

Uninsured Patient Discount and Prompt Payment Discount apply.

6. Indemnity Insurance Company or Medicare Supplement Plan pays members directly

Patient may be billed. Full and Partial Charity Care and other discounts do not apply.

7. Indemnity Insurance Company, PRO or non-contracted third party payer underpays claiming charges are unreasonable or unsupported

Continue to pursue amounts due from insurance and do not initiate collections for these amounts against patient without approval from St. Rose Hospital's General Counsel. Pursue collection of patient liability amounts as set forth herein.

8. Charges not covered by insurance because patient exceeded benefit cap prior to admission

These amounts should be collected from the patient. Patient may be eligible for Full or Partial Charity Care. If the patient is not eligible for Full or Partial Charity Care, the Uninsured Patient Discount and Prompt Pay Discounts apply.

9. Charges not covered by insurance because patient exceeded benefit cap during patient's stay

When a payer pays only a portion of the expected reimbursement for a patient's stay due to exhaustion of the patient's benefits during the stay, St. Rose Hospital should collect from the patient the balance of the expected reimbursement under the payer contract. St. Rose Hospital should not pursue from the patient any amount in excess of the payer's contractual rate under the payer contract. Patients who exceed their benefit cap may apply for Full or Partial Charity Care for the services that are in excess of the benefit cap, and may receive a Prompt Pay Discount. The Uninsured Patient Discount does not apply to these services.

10. Charity care determination creates a credit balance

If the charity care determination creates a credit balance in favor of a patient, the refund of the credit balance shall include interest on the amount of the overpayment from the date of the patient's payment at the statutory rate (10% per annum) pursuant to Health & Safety Code § 127440.

CHARITY CARE 2022 POVERTY FEDERAL GUIDELINES

EXHIBIT B

Family Size	Period	Federal Poverty Guidelines	If income is below 200 % (shown below) of FPIG, eligible for full charity care	If income is above 200 % but below 350% (shown below) of FPIG, eligible for partial charity care. Expected Payment = 10% of Gross Billed Charges	If income is above 350 % but below 500 % (shown below) of FPIG, eligible for partial charity care. Expected Payment = 15% of Gross Billed Charges
1	Annual	\$13,590.00	\$27,180.00	\$47,565.00	\$67,950.00
2	Annual	\$18,310.00	\$36,620.00	\$64,085.00	\$91,550.00
3	Annual	\$23,030.00	\$46,060.00	\$80,605.00	\$115,150.00
4	Annual	\$27,750.00	\$55,500.00	\$97,125.00	\$138,750.00
5	Annual	\$32,470.00	\$64,940.00	\$113,645.00	\$162,350.00
6	Annual	\$37,190.00	\$74,380.00	\$130,165.00	\$185,950.00
7	Annual	\$41,910.00	\$83,820.00	\$146,685.00	\$209,550.00
8	Annual	\$46,630.00	\$93,260.00	\$163,205.00	\$233,150.00
Add this amount for each family member beyond 8					
Each Additional Family Member	Annual	\$4720.00	\$9440.00	\$16,520.00	\$23,600.00

STATEMENT OF FINANCIAL CONDITION/FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME _____ SPOUSE _____
 ADDRESS _____
 PHONE _____
 ACCOUNT # _____ SSN: _____
 (PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents that you support

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT AND OCCUPATION

Employer: _____ Position: _____
 Contact Person & Telephone Number: _____
 If Self-Employed, Name of Business: _____
 Spouse Employer: _____ Position: _____
 Contact Person & Telephone Number: _____
 If Self-Employed, Name of Business: _____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (Before Deductions)	_____	_____
Add:	Income from Operating Business (if Self-Employed)	_____	_____
Add:	Other Income	_____	_____
	Interest & Dividends	_____	_____
	From Real Estate	_____	_____
	Social Security	_____	_____
	Other (Specify)	_____	_____
	Alimony or Spousal Support	_____	_____
Subtract:	Alimony, Support Payments Paid	_____	_____
Equals	Current Monthly Income	_____	_____

Total Current Monthly Income (Patient + Spouse) = \$ _____

FAMILY SIZE

Total Family Members: _____
 (add patient, spouse and dependents from above)

	Yes	No
Do you have health insurance?	_____	_____
Are you eligible for any government programs?	_____	_____
Do you have other insurance that may apply (such as auto policy)?	_____	_____
Were your injuries caused by a third party? (such as during car accident)?	_____	_____

By signing this form, I agree to allow St. Rose Hospital to check employment status and credit history for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing.

