

**Title: Financial Assistance Policy**

**Home Department: Patient Financial Services**

**IMPORTANT NOTICE:**

**The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.**

**I. Purpose**

- a. Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital, Cedars-Sinai's Emergency Department physicians of Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty or physicians employed by Cedars-Sinai Medical Care Foundation ("CSMCF") or by medical groups which have an exclusive Professional Services Agreement with CSMCF (the "Organization") is committed to meeting the health care needs of all patients in the community and based on the following principles:
  - i. Treating all people equitably, with dignity, respect and compassion;
  - ii. Serving the emergency health care needs of all, regardless of a patient's ability to pay; and
  - iii. Assisting patients who cannot pay for part or all of the care they receive.
- b. This Policy demonstrates the Organization's commitment to our mission, vision and principles by helping to meet the needs of the low-income uninsured patients and the underinsured patients in our community. As part of fulfilling this commitment, the Organization provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Policy.
- c. This Policy provides guidelines for identifying patients who may qualify for financial assistance and establishes the financial screening criteria to determine which patients qualify for financial assistance. The financial screening criteria provided for in this Policy are based primarily on the federal poverty level guidelines established by the U.S. Department of Health and Human Services.
- d. This Policy applies to all emergency and other medically necessary care provided by the Organization.
- e. This Policy is intended to comply with State and Federal laws.

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**II. Policy**

- a. **Definitions.** See the "Definitions" section at the end of this Policy for an explanation on terms used. Defined terms are capitalized either in the Definitions section or are defined within the body of this Policy.
- b. **Facilities, Physicians and Other Providers Covered Under this Policy.** Only services provided by the Organization will be covered by this Policy. The Policy is also applicable to physicians who are contracted with the Organization and are required to participate in the application of this Policy.
- c. **Facilities, Physicians and Other Providers Not Covered by this Policy May Have Separate Financial Assistance Policies.** Other members of the Organization's Medical Staff may make financial assistance available to their patients. The Organization will make available, on its website, a list of information it has regarding these physicians indicating whether specific Physicians (or their medical group) will: (i) provide equivalent discounts from the Physician's professional fees to low-income uninsured patients as the Organization provides, based on the criteria set forth in the Policy; (ii) accept the Organization's determination of a patient's eligibility for financial assistance; and (iii) comply with all applicable Federal, State and local laws, regulations, ordinances and orders with respect to the collection of consumer debt accounts. The Organization will not be responsible for such Physicians' administration of financial assistance programs or their billing practices.
- d. **Eligibility Criteria**
  - i. **Financial Assistance.** Financial Assistance will be made available to patients whose family income and assets are at or below 400 percent of the current year's FPL. Patients whose income ranges between 401 to 600 percent of the FPL also qualify for discounted care. Even though assets are included in the financial assistance application ("Application"), they will not be considered in determining eligibility for discounts. Attachment B is the Application and Attachment C sets out the ranges for financial assistance available from the Organization.
  - ii. **Pre-Service Patients (Elective/Non-Emergent Care).** Patients scheduled as elective inpatients or scheduled as non-emergent outpatients require prior approval for financial assistance by the Vice President, Finance and Chief Revenue Cycle Officer or their designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to patients who live in the Organization's service area or as otherwise approved by the Vice President, Finance and Chief Revenue Cycle Officer or their designee. The Organization retains the right to prospectively not grant financial assistance in connection with a patient's proposed non-

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emergency and other non-medically necessary care based on the need of the Organization to judiciously allocate its financial and clinical resources.

- iii. **Additional Financial Resources and Required Patient Cooperation.** Patients approved for assistance under this Policy agree to continuously cooperate in the process needed to obtain reimbursement for the Organization's services from third party sources such as the California Victims of Crime funds, the County Trauma Program, the Medi-Cal program, and health plans that offer coverage through the California Health Benefit Exchange (the "Exchange"). A patient's application for third party coverage for the patient's health care costs shall not preclude eligibility for assistance under this Policy. A patient shall, as a condition of financial assistance, apply for coverage under Medi-Cal, Healthy Families, and the County Trauma Program as applicable and, where appropriate, coverage under the Exchange. The foregoing shall also apply to patients residing out of state and their application for Medicaid within their state.

The Organization will make appropriate referrals to local county agencies including Healthy Families, Covered California, Medi-Cal or other programs to determine potential eligibility.

The Organization shall be entitled to bill any third-party insurer providing coverage to a patient, including any source of third-party liability. Health insurers and health plans are prohibited from reducing their reimbursement of a claim to the Organization even if the Organization has waived all or a portion of a patient's bill pursuant to this Policy.

