

TITLE: SAN FRANCISCO HEALTH NETWORK CHARITY CARE AND DISCOUNT PAYMENT PROGRAM POLICY AND PROCEDURE	Patient Financial Services Department
Reviewers: Thomas Istvan, Director Patient Financial Services; Tim Arnold, Director Patient Accounting; Jenine Smith, Patient Financial Services Manager; Henry Lifton, Deputy City Attorney	Original Date: December 14, 2006 Revision dates: March 8, 2007, September 12, 2007, December 14, 2007, June 22, 2008, June 1, 2009, July 15, 2009, April 1, 2011, April 1, 2012, April 1, 2014, January 1, 2015, July 15, 2016, December 1, 2017, August 3, 2019, January 1, 2023

I. PURPOSE

The purpose of this policy is to define the Charity Care and Discount Payment Programs financial assistance guidelines and eligibility for the San Francisco Health Network (SFHN) consistent with the provisions of Assembly Bills (AB) AB774, AB1020, and AB532 and Senate Bill (SB) SB1276.

II. POLICY

It is the policy of the SFHN to comply with all federal, state, and local regulations to provide financial assistance of the Charity Care and Discount Payment Programs to qualified uninsured and underinsured patients determined ineligible for federal/state and county programs with a payment responsibility for services received. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

III. SCOPE

This policy covers Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG), Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital and Rehabilitation Center, and the Population Health Division of the San Francisco Department of Public Health (SFDPH). This policy applies to services that do not qualify for other discount packages or programs such as the hospital’s maternity package, abortion services package or other package programs that are provided to patients at a global rate with significant discounts below government rates and are not subject to additional discounts. All accounts with patient liability with dates of service within 12 months prior to date of application will be considered. Accounts with dates of services exceeding 12 months prior to date of application are subject to department approval.

This policy does not apply to emergency, inpatient, radiology, and procedure room physician fees which are billed by and covered in the policy and procedure of UCSF Clinical Practice Group, Business Services/dba SFGH Medical Group. An emergency physician, as defined in California Health & Safety Code Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the FPL.

IV. HISTORY

- A.** Effective January 1, 2007 for ZSFG patients, and September 17, 2007 for Community Primary Care (COPC) patients, SFHN made available the Charity Care and Discount Payment Programs to assist uninsured or underinsured patients with limited income of up to 350 percent Federal Poverty Level (FPL) and who are not eligible for the Sliding Scale Program, government programs, or other payers including third party liability.
- B.** Effective November 1, 2010, SFHN made available the Catastrophic High Medical Expense Program to assist uninsured or underinsured patients ineligible for Sliding Scale, Charity Care or Discount Payment Programs with medical expenses exceeding 120 percent of their household annual income and who are not eligible for the Charity Care and Discount Payment Programs,

Sliding Scale Program, government programs, or other payers including payments they might receive because of third party liability.

- C. Effective January 1, 2015, ZSFG amended this policy per SB1276 legislation providing that:
 - 1. The definition of a person with high medical costs includes those persons who do receive a discounted rate from the hospital as a result of third-party coverage.
 - 2. The hospital shall negotiate with a patient regarding a payment plan, taking into consideration the patient's family income and essential living expenses.
 - 3. The hospital shall determine a reasonable payment formula where monthly payments are not more than 10 percent of a patient's family income, excluding deductions for essential living expenses.
 - 4. If the hospital and the patient cannot agree to a payment plan, the hospital shall use the specified formula of deducting 60% for essential living expenses from patient's gross household income and then calculate 10% of the remaining income to determine a reasonable monthly payment amount. The hospital provides patients with a referral for assistance to the Health Consumer Alliance at (888) 804-3536 or The Health Consumer Center/Bay Area Legal Aid at (855) 693-7285.

- D. Effective August 3, 2019 this policy was amended in accordance with the City and County of San Francisco's (City) Health Commission Resolution No. 19-8, which resulted in the following changes:
 - 1. The Charity Care Program qualifying FPL was increased to 500 percent
 - 2. The Discount Payment Program qualifying FPL was changed to include all FPL levels
 - 3. The high medical cost qualifying criteria was eliminated
 - 4. The Catastrophic High Medical Expense program was eliminated.

- E. Effective January 1, 2023 this policy will be amended in accordance with AB1020: Health Care Debt and Fair Billing and AB532: Fair Billing Policies.

V. DEFINITIONS OF POLICY TERMS

- A. **Allowance for financially qualified patient** means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.
- B. **Financial Assistance** means to provide charity care or discounted payment to financially qualified patients.
- C. **Financially Qualified Patient** means an uninsured or underinsured patient with payment liability/responsibility who meets the Charity Care or Discount Payment program's eligibility criteria.
- D. **Federal poverty level (FPL)** means the measure of income as issued annually by the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. FPL is based on a patient's family size and income and used by hospitals to determine financial assistance eligibility.
- E. **Hospital** means ZSFG, Specialty Outpatient Clinics, Community Primary Care Clinics, Laguna Honda Hospital and Rehabilitation Center, and the Population Health Division of SFDPH.
- F. **Patient** refers to the person for whom services were rendered or the guarantor if they are different.
- G. **Guarantor** means the person or entity who is financially responsible for payment on a patient's account.

- H. **Patient's Family** means the following according to the age of the patient:
 - 1. For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, 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.
- I. **Self-pay** means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patients may include charity care patients.
- J. **Uninsured** means a patient who has no third-party source of payment for any portion of the patient's medical expenses, including without limitation, commercial or other private insurance, government-sponsored healthcare benefit programs, or third-party liability and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission or rendered service.
- K. **Underinsured** means a patient who has a third-party source of payment for a portion of the patient's medical expenses with the remaining portion applied to the patient's responsibility/liability. This excludes patients who are covered by Medi-Cal/Medicaid.

VI. HEALTH CARE COVERAGE AND FINANCIAL ASSISTANCE NOTICES

- A. The hospital's policy of providing financial assistance to qualified self-pay patients are provided in multiple ways.
 - i. Notices are clearly and conspicuously posted in locations that are visible to the public in the ZSFG emergency room waiting room, urgent care waiting room, outpatient waiting rooms, the ZSFG Hospital main lobby. It is also posted on hospital website at ZuckerbergSanFranciscoGeneralHospital.org with the Charity Care and Discount Payment program application available to download.
 - ii. Written notices will be provided at the time of service in the Terms and Conditions of Admission for episodic admissions, in the ZSFG Patient Guidebook provided to patients admitted as inpatient, and as a patient handout in outpatient clinics will include the following information.
 - A. Internet address of the Health Consumer Alliance (<https://healthconsumer.org>) and a statement that there are organizations that will help the patient understand the billing and payment process.
 - B. Information about Covered California.
 - C. Information about Medi-Cal presumptive eligibility if the hospital participates in the presumptive eligibility program.
 - D. Internet address for the hospital's list of shoppable services, as required by federal law.
- B. MyChart electronic health portal provides information about financial assistance, preliminary screening tool and allows patients to send a message in the portal to the Patient Financial Services Department to request financial assistance.
- C. Patient billing statements include information for:
 - i. Obtaining billing assistance
 - ii. Requesting an itemized bill
 - iii. Requesting health care application assistance
 - iv. Requesting financial assistance. The final patient billing statement will also include a Charity Care and Discount Payment program application.

