care: Medically necessary services rendered without the expectation of full payment to patients meeting the criteria established by this policy.
2. Medically Necessary: Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:
   - Provided in accordance with generally accepted standards of medical practice;
   - Clinically appropriate with regard to type, frequency, extent, location and duration;
   - Not primarily provided for the convenience of the patient, physician or other provider of health care;
   - Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured; and
   - The most clinically appropriate level of health care that may be safely provided to the insured.
3. Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts.
4. Uninsured: Patients with no insurance or third-party assistance to help resolve their financial liability to healthcare providers.
5. Underinsured: Patient having some insurance coverage but not enough, or when a patient is insured yet unable to afford the out-of-pocket responsibilities not covered by patient insurer.

6. Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care (determined as described in section D of the policy below).
7. Presumptive Eligibility: The process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

PROCEDURE:

A. Referral Process:

1. The referral process will optimally occur prior to or at the time of service, but may occur any time during the collection process, including post-assignment to an outside collection agency.
2. Uninsured patients must first be screened by an eligibility vendor or financial screening software to determine eligibility for an alternate payer source, including but not limited to federal, state, or county assistance.
3. Referrals for the Community Care Program may be made by the following areas: Patient Access, Patient Accounting, Eligibility Vendor, Collection Agency, Physician Practice, and other community organizations.
4. Community Care referrals should be made prior to any planned procedure. An estimate of a planned procedure may be completed using "Attachment C" and must accompany an application.

B. Screening Process:

1. All patients with the inability to pay will be screened for financial assistance by Patient Access, Customer Service, or an eligibility vendor based on time of service. If found not to be eligible for any outside assistance, the patient is referred to the Patient Financial Counselor for Community Care screening using the most current income guidelines released by the Department of Health and Human Services. At this time the Community Care application process begins.
2. Patients must live within the Carson Valley Medical Center service area to be considered for Community Care assistance. Exceptions may be made on a per case basis.
3. The financial screening software can be utilized to determine a patient's ability to pay. Other factors to be considered during the screening process include comparing the patient's gross income to the annually published Federal Poverty Guidelines, legal household determination, treatment received, quantity of accounts under review, patient account balances, and exhaustion of all other payment sources.
4. Uninsured patients are required to apply for government program assistance through the government program directly, or through Carson Valley Medical Center's eligibility vendor for eligibility determination.

C. Healthcare Services Eligible for Assistance

1. Emergency medical services provided in an Emergency Room setting.
2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.

4. Medically necessary services, evaluated on a case-by-case basis at Carson Valley Medical Center's discretion.

D. Eligibility Criteria:

1. Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care program, and who are unable to pay for their care based upon a determination of financial need in accordance with policy.
2. The Financial Assistance Program may only be used for medically necessary care as defined in the definitions section 2 above.
3. All applicants will be assigned a Federal Poverty Level (FPL) using the matrix found in the most current FPL table as defined by the IRS (Attachment A).
4. Household number of legal dependents will be based on the latest filed tax return. Unusual circumstances will be considered on a case-by-case basis.
5. Patients with a household FPL ≤400% will be considered for the Community Care program. Patients with an FPL >400% are not eligible and alternate payment arrangements will be pursued.
6. Patients eligible for the following programs/services are deemed medically indigent and may not require a complete Community Care application in order to be considered for the program:
    - State assistance programs (food stamps, pharmaceutical assistance programs, welfare, etc.) Patient will need to submit proof of enrollment for determination.
    - Patients currently covered for Medicaid, but not eligible on the date of service, or patients eligible for Medicaid emergency or pregnancy services only.
7. For underinsured patients, a payment, denial, or benefit summary from primary insurance must be secured prior to consideration for Community Care program.
8. Patient cost share amounts, if any, will be determined utilizing the matrix shown in Attachment A.
9. Assets exempt from financial consideration include the residence where a patient and/or patient's family resides, automobiles needed to transport all working parties to and from work, savings accounts with less than two months of income, and retirement accounts with less than $50,000.00 are exempted from consideration.