- iv. **Self-Pay Patients.** The Organization has made an assumption based on its historical experience and the current insurance environment that patients who lack insurance are not able to afford insurance. The Organization presumes that these patients are eligible for financial assistance programs and will make the following assistance available to all such patients unless the patient makes other arrangements for services provided by the Organization:
1. Self-Pay patients will automatically be billed at a discounted amount determined by multiplying the total charges by the Organization's AGB percentage for applicable inpatient services, emergency room services or outpatient, non-emergent services.
  2. Self-Pay patients are eligible for these discounts without submitting an Application. This financial assistance does not extend to elective procedures unless a specific agreement is made between the Organization and the patient.
- v. **Medically Indigent Patients (Not Otherwise Eligible).** Patients who are Medically Indigent but who are not otherwise eligible for financial assistance under this Policy may still request financial assistance in accordance with the process set forth in this Policy. The request for

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financial assistance due to Medical Indigency must be approved by Vice President, Finance and Chief Revenue Cycle Officer or their designee, in their discretion.

e. **Financial Assistance Program.** This Program utilizes a single, unified patient Application for financial assistance. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. Any patient who requests financial assistance will be asked to complete an Application.

i. **Initiating the Financial Assistance Application.** The Application process can be initiated by the patient or any staff member of the Organization by contacting Patient Financial Advocates at 310-423-5071 or via email to [patient.billing@cshs.org](mailto:patient.billing@cshs.org). This process includes the following:

1. Patients are provided with the Application, a Medi-Cal Application and information on Credit Counseling.
2. Applicants are offered assistance in completing the forms by Patient Financial Advocates at Cedars-Sinai South Tower, Street Level, Room 1740.
3. The Application may be completed orally with assistance from Organization staff but will still require a patient or representative to sign the Application.

ii. **Reviewing Application**

1. **Determination.** Eligibility guidelines are calculated using the current FPL as the measure of eligibility.
2. **Determinations by Affiliates and Approved Community Partners.** Patients who have recently had financial assistance applications approved by certain affiliates or community partners of the Organization, may be approved on an expedited basis by the Organization, at the Organization's discretion. The Organization will advise patients applying for financial assistance if such expedited approval is available.
3. **Assets.** The consideration of assets in determining eligibility is limited to the definition in this Policy.
4. **Income.** For partial periods shall be included in worksheets using annualized data.

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5. **Deductions.** Other financial obligations including living expenses and other items of reasonable and necessary nature will be considered.
  6. **Patient Maximum Out-of-Pocket Expense.** Any payment from a patient for services covered by this Policy shall be limited to no greater than the AGB.
  7. **Reevaluation.** Eligibility may be reevaluated by the Organization if any of the following occur:
    - a. Patient income change.
    - b. Patient family size change.
    - c. A determination is made that any part of the financial assistance Application is false or misleading, in which case the initial financial assistance may be retroactively denied.
- iii. **Submitting Required Documentation.** The Organization requests various documents from patients applying for financial assistance in order to substantiate their eligibility. The documents may include, but are not limited to, the following:
1. Completed Application.
  2. Income documents may include:
    - a. Current period payroll check stub,
    - b. Prior year's tax return, or
    - c. Written explanation.
  3. Asset documents may include:
    - a. Copies of prior month's bank statement (all pages),
    - b. Money Market account statements,
    - c. Stocks,
    - d. Bonds,
    - e. Certificate of Deposits,
    - f. Brokerage accounts (excludes documents pertaining to retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code)), and
    - g. Unemployment, Social Security benefits, or Disability benefits stub.

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- iv. **Submitting Completed Application.** If a patient submits a completed Application, during the Application Period, then the Organization shall:
1. Immediately take all reasonably available measures to suspend or reverse any ECAs taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, advising collection agencies to cease collection activities, measures to vacate any judgment against the patient, lift any levy or lien on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
  2. Make a determination on eligibility or identify if Application is incomplete or requires additional information, within a reasonable time.
  3. Promptly notify the patient in writing of the eligibility determination, including, if applicable, the assistance for which the patient is eligible and the basis for the determination.
  4. If the patient is eligible for financial assistance, then the Organization shall notify the patient in writing of eligibility, available assistance, the basis for determination and the service dates covered.
    - a. If there is no patient responsibility, then no further steps are required other than refunding amounts paid as provided in the "Refunds" section. If there is a remaining balance, then the Organization shall also notify the patient in writing, the amount the patient owes for care and describe how the patient can get additional account information.
    - b. Once a patient is approved for financial assistance, during the approval period, the patient will not be charged more for emergency or other medically necessary care than the AGB described in this Policy.
    - c. Approvals of eligibility may only be made by individuals specifically authorized by the Organization. This individual is Vice President, Finance and Chief Revenue Cycle Officer or their designee.
- v. **Patients with Limited Information for Application.** The absence of patient financial data available to the Organization does not preclude eligibility for financial assistance. In evaluating all factors pertaining to a patient's clinical, personal and demographic situation, and alternative documentation (including information that may be provided by other

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charitable organizations), the Organization may determine a patient is eligible for financial assistance by making reasonable assumptions regarding the patient's income.

