MADERA COMMUNITY HOSPITAL
Policy / Procedure

SUBJECT:	**Financial Assistance Program**	**DATE:**	10/01/04
		REVISED:	1/1/07, 9/1/10, 4/1/11, 4/1/14, 1/1/15, 6/15/16, 1/1/20, 10/20, **8/1/21**
DEPARTMENT:	**Administration**		
DEPARTMENTS AFFECTED:	**Hospital-Wide and Specifically - Emergency Department, Family Health Services, Chowchilla Medical Center, Family Health Services Mendota, Case Management, Admissions, Credit & Collections and Business Office**	**Reviewed:**	
SUBMITTED BY:	**VP-Finance/CFO**	**DEPT. #**	8610

REFERENCES:

AB 774, as amended, (Chan, 2006), AB 1503 (2010), SB 1276 (2014), Office of Statewide Health Planning and Development Hospital Technical Letters, California Hospital Association *Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patient* (2004), *Hospital Finance Assistance Policy & Community Benefit Law* (2016); Department of Health and Human Services, Office of the Inspector General *Hospital Discounts Offered to Patients Who Cannot Afford to Pay their Hospital Bills* (2004); California Department of Public Health All facilities Letter 14-25.1 (2014); American Hospital Association *Hospital Billing and Collection Practices*; Various letters and publications from other sources. IRC § 501(r)(1 through 6), TD9708 (12/31/14).

PURPOSE:

To promote equal and compassionate access for all individuals needing emergent or imminently necessary healthcare services. To establish guidelines for the authorization of discounts to patients/guarantors who are low-income, underinsured, uninsured or have high medical costs for services provided by Madera Community Hospital (MCH).

POLICY:

Introduction

Consistent with the Mission and Vision Statements of Madera Community Hospital, the Hospital shall have policies and procedures in place, approved by its Board of Trustees, to assist low-income, underinsured, uninsured patients/guarantors, or patients with high medical costs, who claim to not have the ability to pay for their needed healthcare services and who have verifiable family income up to 350% of the published Federal Poverty Level. This policy shall consider the unique cultural, diversity and economic needs of the community at large. The Financial Assistance Program, sometimes also referred to as a Charity Care Program, will be available to all qualified individuals regardless of age, gender, race, socio-economic, sexual orientation or religious affiliation, that meet residency requirements.

This policy shall not prohibit the Hospital's treatment of patients who present themselves at the Emergency Department and does not supersede the rules and regulations set forth in the EMTALA legislation. Only patients with an immediate or imminent need for necessary healthcare services, as determined by a physician or other licensed healthcare practitioner, shall qualify for this program.

Services that are deemed optional or of a cosmetic nature do not qualify for a discount under this policy. The Hospital's Chief Executive Officer or VP-Finance/CFO may make an exception to this policy for certain individuals who would not normally qualify, based on their specific individual circumstances.

Information Available to the Public and Methods of Communication

The following information shall be made available to patients/guarantors or other interested parties by the Hospital, upon request:

- A copy of this Policy in English or Spanish.
- A copy of the Application and Instructions in English or Spanish.
- Information explaining State and Federal Public Benefit Programs available and the benefits available under the Hospital's Financial Assistance Program, which are included with the Conditions of Admission and Authorization for Treatment available to all self-pay patients at time of registration.

The Hospital shall inform the public of its financial assistance program by the following methods:

- Post a notice about the Financial Assistance Program in public areas for patients to see.
- Include information on statements and other collection correspondence sent to self-pay patients about the availability of the program.
- Communicated by the Case Management staff, Credit & Collections staff, financial counselors and all registration personnel when a patient or guarantor indicates they do not have the ability to pay for their care.
- On the Hospital's website (www.maderahospital.org).

All public notices, including this policy, the application & instructions shall be made available in English & Spanish.