E. Determining Discount Amount

1. Once eligibility for financial assistance has been established, Carson Valley Medical Center will not charge patients who are eligible for financial assistance more than the amounts generally billed (AGB) to insured patients for emergency or medically necessary care.
2. To calculate the AGB, Carson Valley Medical Center uses the "look-back" method described in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. Carson Valley Medical Center uses data based on claims processed by Medicare fee for-service and all private commercial insurers for all medical care over the past fiscal year to determine the percentage of gross charges that is typically allowed by these insurers.
3. The AGB percentage is then multiplied by gross charges for emergency and medically necessary care to determine the AGB. Carson Valley Medical Center re-calculates the percentage each year.

4. The discount will be applied to gross charges or balance after insurance once a complete Community Care application has been received and a determination has been made by the committee. (Gross Charges X AGB percentage = Amount adjusted to Community Care or Balance after insurance X AGB percentage = Amount adjusted to Community Care)

F. Application Process

1. Community Care applications (Attachment B) may only be distributed by the Patient Access and Business Office departments. Patients can also retrieve a Community Care application from the CVMC website, or online at: [http://www.cvmchospital.org/patients_visitors/financial_assistance.aspx].
2. Supporting financial documentation must be submitted with a completed Community Care application and will include:
    - Prior year filed tax forms
    - At least past 90 days of pay stubs or other sources of income (i.e. social security, unemployment, etc.)
    - Last three months of bank statements (all accounts)
    - Last three months of mortgage/rent receipts
    - Statements from any other asset accounts (i.e. retirement funds, insurance policies, investments, etc.)
3. Completed applications must be returned along with all supporting documentation within 90 days of issuance. Follow up will be made with the patient every two weeks to ensure timely receipt of completed application. Non-cooperation from the patient to follow-up with Patient Financial Counselor requests will result in a denial after 30 days of no response. If no information is received, the account will be placed back in the regular collection flow.
4. Patients will be notified of incomplete information for applications submitted missing any of the supporting documents. Patients will be given an additional 30 days to comply with required documentation requests. Additional time to submit requested documentation or documentation request waivers may be provided on a case-by-case basis. Failure to comply with additional requests will result in a denial of Community Care application.
5. A denial issued due to patient non-cooperation may prohibit the patient from re-applying for Community Care on the same account(s).

G. Application Review

1. Completed Community Care applications with required supporting documentation will be forwarded to the Patient Financial Counselor, who will be responsible for requesting a credit bureau report, and assembling the complete Community Care application packet.
2. Patients may be contacted at any time during the application review process and asked to submit additional documentation necessary to make a determination. Non-cooperation of such requests can result in a denial.
3. The Admitting department will be the custodian of all Community Care complete, incomplete, and denied applications. All Community Care documentation will be scanned into the patient account and/or retained for a minimum of seven years.
4. Completed Community Care application packets will be routed for approval (including applications for pre-approval) to the Community Care Committee on a monthly or as needed basis. All accounts will be reviewed by the committee including appealed decisions.

H. Approval

1. Adjustments made for Community Care approvals are completed within the month of approval and requested by the Patient Financial Counselor routed to Manager through appropriate WQ for final adjustment.
2. Community Care approvals for a continuing course of treatment will apply to related accounts up to three months following approval. Patient will need to re-apply for Community Care with any updated information if financial assistance is needed beyond the approval period.
3. Community Care approvals will include balances up to 1 year prior to the determination.
4. Approval notification (Attachment D1) is sent to the patient within 10 days of decision and financial arrangements are made for any patient balance remaining.
5. It is expected that physicians making Community Care referrals will provide free or partial pay care in proportion to that provided by Carson Valley Medical Center.
6. Accounts eligible for the Financial Assistance will be addressed by the patient financial counselor or customer service within 240 days of first post-discharge statement.

I. Denials

1. Denial notification (Attachment D2) is sent to the patient within 10 days of decision and efforts are made to collect on remaining account balances.
2. Accounts denied for Community Care Assistance will be sent back through the collection process, including re-placement to collection agency.
3. Reconsiderations can be made for patients who submit new or revised information within 30 days of the denial decision notification.
4. Application denial disputes made by the patient/guarantor must be made in writing and forwarded to the Patient Financial Counselor at Carson Valley Medical Center for review and response.