- vi. **Incomplete Application.** If a patient submits an incomplete Application, then the Organization shall promptly provide the patient with a written notice that describes the additional information and/or documentation required for the Application and include contact information for Application processing. If the patient subsequently completes the Application with required information during the Application Period (or such longer period of time as elected by the Organization), then the Application will be considered complete.
- vii. **Incomplete Application Completed.** If a patient who has submitted an incomplete Application during the Application Period subsequently completes the Application, within a reasonable timeframe given to respond to requests for additional information and/or documentation, then the patient will be considered to have submitted a completed Application, and the Organization will have made reasonable efforts to determine whether the patient is eligible only if it takes the other steps required by this Policy with regard to completed Applications.
- viii. **Anti-Abuse Rule for Applications with Questionable Information.** The Organization shall not make determinations that a patient is not eligible for financial assistance based on information it has reason to believe is unreliable or incorrect or on information obtained from the patient under duress or through the use of coercive practices. A coercive practice includes delaying or denying emergency medical care to a patient until the patient has provided information requested to determine whether the patient is eligible for financial assistance for the care being delayed or denied.
- ix. **Handling of Incomplete Applications.** The Organization may consider a patient's failure to provide reasonable and necessary documentation in making its financial assistance determinations. However, the Organization will act reasonably and make the best determination it can with the available information.
- x. **Presumptive Eligibility.** The Organization may determine that the patient is eligible for financial assistance for the current services based on information it has obtained or assessed without looking to the patient to provide all information required by the usual Application process or the fact that the patient has no health insurance. The Organization's determination may include reliance on a prior determination by the Organization, information provided by another provider of the patient, or a general assessment of information available to the Organization's staff. In such cases, the Organization shall (a) notify the patient of the basis for the presumptive eligibility determination and the manner in which the patient may apply for more generous assistance available under the Policy; (b) give the patient One Hundred Twenty (120) days to apply for more generous assistance; and if the patient submits a complete Application seeking more generous assistance, then determines whether the

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patient is eligible for a more generous discount and takes the other steps required by this Policy with regard to completed Applications. Self-Pay patients receiving discounts described in this Policy shall receive such notice by means of the Plain Language Summary (see Attachment A) printed on their statements.

- xi. **Patient Waivers Do Not Relieve the Organization of Reasonable Efforts Obligations.** Obtaining a verbal or written waiver from a patient, such as a signed statement that the patient does not wish to apply for assistance under the Policy or receive the information to be provided to patients under this Policy, will not itself constitute a determination that the patient is not eligible and will not satisfy the requirement to make reasonable efforts to determine whether the patient is eligible before engaging in ECAs against the patient.
- xii. **Payment Plans.** When a patient is determined eligible for financial assistance and a balance remains, then they shall have the option to pay through a scheduled term payment plan. The Organization will discuss plan options with the patient and develop term payment plans that generally last no longer than twelve (12) months and are interest free.
- xiii. **Dispute Resolution.** In the event a dispute arises regarding qualification for financial assistance, the patient may submit a written appeal for reconsideration with the Organization. The written appeal should explain the rationale for dispute and include supporting documentation. The Organization's Vice President, Finance and Chief Revenue Cycle Officer or their designee will promptly review the appeal and provide the patient with a written determination. In the event the patient believes a dispute remains after the first appeal, the patient may request in writing, a review by the Organization's Vice President, Finance and Chief Revenue Cycle Officer or their designee who shall review and provide a final written determination.
- xiv. **Confidentiality of Application Information.** The Organization shall maintain all information received from patients requesting eligibility under this Policy as confidential information. Information concerning income and Assets obtained as part of the Application and approval process shall be maintained in a file that is separate from information that may be used to collect amounts owed.
- xv. **Time Period for Completion of Application (the "Application Period").** Patients shall be given Two Hundred Forty (240) days to complete an Application. The Application Period begins on the date care that is subject to the Application was first provided (using the commencement of the last course of treatment if multiple dates of services are applicable).