- v. Contacting Health Consumer Alliance <https://healthconsumer.org/> (888) 804-3536, Bay Area Legal Aid <https://baylegal.org/> (855) 693-7285
- vi. Overdue accounts are assigned to the Bureau of Delinquent Revenue (BDR) in the Office of the Treasurer and Tax Collector.

VII. HEALTH CARE COVERAGE ASSISTANCE AND PROGRAMS

- A. Patient Access Eligibility Workers collect patients' demographic, financial and insurance information to determine if the patient has insurance to cover the services, is uninsured or under-insured with only partial coverage. They will refer uninsured or under-insured patients to schedule an appointment with the Patient Access Enrollment Department or financial counselor located in the clinic which services are being provided, if available.
- B. Patient Access Financial Counselors provide uninsured and under-insured patients with healthcare coverage screening and application assistance depending on the program or package for which the patient is determined preliminarily eligible.
- C. Programs and packages may include the following:
 - i. AIDS Drug Assistance Program (ADAP)
 - ii. Breast and Cervical Cancer Treatment Program (BCCTP)
 - iii. California Children Services
 - iv. California Victim Compensation Program
 - v. Child Health & Disability Prevention Gateway to Health Coverage
 - vi. Covered California
 - vii. Every Woman Counts, Breast and Cervical Cancer Detection program
 - viii. Family Planning Access, Care and Treatment Program
 - ix. Medi-Cal, which provides free or low-cost health insurance to eligible California residents with limited income
 - x. Hospital Presumptive Eligibility Medi-Cal Program, which provides immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal
 - xi. Healthy San Francisco Program
 - xii. OB Package Program for prenatal care and delivery at ZSFG.
 - xiii. Department of Public Health Sliding Scale Program
 - xiv. Presumptive Eligibility Medi-Cal for Pregnant Women
 - xv. VIP Package Program for pregnancy termination.
- D. When a Patient Access Financial Counselor determines that a patient is ineligible for a healthcare program or package to cover their service, they will refer the patient to the Patient Financial Assistance Department to apply for the financial assistance programs which may reduce their self-pay payment responsibility.

VIII. FINANCIAL ASSISTANCE PROGRAMS

- A. There are two (2) financial assistance programs available, the Charity Care Program and the Discount Payment Program.
- B. Patients may apply for the Charity Care and Discount Payment Programs if they have been billed with a payment responsibility if the patient has cooperated with exhausting all available insurance, program and third-party liability options to cover their billed services. Examples of patient cooperation includes but is not limited to the following:
 - i. Patients must comply with pursuing and communicating with any commercial or employer sponsored insurance plans for payment of their services, including appeals.

- ii. Patients must pursue all potential third-party liability, and worker's compensation claim and provide notice of any settlement payment.
 - iii. Patients informed to apply for a government program or hospital package must submit a completed application with required verification for that entity to make an eligibility determination.
 - iv. Patients who receive a payment check directly from their insurance for services rendered by the San Francisco Health Network are required to relinquish those payments in full to the ZSFG Patient Accounting Department.
- C. The Charity Care and Discount Payment programs cannot be applied to services that qualify for discount packages or programs, such as the hospital's maternity OB package, VIP abortion services package, or other package programs that are provided to patients at a global rate with significant discounts below government rates. These are not subject to additional discounts.
- D. The Charity Care and Discount Payment program in a single application but have different eligibility requirements as described in the following sections. Patients must provide a completed application and all required verification.
- i. A complete application must be submitted within 12 months from the date of service to the Patient Financial Assistance Department.
 - ii. Applications for dates of services exceeding 12 months are subject to department approval.
 - iii. Verification required by each program must be submitted within 30 days of starting an application.
- E. Patients may contact the Patient Financial Assistance Department for assistance by:
- i. Calling (628) 206-3275 Monday – Friday 8:00am – 11:30am and 1:00pm – 5:00pm
 - ii. Sending a message in the request financial assistance section of the patient's MyChart patient portal account
- F. Applications are mailed to the address below:
- Zuckerberg San Francisco General Hospital
Patient Financial Assistance Department
1001 Potrero Ave, Building 20
San Francisco, CA 94110

IX. CHARITY CARE PROGRAM

A. Eligibility Requirements

- i. Patient's family household income must not exceed 500% of the federal poverty level.
- ii. Patient's family qualified assets may not exceed \$250.00 at the time of service. To calculate qualified assets, the first ten thousand dollars (\$10,000) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars (\$10,000) be counted in determining eligibility.

B. Income Verification

- i. Patients must provide the most recent three (3) months of pay stubs prior to date of application or complete most recent year income tax return for all sources of income. This is required for all qualified household members.
- ii. Patients on a student visa may provide I-20 form as verification.
- iii. Patients without an accepted verifiable source of income will be determined ineligible.
- iv. Patients active with a county or state program that does not cover the dates of service being billed to them, may have their income verification substituted as follows to qualify for a financial assistance program.

1. Patients confirmed with active Medi-Cal may replace the income verification with current eligibility in the Medi-Cal program.
 2. Patients confirmed with active Healthy San Francisco may replace the income verification with current enrollment with Healthy San Francisco.
 3. Patients confirmed with active with a County Medical Services Program (CMSP) may replace the income and assets with current eligibility in the CMSP program.
- v. Information provided by patients to verify income eligibility shall not be used for collections activities.

C. Assets Verification

- i. Patient must provide verification of liquid assets for all applicable sources of assets including the previous three (3) months of bank or brokerage account statements from date of application. This is required for all qualified household members.
- ii. Assets considered for eligibility include cash; checking accounts; savings accounts; money market funds; certificates of deposits; Real Estate property that is an income generating property or is not the primary residence; annuities; stocks, bonds; and mutual funds. Assets that are not considered include statements on retirement or deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans.
 - i. Information provided by patients to verify assets shall not be used for collections activities.
 - ii. Applications not containing asset verification will be determined ineligible for the Charity Care program and will only be considered for the Discount Payment Program.

X. DISCOUNT PAYMENT PROGRAM

A. Eligibility Requirements

- i. Patients who are determined ineligible because of Charity Care program due to excess income, excess qualifying assets, or an inability to provide verification of qualifying assets will be evaluated for the Discount Payment program.
- ii. There is no federal poverty level limit (FPL) or assets test to qualify.
- iii. Patient's household FPL is calculated to determine the discount to be applied.
- iv. Patients are eligible to receive a discounted rate from the hospital if they fully cooperate with verification of third-party liability coverage, discussed in Section VI.E, above.

B. Income Verification

- i. Patients must provide the most recent three (3) months of pay stubs prior to date of application or complete most recent year income tax return for all sources of income. This is required for all qualified household members.
- ii. Patients without an accepted verifiable source of income will be determined ineligible.
- iii. Patients active with a county or state program that does not cover the dates of service being billed to them, may have their income verification substituted as follows to qualify for a financial assistance program.

- a. Patients confirmed with active Medi-Cal may replace the income verification with current eligibility in the Medi-Cal program.
- b. Patients confirmed with active Healthy San Francisco may replace the income verification with current enrollment with Healthy San Francisco.
- c. Patients confirmed with active with a County Medical Services Program (CMSP) may replace the income and assets with current eligibility in the CMSP program.
- d. Information provided by patients to verify income eligibility shall not be used for collections activities.

XI. FINANCIAL ASSISTANCE APPLICATION DECISIONS

A. Approvals

- i. Patients will be notified in writing if approved with the final amount of their account balance after the discount has been applied.
- ii. Patients will be billed for the discounted payment responsibility if a balance remains after the discount is applied.