J. Actions in the Event of Non-Payment

The collection actions Carson Valley Medical Center may take if a financial assistance application and/or payment is not received are described in a separate policy.

In brief, Carson Valley Medical Center will make certain efforts to provide patients with information about our financial assistance policy before we or our agency representatives take certain actions to collect your bill (these actions may include civil actions, debt sales, or reporting negative information to credit bureaus).

For more information on the steps Carson Valley Medical Center will take to inform uninsured patients of our financial assistance policy and the collection activities we may pursue, please see Carson Valley Medical Center's Billing and Collections Policy.

You can request a free copy of this full policy in person at our facility at 1107 Hwy 395, Gardnerville, NV 89410, by mail, at PO Box 790, Gardnerville, NV 89410, by calling us at 775-783-3080, or online at: [http://www.cvmchospital.org].

K. Eligible Providers

1. In addition to care delivered by Carson Valley Medical Center, emergency and medically necessary care delivered by the provider groups listed below is also covered under this financial assistance policy.
    a. Leman Medical Corporation (Emergency Medicine Providers);

    b. Senior Care Clinic services provided by the following providers:
        i. Dr. Evan Easley
        ii. Dr. Garrett Schwartz
        iii. Dr. Glenn Thorp
        iv. Dr. Judith Rosso
        v. Carson Valley Medical Center Employees

    c. EKG reading fees generated by the following physicians:
        i. Dr. Evan Easley
        ii. Dr. Garrett Schwartz

    d. Echocardiogram reading fees
        i. Renown Institute for Heart & Vascular Health

2. Care provided by any of the providers listed below at Carson Valley Medical Center will NOT be covered under this policy. As such, the bills received by Carson Valley Medical Center patients for care provided by any of the following provider groups will NOT be eligible for the discounts described in this financial assistance policy.
    a. South Tahoe Anesthesia Medical Group
    b. Sierra Nevada Medical Imaging
    c. Rural Physicians Group
    d. Tahoe Carson Valley Medical Group
    e. Sierra Nevada Surgical Associates
    f. Sierra Nevada ENT
    g. Dr. Charles Held
    h. Renown TeleHealth
    i. Tahoe Fracture & Orthopedic Medical Clinic, Inc.
    j. Tahoe Orthopedics & Sports Medicine
    k. Any other Provider or Provider Group not listed in Section J. #1.

ATTACHMENT "A"

FEDERAL POVERTY INCOME GUIDELINES

CARSON VALLEY MEDICAL CENTER'S ELIGIBILITY DETERMINATION FOR COMMUNITY CARE ASSISTANCE.

Eligibility Guide for 2016: Using household income and size as calculated in the financial screening process identify eligibility for financial discount. Family Size Period Federal Poverty Guidelines (100%): If income is below 250% (shown below) of FPIG eligible for *Full write-off.* If income is above 250% but below 400% (shown below) of FPG, eligible for *Partial write-off.*

Household Size	2017Yearly Income	0 -250%	250-300%	300-350%	350-400%
1	$12,060	$30,150	$36,180	$42,210	$48,240
2	$16,240	$40,600	$48,720	$56,840	$64,960
3	$20,420	$51,050	$61,260	$71,470	$81,680
4	$24,600	$61,500	$73,800	$86,100	$98,400
5	$28,780	$71,950	$86,340	$100,730	$115,120
6	$32,960	$82,400	$98,880	$115,360	$131,840
7	$37,140	$92,850	$111,420	$129,990	$148,560
8	$41,320	$103,300	$123,960	$144,620	$165,280
add for each additional person	$4,180	$10,450	$12,540	$14,630	$16,720
Per Account not to exceed max co-pay	$0	$0	$100-300	$200-600	$300-900

For each additional person add $4,180 for annual income and $347 monthly. Carson Valley Medical Center Inpatient Outpatient

ATTACHMENT "B" (Page 8 – 10)

Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL

Date: _____

Account number(s) _____
_____

Dear _____,

As you are aware, Carson Valley Medical Center provides quality healthcare services to our community and visitors. It is our desire to assist you in payment of your account(s) as soon as possible. Our Community Care Program may enable you to satisfy your account(s), depending on the information provided regarding your financial status.