**f. Term**

- i. The initial financial assistance for financially qualified patient's approval is valid for a period of six (6) months from the date the Application was complete. Eligibility may be reassessed,



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upon patient request, at the end of the initial approval period. At the Organization's election, a new six (6) month approval period may be authorized without a new Application. After twelve (12) months, a new Application must be completed by the patient. Starting with the date the final Application is approved, open, qualified accounts will be written-off to financial assistance based on the level of assistance granted. On a go-forward basis, qualified accounts for the next six (6) months would be eligible for financial assistance write-off.

**g. Notices, Written Communications and Statements**

i. The Organization provides the following notices and information regarding financial assistance:

a. This Policy.

b. A Plain Language Summary of the Policy. The Plain Language Summary shall be a clear, concise, and easy to understand document that notifies patients and other individuals that the Organization offers financial assistance under this Policy. The Plain Language Summary shall be drafted in a manner that sets out relevant information including the information required by State and Federal laws such as the eligibility requirements and assistance offered under this Policy, a brief summary of how to apply for assistance under this Policy, and information for obtaining additional information and assistance, including copies in other languages.

c. A list of Providers that may make financial assistance available to the Organization's patients.

d. The Application.

e. The Organization's Debt Collection Policy.

ii. These materials shall be made available in a variety of ways including:

a. **Website.** The Financial Assistance Policy, the Financial Assistance Application, and a Plain Language Summary of the Financial Assistance Policy is located on this Organization's website. Links to such materials shall also be posted on the Website.

b. **Email or Paper Copies.** Copies of any of the materials referenced in this Policy may be obtained by making a request to Customer Service at 323-866-8600 or

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via email to [patient.billing@cshs.org](mailto:patient.billing@cshs.org) or access the website at:  
<https://www.cedars-sinai.org/billing-insurance/financial-assistance.html>.

- c. **Posted Signage.** The Plain Language Summary shall be posted in the following locations: the Emergency Department, the Admitting Department, the Billing Department, centralized and decentralized registration areas and other outpatient settings, including observation units.
    - iii. **Registration and Billing Notices.** Patients will be provided various information and notices in their registration and billing communications. For example, see the Organization's Debt Collection Policy.
    - iv. **Notification to the Community.** The Organization shall take various efforts to widely publicize its Financial Assistance programs, such as distributing information to targeted community organizations or other means of alerting the community to the availability of the Organization's Financial Assistance programs.
- h. **Translations.** Patient communications shall comply with the requirements of the Organization. Without limiting the foregoing, notices, formal communications and signage under this Policy shall be in English and in the additional languages required by State and Federal laws. Those additional languages are Farsi, Russian, and Spanish.
- i. **Medically Necessity/Clinical Determinations.** The evaluation of the necessity for medical treatment of any patient will be based upon clinical judgment, regardless of insurance or financial status. In cases where an emergency medical condition exists, any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with all applicable State and Federal laws.
- j. **Refunds.** The Organization will reimburse patients for amounts they paid in excess of the amount due pursuant to this Policy, including any interest paid, at the rate of ten percent (10%) per annum. If the amount due to the patient is less than \$5.00 (or such other amount set by the Internal Revenue Service), the Organization is not required to reimburse the patient or pay interest. The Organization shall refund the patient within 30 days.
- k. **Collections.** For additional information on collection actions, please see the Debt Collection Policy.
- l. **Reporting.** The Organization will submit this Policy to the Department of Health Care Access & Information ("HCAI") every other year on or before January 1 or within thirty (30) days of any update to this Policy. If there are no changes since the Policy was previously submitted, the Organization shall

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notify HCAI within thirty (30) days prior to the January 1 of the Organization's next biennial reporting date.

**m. Related Policies and Plans**

- i. Debt Collections Policy.
- ii. The American Hospital Association Patient Billing Guidelines.

n. Contact Information. Questions regarding this Policy should be addressed to any of the following individuals: Vice President, Finance and Chief Revenue Cycle Officer or their designee.

**III. Approval by Board of Directors and Continuing Review.** This Policy, the Debt Collection Policy, and all material changes to these policies must be approved by the Organization's Board of Directors. The Organization shall routinely review this Policy together with the Debt Collection Policy, and the status of collection efforts to ensure they are best serving patients and the community.

