

 central peninsula hospital 250 Hospital Place Soldotna, AK 99669	POLICY TITLE: Charity Care	DEPARTMENT: CPGH – Facility Wide CATEGORY: Patient Services SECTION: Financial Services
	POLICY NUMBER: CPGH.601.040	EFFECTIVE DATE: August 2026 Original Date of Policy: OP-505 - 02/91
	AUTHORIZED BY: Revenue Cycle Director; Chief Financial Officer	Revised: CPGH.601.040 – 2/15, 6/18, 3/20, 5/20, 1/21, 10/21, 3/22, 11/22, 4/23, 8/23, 10/24, 2/25, 1/26, 2/26 ¹ , 2/26 ² , 6/26, 8/26; (OP-505 – 5/91, 7/92, 9/96, 2/98, 8/02, 11/04, 10/12, 5/13, 8/14) Reviewed: 2/97, 9/01

APPLIES TO: Keeping with the mission of CPH it is considered not only necessary but also appropriate to make adjustments to patient care charges under certain circumstances. It is not the intent of this policy to restrict this practice, but rather to establish clear guidelines by which to accomplish this task.

RESPONSIBILITY: Financial Counselor, PFS Staff, CBO Staff, and Chief Financial Officer (CFO)

DEFINITIONS:

1. Charity Care: Charity care is defined as services provided to patients who are unable to pay based on income level, financial analysis, and/or further healthcare needs based on diagnosis. Patients who qualify for charity will fall into one of three categories.
 - a. Financially Indigent – A person who is uninsured or under insured and is accepted for care with no or limited ability to pay for the services rendered based on the hospital's eligibility criteria set forth in this policy.
 - b. Medically Indigent – A person whose non-elective medical or hospital bills after payment by third-party payer exceed a specified percentage of a household's annual gross income as set forth by this policy and is unable to pay the remaining bill.
 - c. Medicaid Recipient – A person who qualifies for Medicaid in the month in which the service was rendered.
2. Federal Poverty Level (FPL) – An income level judged inadequate to provide a family or individual with the essentials of life. The figure is adjusted to reflect changes in the Consumer Price Index. Alaska FPL is additionally adjusted to meet the geographic location of the state.
3. Household – A household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, were living in the same housing unit, they would constitute one household
4. Amounts Generally Billed (AGB) – The percentage of charges allowed by a combination of Medicare and Private Insurers, this percentage is calculated by the Hospital each year.
5. Financial Assistance Brochure – A plain language summary of the Financial Assistance Policy and Program.

POLICY:

1. Publication of the Financial Assistance Program
The CPH Financial Assistance Program will be widely publicized within the community served. Measures taken to ensure this publicity are:
 - a. Patients are offered a Financial Assistance Program brochure upon registration and in the Inpatient Admission packet.
 - b. Financial Assistance Program brochure and application available at multiple locations within the hospital including the Cashier, Financial Counselor, Admissions/Registration areas and Emergency Room.

- c. Radio Advertisement on local stations instructing patients/guarantors to contact the CPH Financial Counselors to obtain further information regarding Financial Assistance.
- d. CPH Community website containing information regarding the Financial Assistance Program including a URL link to the Financial Assistance Program brochure, policy and application.
- e. Financial Assistance Brochures available at the CPH sponsored Community Health Fair
- f. Billing Statements and letters include a statement regarding the availability of financial assistance, the URL link to the application and the phone number of the Patient Financial Services office to contact for more information.
- g. Local Newspaper Advertisement

2. Applying for Financial Assistance

- a. An application for Financial Assistance must be received in order to be considered for charity care. Patients will obtain a copy of the Financial Assistance application and complete it along with the required documentation attachments to the best of their ability. Incomplete applications (applications with limited information) may be accepted with approval from the Revenue Cycle Director or CFO. Charity determinations made based on Medicaid eligibility are an exception to requiring an application, see section 5.b.i for further details.
- b. Completed applications may be submitted as follows:
 - 1) Turned into the Cashier or Financial Counselor offices in the main CPH Hospital location
 - 2) Faxed to the Cashier office at 907-714-4637
 - 3) Mailed to: Financial Counselor
Central Peninsula Hospital
250 Hospital Place
Soldotna, AK 99669
- c. The following staff are available to answer questions or to provide assistance in completing the application:
 - 1) Financial Counselors at 907-714-4400 or 907-714-4857
- d. Financial assistance requests may be made by the patient, outside healthcare providers, community or religious groups, social services, family members and CPH staff.
- e. Accounts still in the active collection process that have not been turned to Bad Debt status, are always eligible for Charity Care application and consideration.
- f. If the account is in a Bad Debt status, applications for charity care can be submitted up to 240 days after the date of the first billing. After 240 days, the account is no longer eligible for charity care. If an application on an account that is in Bad Debt status is received within the 240 day period, the Financial Counselor will notify the Collection Agency to pend any Extraordinary Collection Activity that may have been initiated. Deceased patient with an open probate case are an exception to the 240 day bad debt exclusion.