 (Signature of Patient or Guarantor) Date

 (Signature of Spouse) Date

CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____

Special Considerations/Circumstances:

	Yes	No
Does Patient have Health Insurance?	_____	_____
Is Patient Eligible for Medicare?	_____	_____
Is Patient Eligible for Medi-Cal?	_____	_____
Is Patient Eligible for Other Government Programs?	_____	_____

If eligibility exists for above programs, patient will not generally be eligible for charity care

Does Patient have other insurance (auto medpay, workers comp)?	_____	_____
Was Patient injured by third party?	_____	_____
Is Patient Self-Pay?	_____	_____

Charity/Financial Assistance Calculation:

Total Family Income (From Statement of Financial Condition) \$ _____

Family Size (From Statement of Financial Condition) _____

Qualification for Financial Assistance (Circle One)

Full	Partial
High Medical Cost	
No Eligibility	

**NOTIFICATION FORM
ELIGIBILITY FOR CHARITY CARE**

St. Rose Hospital has conducted an eligibility determination for charity care for:

PATIENT'S NAME ACCOUNT NUMBER DATES OF SERVICE

The request for charity care was made by the patient or on behalf of the patient on _____.

The determination was completed on _____.

Based on information supplied by the patient or on behalf of the patient, the following determination has been made:

Your request for charity care has been approved for services rendered on _____.

After applying the charity care reduction, the amount owed is \$ _____.

Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

Your request for charity care has been denied because:

REASON:

Granting of charity care is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant charity care and hold you and/or third parties responsible for the hospital's charges. If you have any questions on this determination, please contact _____ at _____.

Important Billing Information for Patients at St. Rose Hospital

Thank you for choosing St. Rose Hospital for your hospital services. The information below is designed to help you understand options available to assist patients pay their hospital bill. This information only applies to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc., that may bill you separately for their services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at St. Rose Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement.

Payment Options

St. Rose Hospital has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. St. Rose Hospital has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. St. Rose Hospital also contracts with a company that may assist you further, if needed.

Financial Assistance Program (Charity & Discount Care). Uninsured patients who have an inability to pay their bill may be eligible for financial assistance. Eligibility for financial assistance is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for financial assistance. Copies of St. Rose Hospital's Financial Assistance Policy, applications for financial assistance, and applications for government programs are available at Patient Registration and our Patient Financial Services Office. We can also send you copies if you contact our Patient Advocate Specialist at 510-780-4342.

If you have any questions, or if you would like to pay by telephone, please contact the Patient Advocate Specialist at 510-780-4342.

NOTICE OF RIGHTS

Thank you for selecting St. Rose Hospital for your recent services. Enclosed please find enclosed a statement the charges for your hospital visit. Payment is due immediately. Please be aware that this the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital such as bills from personal physicians and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. You may receive a separate bill for these services.

An emergency physician, as defined in California Health & Safety Code § 127450, who provides emergency medical services at St. Rose Hospital is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 % of the federal poverty level. You will receive a separate bill for the emergency physician services as well. Any questions pertaining to the emergency physician services should be directed to the physician providing the services as represented on the billing statement.

Our records indicate that you do not have health insurance coverage or coverage under Medicare, Medi-Cal, Healthy Families, or other similar programs. If you have such coverage, please contact our Patient Accounts Financial Advocate at 510-780-4342 as soon as possible so the information can be obtained and the appropriate entity billed.

St. Rose Hospital has many options to assist you with payment of your hospital bill.

Medi-Cal & Government Program Eligibility. You may be eligible for a government sponsored health benefit program. St. Rose Hospital has staff available to assist you with applying for government assistance like Medi-Cal, and California's Children Services to pay your hospital bill. St. Rose Hospital also contracts with a company that may assist you further, if needed.

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If you have any questions, or if you would like to pay by telephone, please contact the Patient Advocate Specialist at 510-780-4342.

NOTICE LANGUAGE ON BILLS FOR UNINSURED PATIENTS

Our records indicate that you do not have health insurance or coverage under Medicare, Medi-Cal, or similar other programs. Patients who lack insurance and meet certain income requirement may qualify for financial assistance. Please contact the Patient Advocate Specialist at 510-780-4342 to obtain further information.