**IV. Definitions**

- a. **Amounts Generally Billed ("AGB")** means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, determined in accordance with 26 C.F.R. §1.501(r)-5(b). Additional information on how the Organization calculates AGB and annual updates to AGB percentages shall be set forth on Attachment D to this Policy and will be included in filings made available to the public on the State of California's Department of Health Care Access and Information website at <https://syfphr.hcai.ca.gov/>.
- b. **Application** means the Organization's Application for financial assistance.
- c. **Assets** mean only "monetary assets." This includes assets that are readily convertible to cash, such as bank accounts and publicly traded stocks. Retirement plans, deferred compensation plans (both qualified and nonqualified under the IRS code) will not be considered. The following are excluded from Assets: the first Ten Thousand Dollars (\$10,000) of a patient's monetary assets and Fifty Percent (50%) of the patient's monetary assets over the first Ten Thousand Dollars (\$10,000).
- d. **Eligible** means that a patient meets the requirements for financial assistance under this Policy.
- e. **Essential Living Expenses** are expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto

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expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

- f. **Extraordinary Collection Actions ("ECAs")** refers to collection activities that the Organization will not undertake before making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. ECAs are specifically described in the Debt Collection Policy.
- g. **Family** means the following: (1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not, (2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.
- h. **Federal Poverty Level ("FPL")** is the measurement used to determine poverty in the United States and is published periodically by the Department of Health and Human Services ("DHHS") on their website, <http://www.dhhs.gov/poverty>.
- i. **Financially Qualified Patient** is a patient who has requested financial assistance from the Organization and has completed and submitted an Application. Review of the Application shows that the patient is eligible for financial assistance and the Application is approved in accordance with this Policy or the patient has been determined by the Organization to be presumptively eligible for financial Assistance under this Policy.
- j. **Financial Assistance** are arrangements under this Policy for health care services to be provided at no charge or a reduced charge to the patient. Reduced charges are generally pursuant to a payment plan or an automatic discount for Self-Pay patients.
- k. **High Medical Costs** relate to the annual out-of-pocket costs of a patient whose family income exceeds the Organization's thresholds for financial assistance. These costs are considered if they are either: (i) incurred by the patient at the Organization's hospital that exceed the lesser of the patient's current family income or family income in the prior twelve (12) months, or (ii) out-of-pocket medical expenses that exceed ten percent (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 twelve (12) months.
- l. **Medical Indigency** refers to a patient who is unable to pay for services due to unexpected high-cost care but who does not qualify for financial assistance under this Policy.
- m. **Patient** means an existing or prospective patient.
- n. **Payment Plan** is a written agreement between the Organization and the patient, whereby the Organization has offered, and the patient has accepted, the opportunity to pay off their liability in

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monthly payments not exceeding 10% of the patient's family income for a month, excluding deductions for essential living expenses.

o. **State and Federal** Laws include but are not limited to:

- i. U.S. Internal Revenue Code Section 501(r)(3).
- ii. California Health & Safety Code Section 127400-127462 (Hospital Fair Pricing Policies and Emergency Physician Fair Pricing Policies).
- iii. California Assembly Bill 1020: Health Care Debt and Fair Billing, effective January 1, 2022.
- iv. California Assembly Bill 532: Fair Billing Policies, effective January 1, 2022.
- v. Office of General, Department of Health and Human Services ("OIG") guidance regarding financial assistance to uninsured and underinsured patients, and IRS regulations.
- vi. Any implementing regulations and agency guidance regarding any of the foregoing.

**List of Attachments**

- A. Summary of Financial Assistance Policy - Plain Language Summary
- B. Financial Assistance Application
- C. Financial Assistance Discount
- D. Amounts Generally Billed

**HISTORY:**

**ORIGINAL ISSUE: 05/01/03**

**POLICY VERSION EFFECTIVE DATE:**

**LAST REVIEW DATES: 10/13/22, 11/20/20, 11/16/19, 05/23/16, 12/30/14, 02/14/11, 09/01/10, 12/28/09, 09/30/09, 12/01/07, 12/12/06, 06/21/06, 01/11/06, 11/10/05, 08/29/05**

## Attachment A

### Summary of Financial Assistance Policy – Plain Language Summary



#### SUMMARY OF FINANCIAL ASSISTANCE AND SURPRISE BILLING PROTECTIONS

As part of our mission, Cedars-Sinai Medical Center, Cedars-Sinai Marina del Rey Hospital and Cedars-Sinai Medical Care Foundation (the "Organization") are committed to providing access to quality healthcare for the community and treating all of our patients with dignity, compassion and respect. This includes providing services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for care as provided by our financial assistance policy (the "Policy"). We also offer our patients a variety of payment plans and options to meet their financial needs, even if they do not qualify for assistance. This document is our plain language summary (the "Summary") of the Policy.