3. Eligibility Considerations for Financial Assistance:

- a. Financial assistance is generally secondary to all other financial resources available to the patient including insurance, government programs, third party liability, and personal assets.
- b. Family size. (number of individuals living in household)

- c. Employment status
 - d. After other financial resources listed above have been exhausted or ruled out, eligibility for financial assistance will be based on the household's gross monthly income. The amount of assistance will be determined utilizing the ***Guidelines for Financial Assistance*** chart below.
 - e. Cosmetic and other services that are not medically necessary are not eligible for charity care. A patient may qualify and be approved for Financial Assistance, but a service may be determined to not meet the medical necessity criteria for Financial Assistance. If a procedure or service's medical necessity is in question, whether it has already been performed or is to be performed, it will be reviewed by the Revenue Cycle Team and compared to Medicare and Commercial Insurance medical necessity guidelines, when available, along with information in the medical record and opinion of Physician's involved in the patient's care. A determination will be made and the patient informed.
 - f. Other catastrophic circumstances may be considered in charity decision. (CFO determination only)
 - g. Medicaid eligibility can be proof of indigence, because the income limits for Alaska Medicaid are lower than the CPH 100% assistance based on poverty level. See section 5.b.i for information on Medicaid charity determinations.
 - h. Medical Indigence – Evaluate additional circumstances
 - 1) Medical bills combined, is greater than 20% of annual gross income.
 - 2) The hospital may consider other financial assets and liabilities of the person when determining the ability to pay.
 - 3) A determination of a person's ability to pay the remainder of the bill will be based on whether the patient reasonably can be expected to pay the account in full over a 2 year period.
 - i. Swing Bed and Long Term Care Medicaid Eligibility

For patients receiving Swing Bed services, Long Term Care Medicaid is considered an available financial resource that must be pursued prior to or in conjunction with consideration for Financial Assistance. Patients who are reasonably considered eligible for Long Term Care Medicaid must cooperate with the Long Term Care Medicaid application process and provide all information necessary to establish eligibility, to be considered for Financial Assistance. If a patient is reasonably considered eligible for Long Term Care Medicaid and declines to apply for Long Term Care Medicaid, fails to cooperate with the eligibility determination process, or otherwise elects to not spend down resources rather than pursue available Medicaid coverage, the patient may be held responsible for balances that otherwise may have been covered by Long Term Care Medicaid, regardless of whether the patient otherwise meets Financial Assistance income guidelines. Eligibility for Financial Assistance does not eliminate a patient's responsibility for balances that could have been covered through other financial resources as stated in 3.a.
4. Documentation Requirements
- For patient/guarantor who is not self-employed:**
- a. Financial Statement (exhibit A)
 - b. Brief written or typed explanation of applicant's circumstances
 - c. Bank statements for the last 3 months including checking, savings, certificates of deposit, etc. (At minimum the statement must list deposits and overall balance, withdrawals and account numbers are not required).
 - d. Proof of Income – 3 most recent pay stub indicating year-to-date earnings and/or unemployment check stubs or determination letter, or Retirement

Benefit Statement, SSI or SSDI statement (or proof of deposit on bank statement).

- e. Medicaid Pre-Screening completed by the Financial Counselor

For patient/guarantor who is self-employed

- a. Financial Statement (exhibit A)
- b. Brief written or typed explanation of applicant's circumstances
- c. Previous year tax return, personal and business if separate returns. Including Schedule C if on a personal return.
- d. Current year business profit/loss or income statement
- e. Bank statements for the last three months for both business and personal use, including checking, savings, certificates of deposit, etc.