B. Denials

- i. Patients will be notified in writing if denied with the denial reason.
- ii. Patients will continue to be billed for the original payment responsibility on their accounts.

XII. APPEALS REVIEW PROCESS

- A. Patients may request an appeal of their Charity Care or Discount Payment program eligibility decision in writing with the reason for appeal and supporting verification to support the appeal reason within 15 business days of receiving an application decision.
- B. Appeals must be mailed to:
Zuckerberg San Francisco General Hospital
1001 Potrero Ave, Ward 15
San Francisco, CA 94110
Attention: Jenine Smith, Patient Access Manager
- C. The appeals reason and supporting verification will be reviewed per each program's eligibility requirements. Additional information and/or verification may be required.
- D. Patients will be notified in writing of the appeal decision.

XIII. PATIENT LIABILITY

- A. Patients are assessed a self-pay payment liability for any portion of their payment responsibility.
- B. A patient cap may be applied for patients who are not excluded. The following patients are excluded and will be billed for their full payment liability:
 - i. Patients who do not live in the United States.
 - ii. Patients with services that are covered by workers compensation or third-party liability
 - iii. Patients whose accounts which have been assigned to the Bureau of Delinquent Revenue
 - iv. Services that are eligible for the OB package or VIP package.
 - v. Patients who have received a direct payment from their insurance for their services and have not surrendered the payment to the San Francisco Health Network.
 - vi. Patients whose accounts have been outsourced to DPH contractor, Health Advocates for eligibility and insurance recovery assistance.
 - vii. Patients whose billed statements have been returned as undeliverable.

viii. Patients who are on a payment plan

XIV. PAYMENT PLANS

- A. Payment plans are available with ZSFG Patient Accounting Customer Service Department or the City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue (BDR) depending on which entity the account is with and the terms of the payment plan.
- B. Patients may request a payment plan from ZSFG Patient Accounting Department if the account(s) have not been assigned to BDR and the payment plan meets the following parameters:
 - a. Monthly payments must be a minimum of twenty U.S. dollars (\$20.00)
 - b. Duration of the payment plan may not exceed twelve (12) calendar months
- C. Payment plan with Customer Service may be established in the following ways:
 - a. Patients may create their own payment plan in their MyChart patient portal.
 - b. Patients may contact Customer Service for assistance with creating a payment plan by:
 - i. Sending a message in their MyChart patient portal account
 - ii. Emailing SFHNPatientFinancialServices@sfdph.org.
 - iii. Calling (628) 206-8448 Monday – Friday 8:00am – 11:30am and 1:00pm – 5:00pm
- D. Patients with delinquent payment plans will receive billing statements notifying them of the delinquent payments and to make a payment to bring their account current.
- E. Patients may contact the Customer Service Office to request a renegotiation of payment plan if it meets the department requirements.
- F. Patients who request a payment plan initially or through renegotiation that is less than twenty U.S. dollars (\$20) per month or that exceeds twelve (12) calendar months will have their accounts assigned to the BDR for assistance. Refer to City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue Zuckerberg San Francisco General Hospital Debt Collection Policies and Procedures.

REFERENCES:

- Assembly Bill 1020: Health Care Debt and Fair Billing 2022
- Assembly Bill 532 Health Care Fair Billing Policies 2021
- UCSF Clinical Practice Group, Business Services/dba SFGH Medical Group Guarantor/AB1020 Policy and Procedure
- City & County of San Francisco Office of the Treasurer & Tax Collector Bureau of Delinquent Revenue Zuckerberg San Francisco General Hospital Debt Collection Policies and Procedures
- Senate Bill 1276 Health care: fair billing policies 2014
- Assembly Bill 774 Hospitals: fair pricing policies 2007



**CITY & COUNTY OF SAN FRANCISCO
OFFICE OF THE TREASURER & TAX COLLECTOR
BUREAU OF DELINQUENT REVENUE**

**ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL
& LAGUNA HONDA HOSPITAL
DEBT COLLECTION POLICIES AND PROCEDURES**

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Introduction

The Bureau of Delinquent Revenue (BDR), a division of The San Francisco Office of The Treasurer & Tax Collector (TTX), is the official collection agency for the City and County of San Francisco (City) and is authorized to collect delinquent and outstanding payments and accounts receivable that are at least 90 days delinquent. BDR collects debt on behalf of the Department of Public Health (DPH), Zuckerberg San Francisco General Hospital (ZSFGH) and Laguna Honda Hospital (LHH). The ZSFGH and LHH are general acute care hospitals licensed pursuant to Section [§1250 of the Health and Safety Code] (each, a Hospital).

Hospital Debt Collections Overview

This document outlines the general workflow and collection procedures for handling medical accounts that are referred to The Bureau of Delinquent Revenue. BDR has a team of Senior Collection Officers and two Collection Supervisors that manage the day-to-day process of healthcare delinquent collections assigned to BDR by the referring Hospital. All BDR personnel are required to complete an annual testing and certification process to maintain compliance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality policies. BDR contracts third-party collections agencies to aid in the collections process after BDR has exhausted its own collections efforts. The third-party collection agencies are also HIPAA compliant.

BDR will not take any collections action until after 180 days from the date the Hospital first billed the patient. BDR follows all ZSFGH's guidelines for Charity Care and Discount Payment Programs consistent with the provisions of Assembly Bill Nos. 774 (AB774) and 1020 (AB1020), DPH's Discount Payment and Charity Care Policy, the San Francisco County Sliding Scale Program, and the CAP Policy. BDR and its contracted collection agencies do not conduct active collections past the statute of limitations in accordance with [CCP § 345], which is 4 years from the date of service or last day of payment on payment plan agreements. Additionally, the Hospital, BDR and the collection agencies do not report adverse information to the credit reporting agencies. Though we are a first party collection agency, we adhere to the guidelines of the FDCPA (Fair Debt Collection Practices Act) and all local, state, and federal regulations.

Assignments to Collections

On the 1st week of each month the Hospital sends over the accounts that qualified for assignment to collections. These accounts:

- Are 181 days or more from the date the patient was initially billed for hospital services
- Only contain balances that are the patient's responsibility (i.e., unpaid co-payments, coinsurance, deductibles)
- Have the final notice from the Hospital available to be included with the initial notice sent by BDR

As part of our quality control, the accounts are assigned to a "pre-collection process" desk, where the accounts go into an evaluation to ensure the collection process does not commence before 181 days from the first billing statement date in the assignment file.

I. Collections Commencement Workflow

BDR's collection process is designed to manage the entirety of the debt collection lifecycle. Our collection staff are thoroughly and regularly trained to tactfully and professionally engage and service patients in the course of performing their collection work, handle escalated patients, skip tracing, perform ability to pay assessments, bankruptcy, probate, and legal action.