#### **Eligibility – Full Discounts and Reduced Amounts**

Financial assistance will be made available to patients receiving medically necessary procedures and whose income and monetary assets (together "income") are at or below 400% of the current year's federal poverty level (FPL). Patients whose income ranges between 401%–600 % of the FPL also qualify for discounted care. Discounts available to patients will be on a sliding scale based on family size, income level and insurance status. Patients seeking financial assistance for elective services arrangements will require prior approval by the vice president of Patient Financial Services or their designee. Only medically necessary procedures are eligible for approval. Financial assistance for elective procedures and for follow-up care following discharge is limited to patients who live in the Organization's service area. If a patient does not qualify for entirely free services but is eligible for a discount under the Policy, the patient will not be charged more than amounts generally billed by the Organization for emergency or other medically necessary care.

#### **Physicians and services**

The Policy only applies to services provided by the Organization and includes physician services if provided by Cedars-Sinai emergency department physicians of the Community Urgent Care Medical Group, Inc., Cedars-Sinai faculty physicians in their capacity as faculty or physicians employed by Cedars-Sinai Medical Care Foundation (CSMCF) or by medical groups that have an exclusive professional services agreement with CSMCF.

#### **Applying for financial assistance**

Patients seeking free or discounted care under the Policy will need to complete a financial assistance application (the "Application") and submit any required documentation. The Application and documentation will go through a review process by the Organization.

#### **Contact information to obtain the Application, the Policy or additional information**

Free copies of this Summary, the Policy or the Application are available in English, Farsi, Russian or Spanish. To request copies or to get additional information, including questions on the financial

continued

**Attachment A (Continued)**



**SUMMARY OF FINANCIAL ASSISTANCE  
AND SURPRISE BILLING PROTECTIONS**

assistance process, you may:

- Ask representatives at the registration or admissions desks.
- Call Patient Financial Services at 323-866-8600.
- Visit the Organization's website at [cedars-sinai.org/billing-insurance/financial-assistance.html](http://cedars-sinai.org/billing-insurance/financial-assistance.html)

**Arrangements for self-pay**

Patients who do not qualify for free or discounted care under the Policy may find other programs of the Organization helpful. Patients who lack insurance may receive a substantial discount, similar to the discounts we provide to managed-care insurance plans. Eligible services include outpatient, emergency and inpatient services.

**Regulatory notice for collections**

We do refer some delinquent accounts to third-party collection agencies. These agencies must follow all California and federal laws as well as comply with the Organization's policies and procedures. For more information about debt collection activities, you may contact the Federal Trade Commission by phone at 877-FTC-HELP (877-382-4357). In the event your account is referred to a collection agency and you experience problems, contact our Patient Financial Services for support at 323-866-8600.

**Protections for surprise medical bills.**

All patients are afforded protections against surprise medical bills. Please see the "Notice to Patients – Your Rights and Protections Against Surprise Medical Bills" on our website [cedars-sinai.org/patients-visitors/resources/patient-rights.html](http://cedars-sinai.org/patients-visitors/resources/patient-rights.html) or ask for a copy.

**Additional resources and information on billing, rates, and price transparency:**

- Patients may be eligible for government assistance programs, such as Medi-Cal, or may also be eligible for subsidized coverage through the California Health Benefit Exchange (Covered California). For questions on these programs, coverages and other organizations that can assist, contact the Patient Financial Advocates office at 310-423-5071.
- For questions regarding commercial health insurance, call 800-233-2771.
- For information on the Organization's pricing and tool for shoppable services, visit [cedars-sinai.org/billing-insurance.html](http://cedars-sinai.org/billing-insurance.html)
- The Health Consumer Alliance (HCA) offers free assistance to patients who need help to get or maintain health coverage and resolve problems with health plans. For more information, visit [healthconsumer.org](http://healthconsumer.org).

## Attachment B

### Financial Assistance Application

#### FINANCIAL ASSISTANCE

Please return completed application and supporting financial documents to:

Cedars-Sinai Medical Center  
Financial Assistance Processing Unit  
1801 W. Olympic Blvd.  
Pasadena, CA 91199-1688

Business Hours: 8 a.m. – 5 p.m., weekdays  
Phone Number: 323-866-8600 File 1688  
24-Hour Access by Fax: 323-866-3077  
Email: Patient.Billing@cshs.org

#### Financial Assistance Required Supporting Financial Documents

Please provide the financial documents requested below. If any documents are missing or are not attached, your application will be delayed or denied. If you are unable to provide specific documents, please provide a letter of explanation.