If you are interested in this program, please fill out the enclosed form **COMPLETELY**, including this Cover letter, and return with application the following.

1. How many people are living in your household? _____.
   - Are they all members of your family? ___Yes ___No
   - What are their names, ages and relationship _____
   _____
2. Copy of Medicaid denial or hospital contracted eligibility service outcome.
3. Financial Information:
   - Income tax form for you and your spouse.
   - 90 days of most recent pay stubs for you and your spouse.
   - 3 most recent bank statements (all pages) for checking, savings and credit union.
4. Last 3 months of mortgage/rent receipts.
5. Statements from any other asset accounts (retirement funds, investments, insurance policies, etc.)

IMPORTANT:
If your completed application is not returned by _____, and/or all the requested information is not included, it may be denied for non-compliance.

If you have further questions concerning the Community Care Program, please do not hesitate to contact our office.

We will advise you of the status of your application. If there is any remaining balance, we will be happy to assist you.

Sincerely,

Patient Financial Counselor
775-783-3080

APPLICATION FOR CARSON VALLEY MEDICAL CENTER COMMUNITY CARE

CONFIDENTIAL FINANCIAL STATEMENT

To be considered for the Carson Valley Medical Center ***Community Care Program*** all applicants must attach a copy of the most recent Federal income tax return and three most recent pay stubs, complete Section A, and sign and date application.

To be considered for the Carson Valley Medical Center ***Community Care Program*** all applicants must first apply for governmental program assistance (Carson Valley Medical Center has resources available within the hospital to assist with the governmental program application process). After governmental program assistance has been determined, applicant can apply for Full or Partial Financial Assistance. To be considered for Full or Partial Financial Assistance applicant **must attach a copy of the most recent Federal income tax return, three most resent pay stubs, last three months of bank statements, last three months of mortgage/rent receipts, statements from any other assets**, and complete Section A and Section B. Finally, applicant must sign and date application before submission.

To be considered for ***Special Circumstance*** Financial Assistance (applicant does not meet qualifications for discount) all applicants must attach a copy of the most recent Federal income tax return or three most recent pay stubs and complete the entire form including Section C, and sign and date application.

SECTION A: All applicants must complete this section CA or NV Resident: How Long? _____ Check box if homeless_____

Name:

_____

First Middle Last Phone #

Mailing Address:

_____

Number & Street City State Zip Code

Physical Address:

_____

Number & Street City State Zip Code

Marital Status (check one): Single ____ Married____ Divorced/Legally Separated: _____ Widowed: _____

Social Security #: _____ Date of Birth: _____

Spouse Social Security #: _____ Spouse date of Birth: _____

Applicant Employer: _____ Applicant Employer Address: _____

Applicant Occupation: _____

Spouse Employer: _____Spouse Employer Address: _____

Spouse Occupation: _____

Amount of child support and alimony paid over the past 12 months: _____

Name	Date of Birth	Income Type	Last 3 Months Income	Last 12 Months Income

Total:

SECTION B: Full or partial Financial Assistance and Special Circumstance <u>Applicants must complete this section</u>

Cash accounts (do not include retirement accounts):

Bank Name: _____ Type of acct: _____ Account #: _____Current Bal: $ _____

Bank Name: _____ Type of acct: _____ Account #: _____Current Bal: $ _____

Number of dependents including spouse (whether or not living at home): (list ages): _____

To my knowledge, the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

X _____ _____

Patient or responsible party signature Date

STATEMENT OF NEED: Full or partial Community Care and Special Circumstance <u>Applicants must complete this section</u>

Please state the reasons or circumstances that led you to apply for assistance. (Some examples: change in employment status, unusual medical circumstances, insurance coverage, other problems)

SECTION C: Special Circumstance Community Care Applicants complete this section

Voluntary Information:
Additional information you wish to be considered for Special Circumstances:

