

HealthBridge - Orange

FINANCIAL ASSISTANCE POLICY

January, 1, 2026

POLICY/PRINCIPLES

It is the policy of VSC HBO, LLC (dba HealthBridge Orange, a pediatric specialty facility only serving patients age 0 to 21 and hereinafter the “Facility”)) to ensure a socially just practice for providing medically necessary care at the Facility. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Facility.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.
2. This policy applies to medically necessary care provided by the Facility. This policy does not apply to charges for care that is not emergency and other medically necessary care.
3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Facility that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- “**501(r)**” means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- “**Amount Generally Billed**” or “**AGB**” means, with respect to medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- “**Community**” for HealthBridge Orange consists of Orange County, California.
- “**Medically necessary care**” means care that is (1) appropriate and consistent with and essential for the treatment of a Patient’s condition; (2) the most appropriate supply or level of service for the Patient’s condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient’s family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be “medically necessary care,” the care and the timing of care must be approved by the Facility’s Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Facility’s discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- “**Facility**” means VSC HBO, LLC, dba HealthBridge Orange, in Tustin, California
- “**Patient**” means those pediatric persons age 0 - 21 who receive medically necessary care at the Facility and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Facility:

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250% of the Federal Poverty Level income (“FPL”), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an “Application”) on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Facility . Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.
2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits an Application on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Facility. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Charity Care Discount - Sliding Scale									
Family Size	Federal Poverty Level	250%	251% - 275%	276% - 300%	301% - 350%	351% - 375%	376% - 400%	> 400%	Uninsured Discount
1	\$12,880	\$32,200	\$32,201 - \$35,420	\$35,421 - \$38,640	\$38,641 - \$45,080	\$45,081 - \$48,300	\$48,301 - \$51,520	Patient may be eligible for Uninsured Discount or additional discounts based on Means Test	Uninsured patients
2	\$17,420	\$43,550	\$43,551 - \$47,905	\$47,906 - \$52,260	\$52,261 - \$60,970	\$60,971 - \$65,325	\$65,326 - \$69,680		
3	\$21,960	\$54,900	\$54,901 - \$60,390	\$60,391 - \$65,880	\$65,881 - \$75,250	\$75,251 - \$82,350	\$82,351 - \$87,840		
4	\$26,500	\$66,250	\$66,251 - \$72,875	\$72,876 - \$79,500	\$79,501 - \$92,750	\$92,751 - \$99,375	\$99,376 - \$106,000		
5	\$31,040	\$77,600	\$77,601 - \$85,360	\$85,361 - \$93,120	\$93,121 - \$108,640	\$108,641 - \$116,400	\$116,401 - \$124,160		
6	\$35,580	\$88,950	\$88,951 - \$97,845	\$97,846 - \$106,740	\$106,741 - \$124,530	\$124,531 - \$133,425	\$133,426 - \$142,320		
7	\$40,120	\$100,300	\$100,301 - \$110,330	\$110,331 - \$120,360	\$120,361 - \$140,420	\$140,421 - \$150,450	\$150,451 - \$160,480		
8	\$44,660	\$111,650	\$111,651 - \$122,815	\$122,816 - \$133,980	\$133,981 - \$156,310	\$156,311 - \$167,475	\$167,476 - \$178,640		
Charity Care Discount %		100%	95%	85%	75%	65%	55%	Varies	47%

Information from the U.S. Department of Health and Human Services as of January 13, 2021
Source: <https://aspe.hhs.gov/poverty-guidelines>

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400% of the FPL may be eligible for financial assistance under a “Means Test” for some discount of Patient’s charges for services from the Facility based on a Patient’s total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to the Facility and any other health care provider, for medically necessary care, that is equal to or greater than such Patient’s household’s gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2 above, if such Patient submits an Application on or prior to the 240th day after the Patient’s first discharge bill and the Application is approved by the Facility. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient’s first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient’s unpaid balance after taking into account any payments made on Patient’s account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.
4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an “Asset Test.” The Asset Test involves a substantive assessment of a Patient’s ability to

pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.

5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.
6. For a Patient that participates in certain insurance plans that deem the Facility to be "out-of-network," the Facility may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.
7. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Facility within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Facility for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Facility's decisions regarding eligibility for financial assistance is as follows:
 - a. Upon receipt of denial of charity care, the Patient will also receive an appeal form in the event the Patient chooses to seek reconsideration. The appeal will be presented to the Charity Care Appeal Committee during a monthly review process, and the Patient will receive an appeal determination based on the decision of the Committee's review.
 - b. All appeals will be considered by the Facility's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Facility. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Facility.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Facility. The highest paying payor must account for at least 3% of the Facility's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Facility's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for medically necessary care and not more than gross charges for all other medical care. The Facility calculates one or more AGB percentages using the “look-back” method and including Medicare fee-for-service and all private health insurers that pay claims to the Facility, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by sending a written request to the following address:

HealthBridge - Orange
Attn: Financial Counseling/AGB – Main Registration
17581 Irvine Blvd, Suite 202
Tustin, CA 92780

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Facility’s. The Facility will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Facility may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Facility will not consider a FAP Application completed more than six months prior to any eligibility determination date.

Billing and Collections

The actions that the Facility may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be

obtained on the Facility's website or by sending a request to:

HealthBridge - Orange
Attn: Financial Counseling/AGB – Main Registration
17581 Irvine Blvd, Suite 202
Tustin, CA 92780

Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.