Staff Training About Availability of Financial Assistance Program

MCH staff who are routinely involved in the registration/admission of patients, those that help manage the healthcare services being received by the patient (such as case managers or social workers) and those in the financial counseling, billing and collection for healthcare services will receive specific training on the availability of the Hospital's Financial Assistance Program to the public. The goal of the training is to make sure that information about the program is available to the public that may qualify for the program and for staff to recognize those patients/guarantors who may qualify for the program but have not yet inquired about it.

Eligibility Criteria and Charges Covered

Those patients/guarantors who claim that they do not have the financial resources to pay for their healthcare services may be eligible for the program if they meet certain income and family size limitations and complete a Financial Assistance Program application. All individuals interested in this program shall cooperate with the Hospital in providing the appropriate information for the Hospital to make a determination of qualification.

This program shall be available to all individuals who meet the qualifications. All amounts due, including co-pays, deductibles, share of costs and non-covered charges remaining after the primary payer (if applicable) has paid, are eligible for discounts under this program.

Individuals that apply for Medi-Cal/CMSP or other State and Federal programs and are denied due to assets or income levels above qualifying limits may be eligible for coverage under the California Health Benefit Exchange (Covered California). The Madera County Department of Social Services shall forward the patient's information to Covered California once it has been determined that the patient doesn't qualify for Medi-Cal or another Public Benefit Plan.

Residency Requirement:

Only those patients whose primary residence is located in the direct service area of Madera Community Hospital are eligible for this program. The Hospital's direct service area generally includes all of western Madera County, mostly west of State Highway 41. This encompasses the zip codes of 93610, 93636, 93637, 93638 & 93639. Patients may be asked to show proof of current address by providing a government-issued photo ID (such as a valid Driver's License), a utility bill or other proof of residence. The direct service area does not include any parts of Merced or Fresno Counties. Residents of those counties or other areas are encouraged to inquire about the charity care programs of the local hospitals serving those areas.

Income Verification, Approval Process and Discount Amount Determination

Once the residency requirement is met, a qualification determination shall be made based on total family income and the number of family members. Income verification may be done by reviewing pay stubs, tax returns, SSI or other information to help establish income levels.

The Hospital shall inform the applicant within 10 business days of receipt of a properly completed Application (a copy of the Instructions and Application are attached to this Policy and made a part thereof) of their acceptance or not into the program. For Applicants who are denied due to lack of information provided on the Application or the Hospital's inability to verify income level or family size, shall have the opportunity to provide additional information for consideration. If the application is again denied, the Applicant can ask for a review by the VP-Finance/CFO for an ultimate determination.

The discount amount shall be determined by a chart developed by the Hospital based on the Family Federal Poverty Guidelines published periodically in the Federal Register. The Hospital's discount chart (a copy which is attached to this Policy and made a part thereof) shall be updated as the Federal Poverty Level amounts are revised. The Hospital shall provide discounts to qualified patients/guarantors at percentages of 100% down to 40% off hospital charges based on verifiable family income levels from 200% to 350% of the published Federal Poverty Level Chart. Generally speaking, people with family income levels below 200% of the Federal Poverty Guidelines will qualify for a 100% discount on their account.

No individual qualifying for this program shall be billed more than the amounts generally billed (AGB) for emergency or medically-necessary care. To obtain the AGB percentage and the calculation for the service to be received, at no cost to you, please contact the hospital Credit Department at (559) 675-5514.

Presumptive Financial Assistance Determination

The Hospital, based on information available at the time, may determine to presume that a patient qualifies for the Financial Assistance Program even though the person has not applied for the program. In some cases where the patient/guarantor is not willing or is unable to apply for the program, the Hospital may presume they would qualify for the program and apply the discounts available to their account(s) as though they had applied and qualified for the program.

Payment of Remaining Balance on Account and Collection Practices

The hospital shall make every reasonable effort to arrange for a reasonable payment plan for that portion of the patient's bill that is not discounted through this program. All payment arrangements with participants in the Financial Assistance Program will be interest free.