For assistance with your **Application,** contact our Patient Financial Counselor at: (775) 783-3080

For Office Use Only:
Met with Social Worker _____
Approved: ____ Denied: ____ Estimated dollar value of benefit provided: $_____

Comments: _____

***<u>Date</u>* the above comments including reason for denial were entered onto patient's account:** _____

ATTACHMENT "C"
Estimate

THIS ESTIMATE IS BASED ON THE FOLLOWING INFORMATION:

Patient Name: _____ Account No: _____

Expected Admit Date: _____

Date of Estimate: _____Estimate completed by: _____

Diagnosis _____

Average Length of Stay for Patients with this diagnosis: _____

Estimated charges for patients with this diagnosis: _____

YOUR ESTIMATED FINANCIAL RESPONSIBILITY: $_____

·Deposit of $ _____must be collected prior to admission.

·Patient/Guarantor has been notified. [ ] N/A. Notified by: _____

[ ] Financial Hardship Assistance information provided

·Comments: _____

_____

_____

By my signature below, I signify that I have read and understand the information above concerning my estimated financial responsibility for hospital services.

_____ _____

Patient/Guarantor Signature Date

Hospital Use Only
CPT Code used
ICD-9 or ICD-10 Code used
Copies: Original to Patient Financial Services
Patient

ATTACHMENT "D1"
APPROVAL LETTER

Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL

Date

Patient Name
Address

Re: Community Care
Account #(s):

Dear ***(Patient Name)***,

After careful review of the information provided, your Community Care Application has been approved for a discount of your balance. As a result of this discount, the remaining balance on account(s) is: $_____.

Please call our Customer Service Department at 775-782-1625 to make interest-free payment arrangements on any outstanding balance.

Thank you for choosing Carson Valley Medical Center.

Sincerely,

Patient Financial Counselor

ATTACHMENT "D2"
DENIAL LETTER

Carson Valley Medical Center
YOUR COMMUNITY HOSPITAL

Date

Name
Address

Re: Community Care
Account(s):

Dear (Patient Name),

After careful review of the information provided, your Community Care Application has been denied due to:

- □ Income exceeds qualification guidelines for Financial Assistance Program
- □ Failure to provide requested information required to complete review
- □ Other: _____

If you feel this information is incorrect, you may submit an appeal in writing with any additional documentation to the address provided below. Appeals for Community Care decisions will be reviewed by a committee monthly for final determination.

Carson Valley Medical Center
Attn: Community Care Appeals
P.O. Box 790
Gardnerville, NV 89410

Please contact our Customer Service Department at 775-782-1625 today to make interest-free payment arrangements for your outstanding balance(s).

Sincerely,

Patient Financial Counselor

ATTACHMENT "E"

Community Care Summary Form

Carson Valley Medical Center

Representative Processing Application: _____

Date of Application: _____ Today's Date: _____

Patient's Name: _____ Med Rec #:_____

D.O.B.:_____ Does Patient have Insurance? Y N

Insurance: _____

Account Detail:

Pt. #: _____ Service: _____ D.O.S.: _____ Acc Bal: _____
Pt. #: _____ Service: _____ D.O.S.: _____ Acc Bal: _____
Pt. #: _____ Service: _____ D.O.S.: _____ Acc Bal: _____
Pt. #: _____ Service: _____ D.O.S.: _____ Acc Bal: _____
Pt. #: _____ Service: _____ D.O.S.: _____ Acc Bal: _____

Need Future Services Approved? (If yes, list in comments) _____
Has Patient been awarded Community Care before? _____
Total Balances: _____

Patient Detail:

Family Size: _____ FPL % Value per Income and Family Size: FPL%: _____
Credit Score: _____ Annual Income: _____ Medicaid Eligible: Y N

Document Check List: ***(Check all and attach to application)***

- ❑ Last Tax Return Unobtainable? Why: _____
- ❑ 3 Months Bank Statements Unobtainable? Why: _____
- ❑ Last 3 Pay Stubs Unobtainable? Why: _____
- ❑ Mortgage / Rent Receipts Unobtainable? Why: _____