#### Primary Documents:

- Proof of income and non-wage income (as described above)
  - Prior two months of Employer Checks or Stubs
  - Prior two months of Unemployment, Social Security or Disability verification statements, etc.
- Federal Tax Return
  - If you did not file a Federal tax return, include your most recent W2 or 1099
  - If you are unable to provide your tax return information due to delay in tax filing, temporary disability, or unemployment, please provide your non-filing tax form. You can obtain a copy by calling 1-800-908-9946 or visit [www.irs.gov/individuals/get-transcript](http://www.irs.gov/individuals/get-transcript) (use form 4506-T or 4506T-EZ)
- Prior two months of Bank Statements for all Checking, Savings, and Credit Union accounts (please include all pages)
- Rent or Mortgage verification

#### Supplemental/Other Documents:

- Proof of Non-Wage Income:
  - Statement of Alimony income
  - Statement of Business income
  - Statement of Child Support income
- If Married or in a Civil Union: Provide the following applicable documents regarding your spouse/partner
  - Proof of income and non-wage income (as described above)
  - Federal Tax return
    - If you did not file Federal tax return, include your most recent W2 or 1099
    - If you are unable to provide your tax return information due to delay in tax filing, temporary disability, or unemployment, please provide your non-filing tax form. You can obtain a copy by calling 1-800-908-9946 or visit [www.irs.gov/individuals/get-transcript](http://www.irs.gov/individuals/get-transcript) (use form 4506-T or 4506T-EZ)
  - Prior two months of your most recent statement for all checking, savings, and credit union accounts

#### Completed Application:

- Completed application with date and signature



**Attachment B (Continued)**

PATIENT INFORMATION			
Patient Name		Social Security Number	Date of Birth
Home Address		City	State   Zip Code
Home Number	Cell Number	Email Address	
Preferred Method of Contact <input type="checkbox"/> US Mail <input type="checkbox"/> Email <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone		Annual Household Income: \$	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Number of Individuals in your Household (as reported on your taxes):	
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed - Last date worked:			
Employer Name		Phone Number	
Employer Address		City	State   Zip Code

SPOUSE/DOMESTIC PARTNER/PARENT/GUARANTOR INFORMATION			
Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Guarantor <input type="checkbox"/> Other:			
Name	Social Security Number	Date of Birth	
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed - Last date worked:			
Employer Name		Phone Number	
Employer Address		City	State   Zip Code
Name of Health Insurance (offered by employer including COBRA) <input type="checkbox"/> Health Insurance not provided			

INSURANCE COVERAGE			
1. Are you eligible for any health insurance coverage?			
<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Veterans Administration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Foreign Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please provide the following information.			
Policy Holder	Insurer	Policy Number	
Policy Holder	Insurer	Policy Number	

**Attachment B (Continued)**

SCREENING QUESTIONS			
<p>1. Is the treatment provided related to any of the following?  <input type="checkbox"/> Accident    <input type="checkbox"/> Crime    <input type="checkbox"/> Workplace injury    <input type="checkbox"/> Other:</p>			
<p>2. Have you hired an attorney or are you pursuing a claim for your injury or illness?            a. If yes, please provide:    <div style="display: flex; justify-content: space-between; border-top: 1px solid black; border-bottom: 1px solid black;"> <span>Attorney Name</span> <span>Attorney Phone Number</span> </div> </p>			
<p>3. Have you already applied for Medi-Cal? (We may ask that you do so)   <input type="checkbox"/> Yes - Awaiting Approval    <input type="checkbox"/> Yes - Ineligible    <input type="checkbox"/> No             a. If no, please check all that apply below:  <input type="checkbox"/> You are 19 years or younger  <input type="checkbox"/> You are 65 years or older  <input type="checkbox"/> You are blind  <input type="checkbox"/> You are taking medication to control diabetes, high blood pressure, or seizures  <input type="checkbox"/> You are disabled as determined by the Social Security Administration  <input type="checkbox"/> You are pregnant  <input type="checkbox"/> You have children under the age of 19 living with you</p>			
EXPENSE AND ASSET INFORMATION			
Current Monthly Income	Patient	Spouse	Total
Gross Pay	\$	\$	\$
Net Self-Employed Income	\$	\$	\$
Interest and Dividends	\$	\$	\$
Real Estate or Rental Property	\$	\$	\$
Social Security/Retirement/Disability	\$	\$	\$
Alimony, Support Payments	\$	\$	\$
Other	\$	\$	\$
<b>Total Monthly Income</b>	\$	\$	\$
Essential Living Expenses	Patient	Spouse	Total
Rent or Mortgage	\$	\$	\$
Real Estate Taxes	\$	\$	\$
Utilities and Telephone	\$	\$	\$