All collection activities being done by the Hospital's Collections Department, or by collection agencies that the Hospital contracts with to perform follow-up collections on unpaid accounts, shall cease when a patient/guarantor claims they do not have the ability to pay these debts.

At that time, the patient/guarantor will have the opportunity to apply for the Financial Assistance Program. If the patient/guarantor's application is denied, such collection activities may resume. The Hospital, or it's contracted collection agencies, will not use aggressive collection practices towards any patient/guarantor who has been accepted into the Financial Assistance Program, received a partial discount, and has made arrangements with the hospital to pay the remaining balance of his/her account. If the patient/guarantor fails to fulfill their commitment to pay the balance of their account, the hospital may resume normal collection practices on the account.

Participation Period / Retroactive Covered Services Period

A patient's approved participation in the program will last for three (3) months. When this period expires, the patient may be asked to reapply in order to be considered for the financial assistance program for future services. If reapproved, another 90 day period may be granted to the patient. The limited participation periods are designed to reevaluate the Applicant's financial situation periodically and confirm his/her qualification for the Financial Assistance Program as personal financial circumstances change. The Patient/Guarantor may be asked to apply for Public Health Programs if it appears they may now qualify for such benefits. No additional Financial Assistance periods shall be approved for a patient who has unpaid accounts from the previous period until those accounts are paid in full.

Any services received by the patient within the prior ninety (90) days from the date of the approved Application will be eligible for a discount under the Program unless it is determined that the patient/guarantor's financial situation at the time of the prior service would not have qualified them for the program. This retroactive application of discounts will not apply to accounts of the patient that have already been paid – no refunds will be issued to any payer for payments received by Madera Community Hospital for services provided during the retroactive period.

Non-Covered Services

This policy does not apply to charges for services provided by attending or consulting physicians or other medical providers that are not billed by the Hospital. Patients/guarantors will have to discuss any such discounts with the individual medical practitioner directly. Madera Community Hospital has encouraged other medical providers to have Financial Assistance policies consistent with this one in place and to encourage people who appear to not be able to pay for their healthcare services to apply for such programs, where available.

This policy does not apply to services of a cosmetic nature. Only emergent services, and those that are determined by a physician or other healthcare provider to be imminently needed, will qualify for discounts under this policy.

Availability of Charity Care and Discounted Payments From Emergency Room Physicians:

California Emergency Physicians, the contractor who staffs Madera Community Hospital's Emergency Department with physicians, physician assistants and nurse practitioners, does have a Charity Care program. Patients who would like to inquire about this program for bills received from this provider should do so by calling toll-free to the CEP/MedAmerica billing office at (800) 498-7157.

What Services and Providers are Covered by this Policy:

As required by IRC § 501(r)(1 through 6), TD9708 (12/31/14), Madera Community Hospital is obligated to inform patients which services are covered by this policy and if any providers, other than the hospital itself, are covered under this policy. This policy only covers those services provided by Madera Community Hospital employees and billed directly by Madera

Community Hospital. Services provided by Physicians, Physician Assistants, Nurse Practitioners or some other medical professionals that are billed directly by them are generally not covered by this policy. Patients should contact the individual practitioner directly to arrange for discounts to billings for services they have provided in the course of treatment at Madera Community Hospital.

Attached to this policy, and accurate as of the date of the policy, is a list of all physicians and other providers that may provide professional services to patients seen at Madera Community Hospital. As noted on the list, none of the services provided by these professionals are covered by this policy. Patients are encouraged to contact the professional directly, the medical group they may be a member of or their billing company to discuss their ability to pay for such services received.

Other

All Financial Assistance Program records shall be kept for a minimum of five (5) years in confidential storage by the Manager, Credit & Collections. No information about the patient/guarantor or the Application shall be distributed to any party outside the hospital without prior written authorization of the patient/guarantor, except in the process of verifying information on the Application. The information contained on the Application or attached thereto as supporting documentation shall not be used for any reason other than the determination of qualification in the Hospital's Financial Assistance Program.