Admission / Registration Diagnosis: _____

Case Specific Comments:

Household Size	2017Yearly Income	0 -250%	250-300%	300-350%	350-400%
1	$12,060	$30,150	$36,180	$42,210	$48,240
2	$16,240	$40,600	$48,720	$56,840	$64,960
3	$20,420	$51,050	$61,260	$71,470	$81,680
4	$24,600	$61,260	$73,800	$86,100	$98,400
5	$28,780	$71,950	$86,340	$100,730	$115,120
6	$32,960	$82,400	$98,880	$115,360	$131,840
7	$37,140	$92,850	$111,420	$129,990	$148,560
8	$41,320	$103,300	$123,960	$144,620	$165,280
add for each additional person	$4,180	$10,450	$12,540	$14,630	$16,720
Per account not to exceed max co-pay	$0	$0	$100-300	$200-600	$300-900

Pre-Approvals:

Letter of Medical Necessity: Yes _____ No _____
Physician: _____
Co-pay required: Yes_____ No ____
Co-pay required: Yes_____ No _____
Amount of Co-pay_____
Decision Letter sent to Patient: Date _____
If yes, reason why: _____

Approval:

Approved: Yes _____ No _____
Account Adjusted: Date: _____
Amount of Co-pay_____
CFO: _____
Special Circumstances: Yes_____ No _____
CFO: _____

Financial Assistance Policy – Plain Language Summary

The Carson Valley Medical Center (CVMC) Financial Assistance Policy (FAP) exists to provide eligible patients partially or fully discounted emergent or medically-necessary hospital care. Patients seeking Financial Assistance must apply for the program, which is summarized below.

Eligible Services – Emergent and/or medically-necessary healthcare services provided by Carson Valley Medical Center, Job's Peak Internal Medicine & Family Practice, CVMC Urgent Care, Alpine Medical, Herbig Family Medicine, and Crenshaw Internal Medicine.

How to Apply – Financial Assistance Applications may be obtained/completed/submitted as follows:

- Obtain an application in person at Carson Valley Medical Center located at 1107 Hwy 395 Gardnerville, NV. 89410.
- Request to have an application mailed to you by calling (775)782-1625.
- Request an application by mail at Carson Valley Medical Center, Attn: Patient Financial Counselor P.O. BOX 790, Gardnerville, NV 89410.
- Download an application through the Carson Valley Medical Center website: http://www.cvmchospital.org/patients_visitors/financial_assistance.aspx

Determination of Financial Assistance Eligibility – Generally, patients are eligible for financial assistance based on their income level and assets as determined by Federal Poverty Guidelines (FPG) and the patient's ability to pay. Eligible patients will not be charged more for emergency or other medically-necessary care than patients who have insurance. CVMC determines amounts generally billed based on all CVMC claims processed by Medicare and private health insurers over the past fiscal year. Patients have 240 days after the first bill to submit an Application for Financial Assistance. If collections are already underway when the application is received, we will stop collection efforts while a patient's application is processed. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. Please refer to the full policy for a complete explanation and details.

This summary, the Financial Assistance Policy, and Financial Assistance application are available in Spanish by request.

Document Metadata

Document Name:	Financial Assistance/ Community Care Policy (English)
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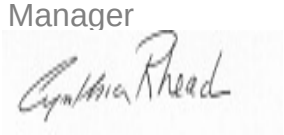
Author(s):	Jorgenson, Rhonda *Administrative Staff*
Approver(s):	Kyhl, Jackie *Manager* Rhead, Cynthia *Manager*
Publisher:	Jorgenson, Rhonda *Administrative Staff*
Description:	Assist patients with limited resources who do not qualify for federal, state , county, or other assistance, by establishing aprocess to evaluate a patient's inability to pay, nottheir willngness to pay, for helathcare services proveded

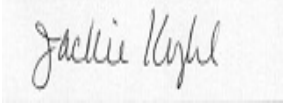
Digital Signatures:

Approver:
Rhead, Cynthia
Manager



Signed in previous version

Approver:
Kyhl, Jackie
Manager



Signed in previous version