**Attachment B (Continued)**

<b>FINANCIAL ASSISTANCE APPLICATION</b>			
<b>Essential Living Expenses</b>	<b>Patient</b>	<b>Spouse</b>	<b>Total</b>
Alimony, Support Payment	\$	\$	\$
Auto Loan/Lease Payment	\$	\$	\$
Education	\$	\$	\$
School/Childcare (Minor Dependents)	\$	\$	\$
Food	\$	\$	\$
Insurance	\$	\$	\$
Other Expenses	\$	\$	\$
Total Monthly Expenses	\$	\$	\$
<b>Current Medical Debt</b>	<b>Patient</b>	<b>Spouse</b>	<b>Total</b>
Outstanding Medical Debt (Cedars-Sinai)	\$	\$	\$
Other Medical Debt	\$	\$	\$
<b>Assets (Exclude Retirement Accounts)</b>	<b>Patient</b>	<b>Spouse</b>	<b>Total</b>
Checking/Savings/Credit Union Accounts	\$	\$	\$
Stocks and Bonds	\$	\$	\$
Money Market/Brokerage Accounts	\$	\$	\$
Certificates of Deposit	\$	\$	\$
Total Assets	\$	\$	\$

I certify that the information in this application is true and correct to the best of my knowledge. I agree to apply for any local, state, and federal assistance for which I may be eligible, to help alleviate the cost of any hospital and professional bills. I understand that the information provided may be verified by Cedars-Sinai Medical Center and/or Marina Del Rey Hospital, and I authorize CSMC/MDRH to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

Signature of Person Applying for Financial Assistance \_\_\_\_\_  
 Spouse/Domestic Partner/Guarantor Signature (when applicable) \_\_\_\_\_

Date \_\_\_\_\_  
 Date \_\_\_\_\_

**Attachment C**

**Financial Assistance Discount  
2022 Federal Poverty Guidelines**

<b>Uninsured Discount</b>	<u>100%</u>	<u>95%</u>	<u>90%</u>	<u>85%</u>	<u>85%</u>
<b>Underinsured Discount</b>	<u>100%</u>	<u>90%</u>	<u>80%</u>	<u>70%</u>	<u>60%</u>

Size of Family Unit	2022 FPL Annual Salary					
1	\$13,590	\$54,360	\$61,155	\$67,950	\$74,745	\$81,540
2	\$18,310	\$73,240	\$82,395	\$91,550	\$100,705	\$109,860
3	\$23,030	\$92,120	\$103,635	\$115,150	\$126,665	\$138,180
4	\$27,750	\$111,000	\$124,875	\$138,750	\$152,625	\$166,500
5	\$32,470	\$129,880	\$146,115	\$162,350	\$178,585	\$194,820
6	\$37,190	\$148,760	\$167,355	\$185,950	\$204,545	\$223,140
7	\$41,910	\$167,640	\$188,595	\$209,550	\$230,505	\$251,460
8	\$46,630	\$186,520	\$209,835	\$233,150	\$256,465	\$279,780
For each additional person, add	\$4,720					
		400%	450%	500%	550%	600%

Note: Schedule Last Revised 2/8/22

**Attachment D**

**Amounts Generally Billed**

Amounts Generally Billed ("AGB") means the amounts generally billed for emergency or other medically necessary care to patients who have insurance covering such care, determined in accordance with 26 C.F.R. §1.501(r)-5(b).

The Organization will use the Look-Back Method for determining the maximum amount that would be billed to an eligible inpatient using the average Medicare and commercial inpatient reimbursement rate (see Attachment D). To further benefit an eligible inpatient, the Organization will use the lower of the AGB or the Medicare MS-DRG reimbursement amount for this episode of care in determining an eligible patient's liability.

The Organization will use the Look-Back Method in determining the maximum amount that would be billed to an eligible outpatient using the average Medicare and commercial outpatient reimbursement rate.

The Organization will use the Look-Back Method in determining the maximum amount that would be billed to an eligible emergency room patient using the average Medicare and commercial emergency room reimbursement rate. Inpatient, outpatient and emergency room reimbursement rates are calculated at least annually using the most recently closed Medicare accounts from the past 12 months.

	<b>Uninsured Self-Pay Discounts <sup>(1)</sup></b>	<b>AGB Reimbursement %</b>
<b>Cedars-Sinai Medical Center</b>		
Emergency Room	81%	19%
Inpatient	84%	16%
Outpatient	83%	17%
<b>Cedars-Sinai Marina del Rey Hospital</b>		
Emergency Room	78%	22%
Inpatient	82%	18%
Outpatient	81%	19%

Note: Effective 12/01/2021