The hospital's Chief Executive Officer or VP-Finance/CFO are authorized to make exceptions to this policy based on individual circumstances.

PROCEDURE:

I. Patient Admissions/Registrars and Financial Counselors (excluding Emergency Room Personnel):

1. At the time of registration of a patient who claims to not have a primary payer source for the services to be received, admissions/registration personnel and financial counselors should question the patient about his/her qualification for Medi-Cal/CMSP benefits, other Public Benefit Programs or Covered California.
   a) If the patient is unwilling to cooperate with the financial assistance application process and, thus, does not qualify for the Financial Assistance Program, the patient should be registered as self-pay and the admissions/registration personnel or financial counselor should discuss payment options with him/her. A review of the patent's recent billing/payment history should be done by the financial counselor to determine if the patient has other unpaid accounts that need to be discussed at the same time.

2. Admissions/registration personnel and financial counselors should distribute copies of the Financial Assistance Program Application and Instructions to those patients/guarantors who claim to not have the financial ability to pay for their healthcare services and would otherwise qualify for the program. This information may come forward during conversations with the patient/guarantor during the registration process or at a later date.
3. Admissions/registration personnel and financial counselors should help answer any questions the patient/guarantor has about the program or application process, stressing the need for proper support documentation to accompany the Application.

4. Patients who are currently admitted into the hospital should be counseled by the financial counselor and/or Case Management staff about the Program. If possible, the Medi-Cal/CMSP or Financial Assistance Program Application should be completed and signed prior to the patient's discharge from the hospital.
5. Completed Applications for the Financial Assistance Program, along with support documentation, should be forwarded to the Manager, Credit & Collections for a determination.
6. Appropriate notes about the discussions with the patient/guarantor should be documented in the patient accounting system for future reference.
7. For those patients who have already been approved for the Program and are receiving additional health services during the approved period (within 90 days from the date of approval), registration staff should recognize this during the registration process and complete the registration of the patient as a Financial Assistance Program patient. For those patients who are in the program and are not receiving a 100% discount, the registrar or financial counselor should discuss the need for the patient to pay the non-discounted portion of the estimated amount of the charges for the services being received. If the patient absolutely refuses to make a payment for their portion of the charges for the current visit, the registrar should continue with the registration process and have the financial counselor, if available, meet with the patient to discuss payment terms.

II. Credit & Collections Personnel:

1. During the collections follow-up process, Credit & Collections personnel should introduce the Hospital's Financial Assistance Program to those patients/guarantors who claim to not have the financial ability to pay for their prior healthcare services and offer to send to them a Medi-Cal/CMSP Application and/or the Financial Assistance Program Instructions/Application. Credit & Collections personnel should advise the patient/guarantor that only services received within the last 90 days or the 90 day period after approval of their application are eligible for a discount through the Program.
2. Credit & Collections personnel should help answer any questions the patient/guarantor has about the Program or Application process. Stressing the need for proper support documentation will help with the approval of the Application.
3. Completed Applications, along with support documentation, should be forwarded to the Manager, Credit & Collections for approval or denial.
4. Credit & Collections personnel should advise the patient/guarantor that if they do not qualify for the Program or do not cooperate with the application process, that they will be financially responsible for the charges accumulated on the account and if they fail to pay their portion due that their account may be turned over to a collection agency for further action. The patient/guarantor should be advised of the discount that the hospital applies to all self-pay accounts.
5. Credit & Collections personnel should offer and set-up acceptable payment plans for the portion of their account that they remain responsible for to those patients/guarantors who qualify for and receive a partial discount. The monthly payment amounts should be based on the policy/procedure regarding in-house self-pay payment plans.
6. Appropriate notes about the discussions and progress made with the patient/guarantor should be documented in the patient accounting system for future reference.