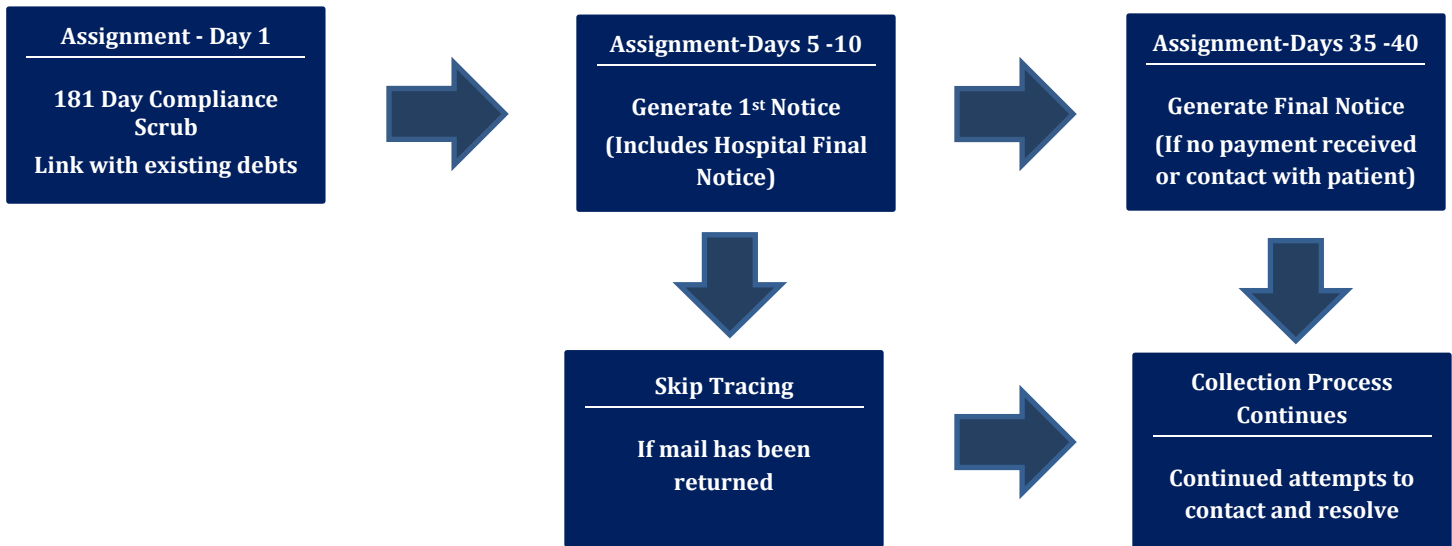
Ia. Account Assignment Campaigns: All unpaid accounts are loaded into our collection software and assigned an identifier that designates them as a Hospital account. The system assigns the account to a collector's inventory, and links together the newly assigned accounts with other preexisting obligations in our system for that patient. From here the account graduates to the "Outreach Process".

Ib. General Outreach Process: Accounts are placed into a queue for staff to initiate outreach. BDR sends an initial collection notice with a copy of the original final notice sent by the Hospital to the patient, pursuant to California Health & Safety Code Section 127425(e). BDR's initial collection notice will state that BDR will wait at least 180 days from the date the patient was initially billed for the Hospital service before filing a lawsuit and that BDR will not report adverse information to a credit reporting agency. The patient is given 30 days to respond, which can be a request to validate debt, pay the balance in full, or request to enter into a payment plan agreement, or discuss other resolution options. If a request for validation is received, the patient is provided with an itemized statement and/or a signed Conditions of Admissions form if available.

If a response from the patient is not received or arrangements were not made to resolve the account (i.e., installment payment plan agreement), then a final notice will be sent to the patient. Simultaneously, email and phone contact

attempts will also be attempted. If at any point we have mail returned as undeliverable, our staff will perform comprehensive skip tracing to locate contact information for the patient. If we have no contact with the patient, efforts will continue to be made to progress the account to the next to step on the collection process.

Collections Commencement & General Outreach Overview



Collections Process

Our collection process includes other common collection techniques, including auto-dialing, skip tracing, setting payment arrangements, and legal actions. In addition, we file proofs of claim in bankruptcy cases, creditor claims in probate cases, small claims actions and related post-judgment collections, and liens in third party claims cases. The patients can also be screened for the same charity and discount programs provided by the Hospital.

II. Payment Arrangements

Once contact with the patient has been made, BDR requests immediate payment of the full balance. For patients who are unable to pay the full balance, collectors are trained to probe for information and determine if a payment arrangement can be reached.

Iia. Ability to Pay Assessments: The patient is interviewed about the patient’s financial situation. The collector will have the patient complete the Financial Verification form. The patient will be required to provide supporting documentation within 30 days from the date of contact. Once all documentation is completed, the collector will finalize the ability to pay assessment. If approved, the collectors will then negotiate a payment arrangement to fit the patient’s situation.

Iib. Booking the Payment Arrangement: The patient is required to sign a payment plan agreement to initiate the final step in setting up the arrangement. The patient is provided with monthly reminder notice that is sent 15 days before the next installment in the arrangement is due. In the event of a default, the patient will be allotted an opportunity to cure the default and resume the arrangement.

Payment Arrangement - General Outreach Schedule

Event Days	Action	Trigger	Notice Name	Description of Notice
1	Payment Plan Activated	Signed Agreement	PP Letter	Confirm Arrangement
15 days before due date	Send Reminder Notice		MBS Letter	Monthly Billing Statement
30	Payment is due			
30 days after due date (Day 60)	Send PP Reminder Notice	No payment received	PP Reminder Letter	Payment(s) Missed
90	Send Notice of Default	No payment received	PP Default Letter	30 Day PP Cancel Notice
105	Courtesy Call or E-Mail	No payment received		

The payment arrangements on healthcare accounts are interest free. The arrangement may be adjusted based on changes to the patient's financial circumstances, such as the patient experiencing a loss income or if a different payer source has been identified (i.e., insurance, or the patient filed a claim against a 3rd party).

DPH Charity or Discount Programs

As part of our collection process, BDR will screen patients for both Charity Care and Discount Payment programs offered by DPH. Our collectors will review the Hospital's billing system to obtain updates on the status of the bill. If the patient became eligible for one of these programs, BDR will also apply that adjustment to the account, so the patient is billed appropriately. Once contact has been made with the patient, the collectors will include DPH's Charity Care or Discount Payment programs as part of the ability to pay assessment. The financial information obtained for this assessment will not be used for debt collection purposes by BDR or its collection agency vendors. The following balance reduction policy or financial assistance programs BDR will screen patients for are:

- CAP Billing Policy (CAP Policy)
- DPH Discount Payment or Charity Care Program
- San Francisco County Sliding Scale Program (Sliding Scale)

For the specific criteria for these programs, please see the DPH Charity Care and Discount Payment Program Policies & Procedures.

Medicare, Medi-Cal & Private Health Insurance

If the Hospital discovers, or the patient provides health insurance information, BDR may place the account on hold and coordinate with the Hospital to submit a claim to the insurer for payment. The collectors are trained on health care insurance billing and will work with the patient to obtain the information necessary for the Hospital to submit the bill to the patient's insurance (or to a 3rd party's insurance – See Third Party Claims section). If the bill will be paid by the patient's, insurance BDR will only pursue the amount that is determined to the patient's liability (i.e., co-pay, deductible, coinsurance, share of cost).