5. Determination

- a. Determination of eligibility will be made by the PFS Department within 30 working days, after receipt of all necessary information to make a determination. A determination of eligibility for financial assistance may be made on a partially completed application without all of the required documentation items, if the patient or information is not reasonably available and eligibility is warranted under the circumstances.
- b. Determination based on Medicaid eligibility-
 - i. Patients eligible for Medicaid on the date of service qualify for 100% charity on their Medicaid copay and coinsurance balances without submitting an application. The Electronic Health Record system may be set up to automatically make these adjustments. (Income criteria is met and insurance resource has been exhausted)
 - ii. Patients eligible for Medicaid who are have restricted Medicaid status, and whom Medicaid has denied, even after appeal, their services as not eligible for payment due to not having a referral letter from their locked in Provider, are eligible for 100% charity without submitting an application. (Income criteria is met and insurance resource has been exhausted)
 - iii. Patients eligible for Medicaid, who receive a Medicaid non-covered service that is traditionally covered by other payors, are eligible for 100% charity without having to submit an application. Examples of these include Diabetes Education if Medicaid does not cover it. Adult Podiatry will qualify in this situation when approved by Administration to be seen by the Podiatrist instead of an Orthopedic or Family Practice provider, as sometimes Administration may agree it is in the best interest of the patient to be treated by the podiatrist therefore ruling out the insurance resource. (Income criteria is met and insurance resource has been exhausted) Services for infertility and sexual dysfunction would not automatically qualify for charity (not medically necessary).
 - iv. Patients eligible for Medicaid, but where Medicaid has denied or not approved a required service authorization for a medical service, will not automatically be eligible for charity for that service. An application would need to be submitted and the service reviewed under section 3.e. Examples of this may include Medicaid denying a surgery or advanced imaging service authorization request for reasons of

conservative treatment not yet completed or not medically necessary.
(Income criteria is met, but service is not medically necessary)

- c. Patients will be notified of financial assistance determination in writing.
 - d. Approval of charity care is based on need, and are reviewed and approved by the Billing Supervisor and/or Revenue Cycle Director. Revenue Cycle Director will submit a monthly report of all charity adjustments over \$5,000.00 to the CFO for review.
 - e. Approved Financial Applications are valid for 3 months from the date of determination. Services rendered after 3 months from the date of approval, will require additional documentation to support the need of continued financial assistance. Patients with fixed income may be approved for 6 months at the discretion of the Billing Supervisor, Revenue Cycle Director and/or CFO.
6. Application of Charity Percentage Discount
- a. Financial Assistance Program eligible patients will not be charged, more than the Amounts Generally Billed percentage established by the Hospital annually using the look back method. The amount charged is defined as the balance they are personally responsible for paying after all deductions and discounts including the FAP discount have been applied, and less any amounts reimbursed by insurers.
 - b. The Calendar Year 2026 AGB percentage is 43.02%. Reflecting an average discount of 56.98% from Medicare and Commercial financial classes, based on calculations from the calendar year 2025.
 - c. Initially charges will be placed on the patients account equal to that found in the facility charge master for that date of service, regardless of financial assistance eligibility.
 - d. After applicable insurance and existing self-pay payments are applied, and after the determination of Financial Assistance eligibility has been made, an adjustment will be entered in the amount of the remaining balance on the account as of the date the application was received (Gross charges less any payments already made), multiplied times the approved charity discount percentage.
7. Financial Assistance Program coverage
- a. The Financial Assistance Program at Central Peninsula Hospital covers multiple providers. The following is a list of providers that deliver services at Central Peninsula Hospital and that honor the FAP determination.
 - 1) Central Peninsula Hospital
 - 2) Central Peninsula Hospital Physician Group (including Emergency Room Physicians, Anesthesia Providers, Pathologists and Physicians performing EKG/ECHO/EEG interpretations at CPH)
 - 3) Central Peninsula Hospital owned Physician Clinics, Central Peninsula Urgent Care and Central Peninsula Surgery Center
 - 4) Skagit Radiology/North Star Medical Imaging
 - 5) The Alaska Hospitalist Group
 - b. The following is a list of providers that deliver services at Central Peninsula Hospital and that do not honor the FAP determination.
 - 1) All other Non-CPH Employed physicians not described above do not routinely accept the Financial Assistance program determinations.

8. Income Guidelines for Financial Assistance

- a. Monthly Poverty Guidelines are updated annually based on Alaska Poverty levels; income levels used will be as of the date the application is received.

Monthly Poverty Income Level ≤ 200%	Monthly Poverty Income Level ≤ 201-250%	Monthly Poverty Income Level ≤ 251-300%
100% Assistance	70% Assistance	60% Assistance

PROCEDURE: N/A

REVISION

RESPONSIBILITY: Administration and/or designee(s)

REFERENCES: CORP.101.100 Charity Care
PFS.601.350 Private Pay Collection