III. Manager, Credit & Collections:

1. Upon receipt of a completed application the Manager, Credit & Collections shall initiate the completion of the Financial Assistance Program Application Approval Form (attached to and made part of this Policy). If the Applicant meets the residency requirement of this policy, the Manager, Credit & Collections shall review the Application for completeness and appropriate support documentation and document such on the Approval Form. If he/she finds the Application complete and can verify income and family size information from support documentation, he/she shall determine the percentage discount that the patient/guarantor is entitled to per the Financial Assistance Chart (attached to and made part of this Policy). He/she

shall determine the discount amount by first locating family size in the left-hand column and scrolling across to the monthly or annual income amount range. The discount percentage is shown at the top of that column.

2. Upon approval of an Application, a letter of approval shall be sent to the patient/guarantor stating acceptance into the Program and what discount percentage he/she has qualified for, the adjustment made to the account and the balance remaining on the account that the patient/guarantor is responsible for, if any. The financial class of the patient shall be changed to CH and a note shall be entered into the patient accounting system stating the date of approval, when the initial 3 month charity period ends and any other relevant facts that need to be documented.
3. Upon denial of an Application, the Manager, Credit & Collections shall send a letter of denial to the patient/guarantor stating reason for denial. The patient/guarantor should be encouraged to provide additional information if the Application has been denied due to lack of support documentation. If possible, notes about the application and denial should be entered into the patient accounting system for future reference.
4. The Manager, Credit & Collections, or designee, shall work with the patient/guarantor as much as possible to help qualify them for the Program. The contact information for the patient/guarantor may be turned over to the outside contractor that assists patients of the Hospital to qualify for Public Assistance Programs.
5. All approved Applications should be reviewed with the patient in the month in which their 90 day financial assistance period ends. The Manager, Credit & Collections or a staff member should contact the patient to complete an update of his/her Application information and make a determination if the patient is approved for another 90 day period. Patients who have unpaid balances from the previous approved period shall not be eligible for a renewal period until the accounts are paid in full.
6. At the end of each month, prior to the closing of the patient financial system (B/AR) for that month, run a listing of patients who are in the Financial Assistance Program and make the appropriate discount adjustments to those accounts that have accumulated charges during the month.

Madera Community Hospital
1250 E. Almond Ave. • Madera • CA 93637 • 559·675·5555 • MaderaHospital.org

MADERA COMMUNITY HOSPITAL
Hospital Financial Assistance Discount Program Instructions & Application

Please complete the attached application in ink as fully as possible and sign where indicated.
In order to qualify for the MCH Financial Assistance Discount Program, you need to claim that you do not have the ability to pay for these services you are about to receive or have received and will have to complete the attached application. You will be asked to apply for State & Federal Public Health Programs that you may qualify for. Please complete the application in its entirety and provide as much support documentation of your income as possible. The more detailed information you provide will help us make a quicker decision about your qualification for the program and could prevent a delay in your care.
Information such as check stubs, tax returns or other documents will help us confirm your income level and determine your qualification in this program.

Individuals who have no insurance coverage and who do not have the ability to pay for health care services may qualify for this program. Also, individuals who have primary coverage but have a deductible/co-pay or a share of cost may also qualify if they do not have the ability to pay for their share of the hospital charges. Depending on your income level and the number of people in your family, you may qualify for a 40% to 100% discount off the charges accumulated on your account for services received from the hospital.

Upon successful completion of the application and meeting other requirements, the hospital will review the information submitted and approve or deny your application. If denied due to incomplete information, you will have the opportunity to submit additional information that may help the hospital approve your participation in the program. You will receive a determination letter from the hospital within 10 business days from the submission of the application.

Financial Assistance Program Applicants will have the option to complete a Medi-Cal application before applying for the Hospital Financial Assistance Program. If the Medi-Cal application is approved, Medi-Cal will become your primary payer. If the Medi-Cal application is denied due to non-qualification, you can proceed with the Hospital Financial Assistance Discount Program Application.