III. Requirements for Billing Health Insurance

To bill a patient's health insurance the patient must provide proof of coverage for the period of the service, and that the patient's insurance will cover the type of medical services the patient received. If the bill is within the timely filing period, which varies based on the insurance carrier and/or type of plan, the collector will obtain the necessary documents to provide to the Hospital for a claim to be submitted. If the patient is providing health insurance information after the timely filing period has passed, then the patient will be required to provide a written confirmation from their health insurer that they will accept and process the claim after timely filing period. In most circumstances we would require the patient to provide one or more of the following:

- Copy of the Health Insurance Card
- Benefits document that reflects period and type of coverage
- Where applicable, letter from insurance to confirm they will accept a claim that is passed the timely filing period

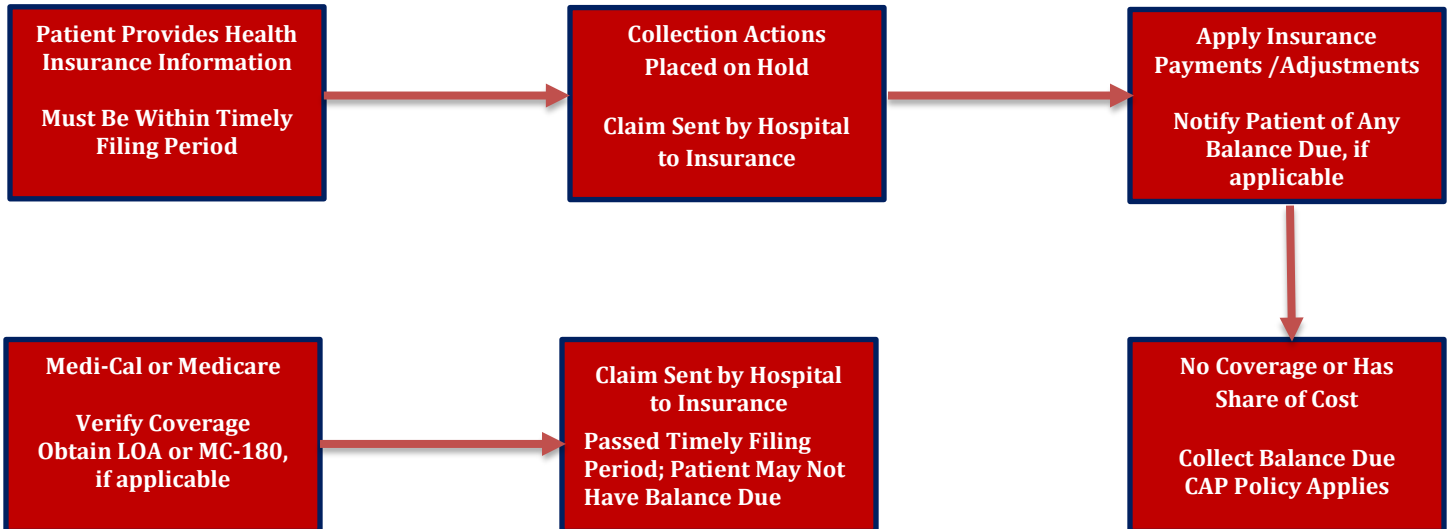
If the patient is unable to provide proof of coverage or the patient is providing insurance information after the timely filing period, the patient will be billed for the full amount of the services received. Under this circumstance, the patient is not eligible for a balance reduction under the CAP Policy, Sliding Scale, or DPH Discount Payment or Charity Care Programs. If the patient is working with the patient's health insurer to secure coverage, the collector can grant the patient additional time and provide a copy of the itemized statement(s) to the patient to assist in obtaining payment from the patient's insurance.

IIIa. Medi-Cal: If the patient is a Medi-Cal recipient, BDR or the Hospital can verify coverage for the period of service up to 1 year of the date of service. If the bill is still within the timely filing period, BDR will coordinate with the Hospital to submit a claim to Medi-Cal. If the type of coverage includes the services received but the patient is beyond the timely filing period or the year for us to verify, we will require the patient to provide a Letter of Authorization (or MC-180 form) that confirms the coverage for the period. Based on the type of coverage the patient may not have an out of pocket share of cost and the bill may be extinguished.

IIIb. Medicare: If the patient has Medicare and the bill is still within the timely filing period, BDR will coordinate with the Hospital to submit a claim for payment. If the type of coverage includes the services received but the patient is beyond the timely filing period, we will require the patient to show proof of coverage, which must include the Medicare type and period of coverage. If the coverage has been verified, the patient may not have an out of pocket share of cost and the bill may be extinguished.

IIIc. Work-Related Injuries & Coverage: If the patient indicates that the patient’s treatment was related to injury that occurred while performing work and that the patient’s employer is required to cover the treatment, we will require the patient provide the employer’s Worker’s Compensation insurance information. BDR will coordinate to submit the claim to the Worker’s Compensation insurance. If the insurance carrier approves the claim for payment, the patient will be only required to pay the patient’s share of cost, if applicable. If the claim is rejected (i.e., care received is determined to not be a work-related injury), then patient will be billed for the maximum amount set by DPH’s CAP Policy.

Health Insurance Billing – General Collections Workflow



Escalated Collections - Legal Action

If, after 180 days from the collections commencement, the patient has not responded to BDR’s collection attempts or the debt has not been resolved, BDR will begin evaluating the patient for other options to recover the debt. BDR performs comprehensive research to identify income, real property, and other financial assets. If the results reflect that the best course of action is to obtain a judgment, such as an unresponsive patient having sufficient means to pay or possess assets with the potential for payment, BDR may file a claim in small claims court or, if the amount due is substantial, a civil lawsuit. BDR may also file a legal action in other circumstances, including securing the debt with a judgment before the statute of limitations is exceeded.

IV. Small Claims Action

The BDR collection staff are trained in filing lawsuits in Small Claims court. Prior to filing the suit, BDR sends a final demand letter to the patient, which clearly states our intent to file a lawsuit, to allow the patient a final opportunity to contact BDR to resolve the unpaid bill. If the patient does not pay or respond to the final demand, the assigned collector will file the lawsuit, coordinate having the patient served within the timeframe set by the court and will actively pursue a judgment at the hearing (for both contested and uncontested cases). The complaint filed by BDR will allege each of the elements in Civil Code Section 1788.185.

IVa. Case Hearing: For contested cases, the collector will meet with the patient and can still accept a payment arrangement at that time, or still be screened for eligibility for the DPH Charity Care or Discount Payment programs. The patient will be required to pay for the process server costs in addition to the balance owed on the bill. Any agreement made between the collector and patient is entered into the court record, with the intent to obtain a judgment in the event the patient defaults on the payment arrangements or fails to comply with the requirements for the DPH Charity Care or Discount Payment program review. The collector will attend the progress report hearings to provide updates to the court.

