Sutter Health
Sacramento Sierra Region

Important Billing Information for Uninsured Patients at Sutter Davis Hospital

Thank you for choosing Sutter Davis Hospital for your hospital services. This handout is designed to help our uninsured patients understand our billing process, payment options, and services available. Uninsured patients are patients who have no health insurance or third-party payer source to assist with the payment of their hospital bill. This information applies only to your hospital bill and does not include any bills received from physicians, anesthesiologists, clinical professionals, ambulance companies, etc. that may bill you separately for their services.

Uninsured Patient Discount: Sutter Davis Hospital offers a 20% **discount** off of hospital inpatient charges and a 20% **discount** off of outpatient charges at time of billing. An itemized bill reflecting your discount will be mailed to the address obtained at time of registration five to seven days after the service/ discharge date. Please review your bill and contact us if you have any questions.

Payment Options

Sutter Davis Hospital has many options to assist you with payment of your hospital bill.

Prompt-pay Discount Sutter Davis Hospital offers a prompt-pay discount option to our uninsured patients. If your account is paid in full within 30 days of your bill date you will receive an additional 10% discount off of the balance due.

Payment Plans: Patient account balances are due upon receipt. Patients may elect to make payment arrangements for their hospital bill. A Financial Agreement must be signed before the Business Services Office can accept payment arrangements that allow patients to pay their hospital bills over time. These arrangements are interest-free for low income uninsured patients and certain income-eligible patients with high medical costs.

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

Healthy Families: You may obtain information about Healthy Families (California's low-cost, comprehensive medical, dental and vision care insurance program) by contacting the hospital Business Services Office.

Charity Program: Uninsured patients who have an inability to pay their bill may be eligible for charity assistance. The eligibility for charity is based on income and family size. All potential payer sources must be exhausted before a patient is eligible for charity. A charity application is attached.

Copies of this hospital's Uninsured Patient Discount Policy, Prompt Pay Discount Policy, Charity Care Policy, as well as government program applications are available at Patient Registration and our Business Services Office. We can also send you copies if you contact our Business Services Office at (530) 759-7446.

Notice of Availability of Financial Estimates: You may request a written estimate of your financial responsibility for hospital services. Requests for estimates must be made during business hours. The estimate will provide you with an estimate of the amount the hospital will require the patient to pay for health care services, procedures, and supplies that are reasonably expected to be provided by the hospital.

Estimates are based on the average length of stay and services provided for the patient's diagnosis. They are not promises to provide services at fixed costs. A patient's financial responsibility may be more or less than the estimate based on the services the patient actually receives.

The hospital can provide estimates of the amount of hospital services only. There may be additional charges for services that will be provided by physicians during a patient's stay in the hospital, such as bills from personal physicians, and any anesthesiologists, pathologists, radiologists, ambulance companies or other medical professionals who are not employees of the hospital. Patients will receive a separate bill for these services.

If you have any questions about written estimates, please contact the Business Services Office at (530) 759-7446.

If you have any questions, or if you would like to pay by telephone, please contact the Business Services Office (800) 353-3369.

FINANCIAL ASSISTANCE PROGRAM FOR LOW INCOME UNINSURED PATIENTS FREQUENTLY ASKED QUESTIONS

How Do I Determine Whether I Qualify For Financial Assistance For My Hospital Medical Bills?

Affiliate offers Financial Assistance to our low-income, uninsured patients that meet the program eligibility requirements. Please refer to the chart, located on the back of this notice, for the family income eligibility criteria.

If your family income is below 200% of the Federal Poverty Income Guidelines you may qualify for 100% Charity Care for your hospital bill.

If your family income is between 201% and 400% of the Federal Poverty Income Guidelines you may qualify for partial Charity Care.

If your family income is below 350% and you have high medical costs (exceeding 10% of your family income) you may qualify for full or partial Charity Care. Catastrophic medical coverage is also available for low income uninsured patients whose eligible medical bills exceed 30% of the patient's annual family income.

The Business Services Department will begin the eligibility determination process once they have received a completed application form along with your income verification documents. Failure to submit a completed application and supporting documentation in a timely manner may result in denial of charity care.

How Do I Apply For Financial Assistance?

Complete the attached form and return to the Business Services Office at the following address:

Central Billing Office
PO Box 160100
Sacramento, Ca 95816-0100

You must provide income documentation, such as tax return, pay stubs, or employer salary history, with your application to process your charity request.

The Business Services Office will process your application and may need to contact you as part of the application process and may request additional information. If you need assistance in completing the form please call (800) 353-3369.

How Does The Notification Process Work?

Once the eligibility process is complete you will receive a Financial Assistance Notification form in the mail. The form will indicate if you are eligible for full or partial Financial Assistance. You may receive a notification that you are ineligible for financial assistance or that more information is needed to make a determination.

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME ________________________________ **SPOUSE**________________________
ADDRESS ____________________________________ **PHONE**__________________________
ACCOUNT#____________________________________ **SSN#**____________ ____________
(Patient) (Spouse)

FAMILY STATUS: List all dependants that you support

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION
Employer____________________________________ Position__________________________
Contact Person & Telephone____
If Self-Employed, Name of Business____

Spouse Employer______________________________ Position__________________________
Contact Person & Telephone____
If Self-Employed, Name of Business____

CURRENT MONTHLY INCOME

		Patient	Spouse
	Gross Pay (before deductions)	____________	____________
Add:	Income from Operating Business (if Self-Employed)	____________	____________
Add:	Other Income:		
	Interest and Dividends	____________	____________
	From Real Estate or Personal Property	____________	____________
	Social Security	____________	____________
	Other (specify):	____________	____________
	Alimony or Support Payments Received	____________	____________
Subtract:	Alimony, Support Payments Paid	____________	____________
Equals:	Current Monthly Income	____________	____________
	Total Current Monthly Income	____________	____________
	(add Patient + Spouse income from above)	____________________________	

FAMILY SIZE
Total Family Members (add patient, spouse and dependents from above) ____________

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

____ ______________________
(Signature of Patient or Guarantor) (Date)

____ ______________________
(Signature of Spouse) (Date)

Sutter Health Federal Poverty Income Guideline Sliding Scale

Eligibility Guide for 2007: Using household income and size as calculated in the Attachment A, identify eligibility for financial discount.

FAMILY SIZE	PERIOD	FEDERAL POVERTY GUIDELINES	If income is below 200% (shown below) of FPIG eligible for Full Write-off	If income is above 200% but below 400% (shown below), eligible for Partial Write-off
1	Annual	$10,210	$20,420	$40,840
	Monthly	$851	$1,702	$3,403
2	Annual	13690	$27,380	$54,760
	Monthly	$1,141	$2,282	$4,563
3	Annual	17170	$34,340	$68,680
	Monthly	$1,431	$2,862	$5,723
4	Annual	20650	$41,300	$82,600
	Monthly	$1,721	$3,442	$6,883
5	Annual	24130	$48,260	$96,520
	Monthly	$2,011	$4,022	$8,043
6	Annual	27610	$55,220	$110,440
	Monthly	$2,301	$4,602	$9,203
7	Annual	31090	$62,180	$124,360
	Monthly	$2,591	$5,182	$10,363
8	Annual	34570	$69,140	$138,280
	Monthly	$2,881	$5,762	$11,523

For each additional family member add $3,480 for annual income.