Approved Financial Assistance Applications are good for 3 months. After this time, the original approved application information will need to be updated for a determination of continuing in the program. The Hospital's Credit and Collections Department will contact patients about their continuation in the program. A patient who has unpaid balances from the prior 90 day period will not be eligible for continuing in the program until the previous balances are paid in full.

For more information about the MCH Financial Assistance Discount Program, please contact the Credit Office at (559) 675-5514.

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Hospital Financial Assistance Discount Program Application

Application Date / /

Patient's Name

Patient's Address

Phone Number ( ) Alternate Number ( )

Spouse

Children

EMPLOYMENT AND OCCUPATION:

Employer Name Position

Address

Contact

Contact Person Phone Number

Spouse Employer Position

Address

Contact

Contact Person Phone Number

		Patient	**S**
Gross Monthly Income From Employment (before deductions)			
Add:	Income from Operating Business (if Self-Employed)		
Add:	Other Income:		
	Interest and Dividends		
	Rental Income		
	Social Security		
	Other - Specify:		
	Alimony or Support Payments Received		
Subtract:	Alimony and/or Support Payments Made		
Equals:	**Currently Monthly Income**		
	Patient and Spouse Total Combined Monthly Income		

By signing this form, I agree to allow Madera Community Hospital to verify employment and income for the purpose of determining my eligibility for a discount through the Financial Assistance Program. I understand that I may be asked to provide documentation of proof of employment and income amounts disclosed on this application.

Signature of Patient or Guarantor

MADERA COMMUNITY HOSPITAL
Financial Assistance Program Discount Chart

Madera Community Hospital

This chart is used to determine the discount that will be applied to charges accumulated on accounts of patients who qualify for the Hospital's Financial Assistance Discount Program. Discounts apply to eligible patients whose income level is below 350% of the federal Poverty Guidelines. All Self-Pay patients not meeting the Financial Assistance Discount Program qualify for the Hospital's self-pay discount.

Based on 2020 Federal Poverty Levels (Published in the Federal Register in January, 2020)