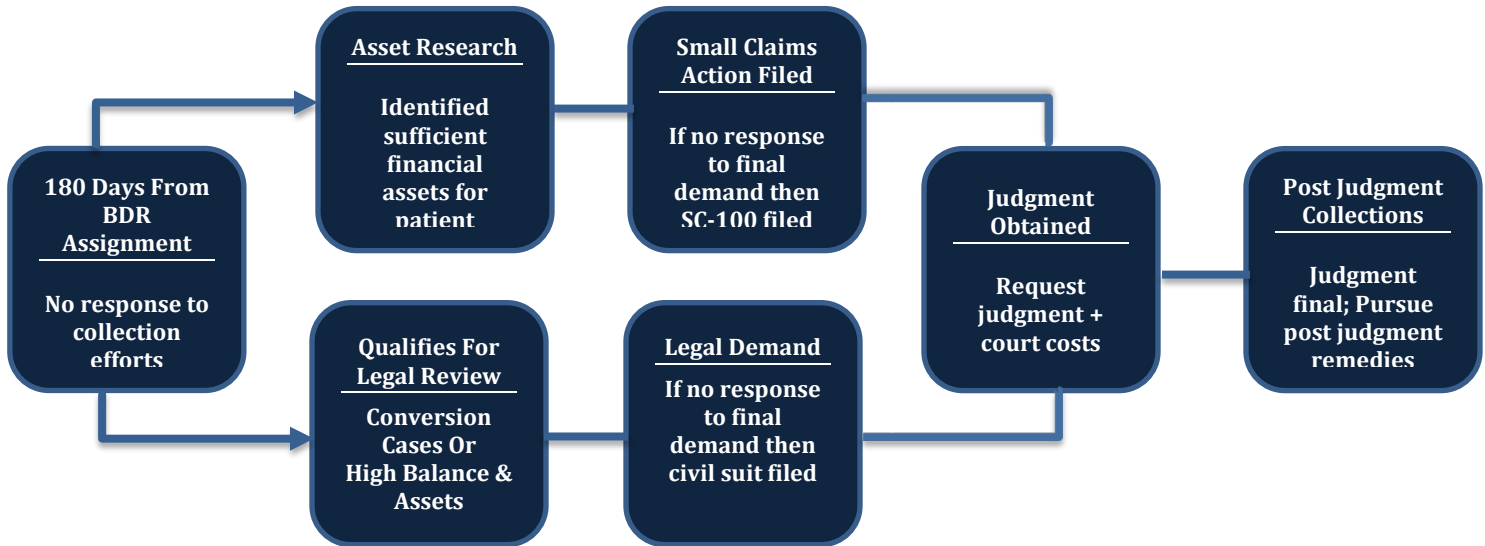
IVb. Post Judgment Collections: In the event that BDR obtains a judgment, after the appeal period has passed and the judgment is final, the collector will begin implementing post-judgment collection efforts. These efforts include filing and recording an Abstract of Judgment, wage garnishment, bank levies, Orders of Examination, interception of tax refunds or lottery winnings, and other judgment enforcement recovery options permitted by law. The patient is still allowed to make payment arrangements after the judgment is obtained. If a payment arrangement is approved the post-judgment collection efforts are placed on hold. Judgments accrue interest at the legally permissible rate and

are collectable for 10 years. If the judgment has not been satisfied, BDR will renew the judgment up to the 30 years maximum. Once the judgment is satisfied, BDR will file the Satisfaction of Judgment and provide a copy to the patient.

V. Civil Action

For high balance accounts where the patient has not resolved the bill, BDR may refer these accounts to the Legal Section of the Office of the Treasurer & Tax Collector for civil lawsuit review. Common accounts that would qualify for this level of escalated collections are instances where the patient’s health insurer has sent the payment directly to the patient, and the patient chooses not to send the payment to the Hospital (Conversion). Before the lawsuit is filed, a demand for payment is sent to provide the patient with a final opportunity to make arrangements to resolve the bill. The complaint filed by TTX’s Legal Section will allege each of the elements in Civil Code Section 1788.185. The legal costs for the suit will be included with the judgment and collected from the patient. If a civil judgment is obtained, BDR will implement post judgment enforcement actions to recover the debt.

Escalated Collections – Legal Action General Workflow



Supplemental Collection Agencies

Due to the large volume of accounts in its inventory, BDR contracts with third-party collection agencies who are experienced in collecting on municipal debts, including county hospital healthcare services. For accounts that are low value or where BDR has exhausted collection efforts, we can assign accounts to these agencies for supplemental collection efforts. The agencies also adhere to the requirements and specifications set by the scope of work in the contract when administering their collection services, and only collect on accounts while they are within the statute of limitations. As part of the requirements for the handling of the accounts we refer to them, the agencies do not report the accounts to the credit bureaus.

VI. Third-Party Collection Services

As BDR is the official collection agency for the City and County of San Francisco and is a first-party agency, the contracted collection agencies are secondary with respect to placements BDR assigns to them, and they provide supplemental collection services. As part of its agreements with the collection agencies, BDR requires the collection agencies to adhere to this policy and procedure for the collection of Hospital debt. These services include skip tracing, asset research, standard collections outreach such as sending notices, making collection calls, email and text message blasting, and filing lawsuits when appropriate. When handling healthcare accounts and their outreach, specifically notices, prioritizing refunds for overpayments, and setting up payment arrangements, the collection agencies follow the same process as BDR outlined in Section II above. The collection agencies also coordinate with BDR to bill a patient’s healthcare insurance in the event they obtain sufficient information for a claim to be submitted to the patient’s insurance. In the event that the agencies believe that filing a lawsuit is the best and appropriate step to recover the debt, the agencies will obtain approval from BDR before proceeding.

Via. Healthcare Account Outreach: After accounts are assigned to the collection agencies, they are placed on a suspense hold until a copy of the final notice from the Hospital has been received. Once that copy has been received, the agency will combine the Hospital final notice with their first notice that will be sent to the patient.

The collection agency gives the patient 30 days to request validation of the debt. For validation requests, the collection agencies coordinate with BDR to obtain the necessary documentation to provide to the patient.

Vib. Payment Arrangements: On healthcare accounts, the collection agencies offer payment arrangements to assist patients in resolving their delinquent account. In the event of a default, the agencies will give the patient an opportunity to maintain the arrangement by curing the default. The agencies will send a notice or make a phone call to the patient in an attempt to have the patient pay the defaulted amount. If the patient has not resolved the default within 90 days, the agency will cancel the payment arrangement and pursue recovery of the full balance. The agencies may, in some cases, settle the balance due with the patient, with approval from BDR.

Vic. Refunds: Please see the BDR Refunds section, below, for the handling procedures.

Refunds

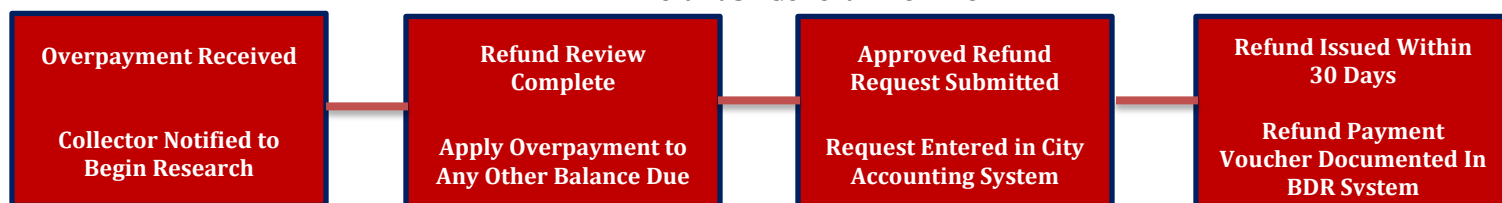
If the patient has overpaid on the patient's account, BDR will issue a refund within 30 days from the overpayment date if the patient does not have any other balances owed. The collector will perform a thorough review of the BDR collection system to confirm no other balances are outstanding. If the patient has a balance due on another account, the overpayment will be applied to that account first. If the patient still owes an amount due after the overpayment has been applied, no refund will be issued. All refund review results are documented in the BDR collection system. If the patient has no other balances due, the collector will complete the refund request form, provide the necessary supporting documentation, obtain the supervisor's approval, and then submit the approved request to the BDR Account Support Unit.

VII. Refunds From The Collection Agencies

The collection agencies will first apply any overpayments to any other outstanding balance the patient owes. If all debts are fully paid, the agency will transmit the overpayment to BDR within 10 business days of receipt. The agencies collections are submitted to BDR on a weekly basis in the form of a wire payment and an accompanying payment file. In the payment file the overpayment amounts have an identifier code, and upon posting the file the refunds are prioritized and processed within 30 days from the payment date indicated in the file. The BDR Account Support staff will coordinate with the collectors to perform the sub-system review for any other obligations owed. If no other obligations are owed the collector will follow the refund handling procedures above. .