Effective: March 1, 2020

Number of Persons in Family		(200% FPL)	********** Percentage Discount Applied to Charges **********					(350% FPL)
		100%	90%	80%	70%	60%	50%	40%
1	mo	$2,127 and Below	$2,128 to $2,447	$2,448 to $2,767	$2,768 to $3,087	$3,088 to $3,407	$3,408 to $3,721	$3,722 and Above
	yr	25,520 and Below	25,521 to 29,360	29,361 to 33,200	33,201 to 37,040	37,041 to 40,880	40,881 to 44,648	44,649 and Above
2	mo	$2,873 and Below	$2,874 to $3,305	$3,306 to $3,737	$3,738 to $4,169	$4,170 to $4,601	$4,602 to $5,027	$5,028 and Above
	yr	34,480 and Below	34,481 to 39,664	39,665 to 44,848	44,849 to 50,032	50,033 to 55,216	55,217 to 60,328	60,329 and Above
3	mo	$3,620 and Below	$3,621 to $4,164	$4,165 to $4,708	$4,709 to $5,252	$5,253 to $5,796	$5,797 to $6,334	$6,335 and Above
	yr	43,440 and Below	43,441 to 49,968	49,969 to 56,496	56,497 to 63,024	63,025 to 69,552	69,553 to 76,008	76,009 and Above
4	mo	$4,367 and Below	$4,368 to $5,023	$5,024 to $5,679	$5,680 to $6,335	$6,336 to $6,991	$6,992 to $7,641	$7,642 and Above
	yr	52,400 and Below	52,401 to 60,272	60,273 to 68,144	68,145 to 76,016	76,017 to 83,888	83,889 to 91,688	91,689 and Above
5	mo	$5,113 and Below	$5,114 to $5,881	$5,882 to $6,649	$6,650 to $7,417	$7,418 to $8,185	$8,186 to $8,947	$8,948 and Above
	yr	61,360 and Below	61,361 to 70,576	70,577 to 79,792	79,793 to 89,008	89,009 to 98,224	98,225 to 107,368	107,369 and Above
6	mo	$5,860 and Below	$5,861 to $6,740	$6,741 to $7,620	$7,621 to $8,500	$8,501 to $9,380	$9,381 to $10,254	$10,255 and Above
	yr	70,320 and Below	70,321 to 80,880	80,881 to 91,440	91,441 to 102,000	102,001 to 112,560	112,561 to 123,048	123,049 and Above
7	mo	$6,607 and Below	$6,608 to $7,599	$7,600 to $8,591	$8,592 to $9,583	$9,584 to $10,575	$10,576 to $11,561	$11,562 and Above
	yr	79,280 and Below	79,281 to 91,184	91,185 to 103,088	103,089 to 114,992	114,993 to 126,896	126,897 to 138,728	138,729 and Above
8	mo	$7,353 and Below	$7,354 to $8,457	$8,458 to $9,561	$9,562 to $10,665	$10,666 to $11,769	$11,770 to $12,867	$12,868 and Above
	yr	88,240 and Below	88,241 to 101,488	101,489 to 114,736	114,737 to 127,984	127,985 to 141,232	141,233 to 154,408	154,409 and Above
9	mo	$8,100 and Below	$8,101 to $9,316	$9,317 to $10,532	$10,533 to $11,748	$11,749 to $12,964	$12,965 to $14,174	$14,175 and Above
	yr	97,200 and Below	97,201 to 111,792	111,793 to 126,384	126,385 to 140,976	140,977 to 155,568	155,569 to 170,088	170,089 and Above
10	mo	$8,847 and Below	$8,848 to $10,175	$10,176 to $11,503	$11,504 to $12,831	$12,832 to $14,159	$14,160 to $15,481	$15,482 and Above
	yr	106,160 and Below	106,161 to 122,096	122,097 to 138,032	138,033 to 153,968	153,969 to 169,904	169,905 to 185,768	185,769 and Above

For more than 10 persons in the family, add $4,480 for each additional person. S: Administration/Charity Care/Financial Assistance Program Discount Chart 3-1-20

Madera Community Hospital

1250 E. ALMOND AVE
MADERA, CA 93637

DATE

NAME
ADDRESS
CITY,STATE,ZIP

Regarding: Patient name
Account#:V00000000
Date of Service: 01/01/04-01/01/04
Balance Due: $$$

Dear Patient Name:

Thank you for applying for Madera Community Hospital's Financial Assistance Program benefits. Your application has been approved and you qualify for a ___ % discount off the balance due on your account(s). You are qualified to participate in the program through xx/xx/xx.

Prior to the expiration of your participation in the Program, we will contact you to update your income and family size information and make a determination if you qualify for another 90 day period.

After applying this discount, the remaining portion that is your responsibility is $$$$. You will soon be receiving a statement showing this amount due. Please pay it as soon as possible. If you cannot pay this balance in full, please contact our Credit Office at (559) 675-5514 to make payment arrangements.

Sincerely,

Mike Brink
Manager, Patient Financial Services

Madera Community Hospital

1250 E. ALMOND AVE
MADERA, CA 93637

DATE:

NAME
ADDRESS
CITY,STATE,ZIP

Regarding: Patient name
Account#:V00000000
Date of Service: 01/01/04-01/01/04
Balance Due: $$$

Dear Patient Name:

Thank you for applying for the Madera Community Hospital's Financial Assistance Program benefits. After reviewing your application, we are unable to approve your participation in the Program due to (What ever the reason).

If you have any questions regarding this decision or would like to provide additional information for us to consider, please feel free to contact our Credit Department at (559) 675-5514

Sincerely,

Mike Brink
Manager, Patient Financial Services