VIIa. Interest on Refunds: Refunds in excess of \$5 will be paid interest at 10% per year as currently prescribed in the California Code of Civil Procedure Section 685.010, including as it may be amended.

BDR Refunds - General Workflow



Probate Creditor's Claims

In the event the patient passes away and has unpaid the Hospital accounts, our collectors will research to see if the patient has an active probate case filed in superior court. If there is an active case, and we are still within the filing period for BDR to file a Probate Creditor's Claim, then the collector will perform the following steps:

- Confirm we are within the period to file a claim (4 months from the date the executor or personal representative is appointed or 60 days from the notice of administration is issued to creditors, whichever is the later date).
- File a Creditor's Claim that includes all obligations owed by the patient to BDR, including the Hospital healthcare services accounts.
- File the Request For Special Notice.
- Schedule a review of the account every 30 days to monitor the progress the estate distribution; Reach out to the Administrator of the Estate as needed.

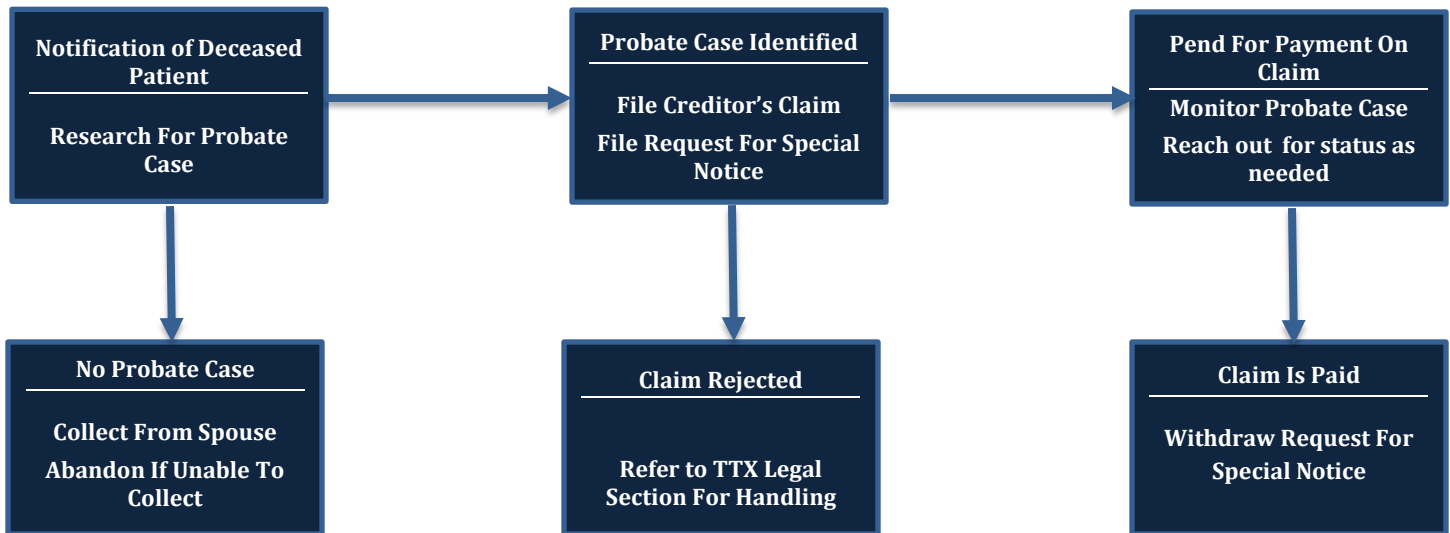
If the patient's health insurance is still active, the collector will still coordinate with the Hospital to process the claim. The Creditor's Claim will be amended, as needed, to account for any insurance payments received or adjustments made on the bill, so that only the amount the patient would have been liable for is included in the Creditor's Claim. Depending on the value of the estate, BDR may compromise on the claim as needed. Upon satisfaction of the Creditor's Claim, BDR will file a Withdrawal for the Request For Special Notice.

If the Administrator of the Estate fails to pay the Creditor’s Claim, BDR will pursue the Administrator for payment, including referring the account to TTX Legal Section. If a Creditor’s Claim is rejected by the Administrator, BDR will refer the matter to TTX Legal Section for handling. TTX Legal Section will respond to the rejection as appropriate and will advise BDR on next steps.

VIII. No Probate Case Filed

If there is no probate case filed in superior court, then the collector will research to confirm if the patient has a surviving spouse or guarantor (i.e., parent of a minor child) to continue the collection effort. If the patient does not have a surviving spouse or no assets that are being administered through a probate court proceeding, BDR will thoroughly document the collection system and will abandon the account(s). Abandonment is the equivalent of the account being written off as uncollectable.

Probate Creditor’s Claims – General Collections Workflow



Bankruptcy

If the patient has filed for bankruptcy, BDR will suspend all collection actions to comply with the automatic bankruptcy stay. Even if the Hospital account is post-petition, BDR will adhere to the stay, as the petitioner can amend the petition to include the Hospital accounts. We require that the patient provide the bankruptcy attorney’s contact information. If the patient does not have an attorney then, at minimum, we will require the patient to provide the case number. During the stay, BDR will not send any notices or make any collection calls to the patient but will respond to inbound inquiries from either the patient, the patient’s authorized representative, or legal counsel. BDR will research the bankruptcy case in the Pacer system. If applicable, BDR will file a proof of claim (POC) for all debts owed by the petitioner (the patient) and will monitor the case for next steps. On an as needed basis, TTX Legal Section may attend the 341 creditor’s meeting.

IX. Bankruptcy Chapter Filed

BDR may or may not be able to file the proof of claim, and that is usually determined by chapter filed or specific notifications received over the course of the bankruptcy. The most common chapters BDR encounters are chapters 7, 11, and 13. If the patient has filed for chapter 13 (repayment plan) or chapter 11 (reorganization – common for businesses), then we will file the POC and wait for the trustee to distribute payment to the creditors, including BDR. There can be other debts that have higher priority than the hospital accounts, especially if not secured by a judgment, so payment may not be immediate if there are higher priority debts being paid first. If the patient filed for bankruptcy protection under a no asset chapter 7 (asset liquidation), BDR cannot file a POC since there are no assets to liquidate. If it is later determined that the patient does have assets that can be liquidated, the bankruptcy court usually issues a notification to creditors. At that time BDR can file the POC.

IXa. Case Dismissal: While the case is active and being adjudicated, BDR will monitor the case. During this period, no active collection attempts will be performed. If the case gets dismissed, which can occur for a number of reasons, BDR can resume its standard collection process. The patient may still be able to refile for bankruptcy. If they do, then BDR will place our collection efforts on hold in compliance with the stay.

IXb. Discharge: While some debts handled by BDR cannot be discharged in a bankruptcy, hospital debt is dischargeable. If the bankruptcy court discharges the debt, then the patient is released from liability. The collector must thoroughly document the bankruptcy case results in the account records and code the effected accounts as bankruptcy discharge. The discharge code will mark the accounts as uncollectable and that the balance will be written off as a loss.

Bankruptcy Table of Actions For Hospital Accounts

BDR Action & Response	Chapter 7	Chapter 11	Chapter 13	Resume Collection Efforts
Automatic Stay	X	X	X	No
File Proof of Claim*		X	X	No
Monitor Case	X	X	X	No
Dismissal				Yes
Discharge				No

*Chapter 7 POC filed if receive notice of assets from bankruptcy court

Medical Reimbursement & Worker's Compensation Appeal Board Liens

If the patient incurred the medical services of the Hospital as a result of an accident with a potentially liable 3rd party (i.e., automobile accident is the most common), the patient may file a claim for damages against the 3rd party and may be awarded a settlement to compensate the patient. As prescribed by the San Francisco Health Code Section 124.5 (a)–(f), a lien attaches to the settlement or judgment awarded to the patient, and BDR will be entitled to collect on the amount owed for the Hospital bills related to the incident. If the patient claims injuries were incurred during the scope of performing work related job functions and files a claim with the Worker's Compensation Appeals Board (WCAB), a lien will be filed in that action by BDR and will attach to the recovery (if any) awarded to the patient. Due to the amount, time, and complexity involved with these claims, including instances where the patient also has health insurance coverage for these services, BDR may need to take a number of actions, some described below, to protect the Hospital's interests and ability to obtain payment for the medical services that are determined to be the patient's liability.

X. Types of Claims

A patient may file one of several types of claims that could result in the Hospital receiving payment for services rendered. While these claims are active, the patient will not be eligible for the DPH Charity Care or Discount Payment programs, or the CAP Policy. If the patient does not receive a settlement award, the patient may be screened for those programs or the CAP Policy at that time. If a settlement is awarded, the patient will be expected to pay the incident related Hospital bills in their entirety or, if the payment is not sufficient to cover all medical services and other claims-related expenses, must negotiate a compromise with BDR. The most common claims BDR encounters are:

- **1st Party Claim:** A first party claim is when the patient files a claim with the patient's auto insurance. Since this claim does not involve a 3rd party, BDR is unable to file a lien against any payment issued to the patient. The collector will continue BDR's standard collection efforts, described in Section II, above, to recover payment.
- **3rd Party Claim:** This is the most common. The patient opens a claim with liable 3rd party's auto insurance carrier. BDR will have the ability to file a lien.
- **WCAB Claim:** The patient files a claim with the WCAB for various reasons, with the most common being the patient's employer did not have sufficient coverage to pay providers for work-related injuries or does not agree that the patient's injuries are work related. The WCAB will determine liability and any award. This course of action does not restrict a patient to only pursuing compensation through the WCAB. The patient can also file a civil suit against the patient's employer. BDR will have the ability to file a lien in both the civil suit and the WCAB claim.

XI. Types of Liens Filed

Based on the types of claims and/or actions that the patient pursues, BDR will file a lien in those claims or lawsuits in order to secure the City's interests. The liens will only include the amount determined to be the patient's liability and related to the incident. The most common liens filed by BDR are:

XIa. Insurance Lien (IAL): Once BDR discovers the 3rd party insurance claim, BDR will put the carrier on notice of our lien. A lien is sent directly to the 3rd party's insurance, typically to the attention of the assigned claims adjuster. The patient may or may not have an attorney representing the patient, so BDR will typically negotiate resolution of the lien with the claims adjuster. We are either sent a separate payment for the agreed upon amount to satisfy the lien or named as a payee on the settlement check. If we are named as a payee, BDR will have the patient sign an acknowledgement of the patient's obligation to pay the lien and will endorse the check so the patient can deposit it and then make the payment to BDR.

XIb. Acknowledgement of Medical Lien (AML): If the patient is being represented by an attorney to handle the claim with the 3rd party, BDR will obtain a letter of representation and HIPAA-compliant authorization to release information to, and discuss the resolution of the lien with, the patient's attorney. The AML can be sent in addition to the IAL if the 3rd party has auto insurance coverage. If the patient agrees to settle the claim, BDR will require payment in full or will negotiate the lien based on the amount the patient is awarded.

XIc. Lawsuit Filed In Superior Court – Medical Reimbursement Lien (ML): If the patient decides to file a lawsuit in superior court, BDR will file the Medical Reimbursement Lien in the case and serve the appropriate parties. The ML can be filed in addition to the IAL and/or the AML. Often these cases may go through various pre-trial resolutions, such as mediations, settlement conferences, or arbitrations. TTX Legal Section will be on standby as needed to represent BDR (as the lien claimant) and address any questions regarding the lien. Once the case settles, BDR will negotiate payment for the lien with the patient's attorney.

XId. Claim Filed With the WCAB – Workers Comp Appeal Board Lien (WCC): If the patient files a claim with the WCAB, BDR will file a lien and serve all parties. If the patient is also pursuing a 3rd party claim, BDR will also issue the other applicable liens as described above. Similar to civil cases filed in superior court, the WCAB also has pre-trial proceedings, where TTX Legal Section will attend as needed to represent BDR and address any questions regarding the lien. Once the case has settled, BDR will negotiate payment for the lien.

XII. No Settlement Awarded

It may be determined that no settlement will be awarded to the patient. For example, if the patient is determined to be at fault, have a high degree of culpability in the accident, fail to provide required documents to adjudicate the claim, or the injuries are determined to not be work-related, then the patient may not receive a recovery. In the event that patient is not receiving an award, BDR will require confirmation that the claim is resolved, and no award will be granted. Once the confirmation is received, the standard collection process will resume with the patient. The patient can then be screened for the DPH Charity Care or Discount Payment programs and/or the CAP Policy may be applied to the patient's bills.

Table of Actions For 3rd Party & WCAB Liens

	1 st Party Claim Patient Insurance Only	3 rd Party Insurance Claim	Civil Suit Filed	Workers Comp Appeal Board Case Filed	Resume Collection Efforts
No Lien Sent	X				Yes
Send IAL*		X	X		Not while claim is active; No collections if settlement award and lien paid
Send AML*		X	X		
File ML*		X	X		
File WCC*				X	If services are determined to be work related injuries, collections will apply to seeking reimbursement from liable party

* These actions can occur concurrently, meaning if there is both a civil and WCAB case filed there will be a lien filed in both actions; Or if a claim graduates to a civil suit a lien will be filed in each action

For any questions contact BDR at ttx.bdr@sfgov.org.

Title: Guarantor/AB1020	Policies and Procedures	Policy No: 1.21
Page: 21		Effective Date:
Division: UCSF Clinical Practice Group, Business Services/dba SFGH Medical Group		Approved by: Department Manager
Unit: Customer Service		Supersedes Policy:
		Dated: 06/22/2022

AB1020, as it relates to physician services, states:

(B) The written policy regarding discount payments shall also include a statement that an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

SFGH Medical Group’s policy was previously amended to align with ZSFG’s AB774 charity policy. Our current policy exceeds the requirements of AB1020. Specifically, our policy is based on the FPL% as determined by the Financial Counselors at ZSFG. After the patient has qualified for charity care at ZSFG, SFGH Medical Group applies discounts based on the patient’s financial need, at rates shown in the following table.

FPL Range	Patient Liability	SFGH Medical Group Adjustment
0-138% FPL	0%	100% of guarantor balance
139-200 % FPL	20% of guarantor balance	80% of guarantor balance
201-350% FPL	25% of guarantor balance	75% of guarantor balance
351-500% FPL	30% of guarantor balance	70% of guarantor balance
501-700% FPL	35% of guarantor balance	65% of guarantor balance
701-1000% FPL	40% of guarantor balance	60% of guarantor balance
1001%+ FPL	45% of guarantor balance	55% of guarantor balance