Catholic Health	POLICY AND PROCEDURE	
TITLE: Uninsured Expected Payment and Healthcare Assistance Policy	**POLICY NUMBER:** CHS-RMC-03	**PAGE #** 1 of 13
RESPONSIBLE DEPARTMENT: Finance	**POLICY LEVEL:** CHS	**EFFECTIVE DATE:** 6/27/19
PREPARED BY: Patricia Schlemmer, Vice-President, of Patient and Resident Financial Services	**APPROVED BY:** Jim Dunlop, CHS Executive VP, Finance/CFO, Finance, Bart Rodrigues, Senior Vice-President, Chief Mission Officer, CHS Corporate Operational Policy Council 12/14/15	**MSMH:** 6/19/16
This document is not intended to create, nor is it to be construed to constitute a contract between CHS and any of its Associates for either employment or the provision of any benefit. This policy supersedes any policy previous to this policy for any CHS organizations and any descriptions of such policies in any handbook of such organization. Personnel failing to comply with this policy may be subject to disciplinary action up to and including termination.		

PURPOSE:
To define and document the Catholic Health policy and procedures for expecting and collecting payments from uninsured patients, including the provision of healthcare assistance. All allowances applied under this policy and procedures are part of Catholic Health's overall program and are charity care discounts.

APPLIES TO:
This policy applies to all Catholic Health ministries and services as defined by ministry below.

Acute Care:
All uninsured patients of Catholic Health receiving treatment at one of the Catholic Health's acute care facilities who are residents of New York State, a contiguous State or the state of Ohio, excluding the following services:

- Non-Medically Necessary Elective Services,
- Long term level of care services (Sub-Acute or Skilled Nursing),
- Physician services other than Catholic Health primary care physician services, and
- Medical equipment and supplies.
- Professional Medical Services from the following departments and specialties may be excluded from this policy under separate billing; Anesthesia Family Practice, Pathology and Clinical, Laboratories, Vascular Surgery, Neurosurgery, Emergency Medicine, Radiology, Podiatry, Obstetrics and Gynecology, Pediatrics, Surgery, Medicine, Cardiothoracic Surgery, Ear, Nose and Throat/Head and Neck Surgery, Orthopedic Surgery, Urology

Community Based Care:
All residents of Catholic Health receiving treatment at one of the Catholic Health's Long Term Care facilities (Hospital and Non Hospital Based) that are subject to insurance co-payments or deductibles may be eligible for charity care.

Home Healthcare:
All patients that receive services within the Catholic Health Home Care division (Certified Agencies, Licensed Agencies, and Infusion Pharmacy) may be eligible for Charity Care.

POLICY:
The mission of Catholic Health is to extend the healing ministry of Jesus by improving the health of our communities with emphasis on people who are under-served. Perpetuating our mission to benefit the communities we serve depends on our professional and ethical stewardship of resources. One part of that stewardship involves ensuring that we receive the appropriate reimbursement for the services we provide.

It is the policy of Catholic Health to ensure a socially accountable practice for expecting payment from all patients receiving care at one of our facilities. Patients served by Catholic Health are expected to pay for services provided based on non-medically necessary elective service rates, uninsured rates, rates negotiated by a third

party payer or regulated by a governmental agency. This Policy is specifically designed to address those patients who are uninsured and require care from one of the facilities within Catholic Health.

Confidentiality of information and individual dignity will be maintained for all those requesting consideration for healthcare assistance or being provided any allowance under this policy. Healthcare assistance will be awarded to uninsured patients based solely on their financial resources and ability to pay and will not be abridged on the basis of age, sex, race, religion, or national origin.

Catholic Health may refer an individual to alternative programs or services within the patient's community, as long as the referral is medically appropriate, in conformance with all applicable New York State and federal laws such as EMTALA, and places no undue burden on the patient or the patient's family. Catholic Health will assist such patients to locate alternative payment sources for the referred services. Such appropriate referrals will enable Catholic Health facilities to provide the maximum level of necessary healthcare assistance services within the limits of resources.

Eligible individuals will not be charged more than "amounts generally billed" ("AGB") to insured individuals for emergency or other medically necessary care. The AGB is based on the lessor of the current year Medicaid rates for the applicable Catholic Health System Facility or charges.

At its sole discretion, Catholic Health may attempt to assist patients in an effort to obtain healthcare benefits to which the patient may be eligible, including but not limited to Medicaid. Under no circumstances will application for such healthcare benefits be a criterion for eligibility under this policy for healthcare assistance.

Definitions:

"After Insurance Balance" ~ balances after insurance payment due from the patient or patient guarantor. These balances include, but are not limited to, co-pays, deductibles and co-insurance. After Insurance balances also include medically necessary care that is denied payment by the patient's insurance.

"After Insurance Balance Allowance" ~ for insured patients without the financial ability to pay After Insurance Balances, After Insurance Balance Allowances are available based on the sliding scale included as **Attachment C**
– After Insurance Balances. The procedures specified under section; Procedures, Acute Care, 4. After Insurance Balance Allowance Procedures must be followed in order to be the eligible for this allowance.

"Amounts Generally Billed (AGB) " ~The AGB for emergency or other medically necessary care to individuals who have insurance covering such care, which can be determined by a variety of methods described in 501(r) Internal Revenue Code

"Bad Debts" ~ with respect to a patient account, any amount uncollected and determined to be uncollectible, as a result of a patient's unwillingness to pay after appropriate, diligent and repeated collection efforts, is classified as a bad debt. Only account balances after all allowances defined in this policy have been provided will be eligible to be considered Bad Debts.

"Charging Process" ~ charges, which represent the fees for services provided to each patient, are applied to each individual patient account based on the services provided during each encounter. Typical charges include emergency room evaluation and management, imaging charges for x-rays of a sprained ankle, or daily room charges for inpatient encounters. The amount charged for each service is consistent for all patients regardless of the type of expected payment, e.g., insurance, Medicaid, patient responsibility.

"**Contractual Allowances**" ~ are the differences between amount billed at the provider's established rates and the amount received or to be received from third-party payers based upon a negotiated contractual agreement rate. The contractual allowance is applied to the patient account of any patient whose care is covered by the particular third-party payer.

"Guarantor" ~ shall mean the person who is financially responsible for the care of the patient, and may be the same person as the patient or the parent of a minor patient.

"**Healthcare Assistance Program (HAP)"** ~ is the part of Catholic Health's charity care program established for the provision of a Healthcare Assistance Program Allowance for uninsured patients who lack the financial resources necessary to obtain healthcare, granted based on need beyond the normal Uninsured Allowance issued for all uninsured including those patients that do not qualify for the HAP. The program is established and performed in a compassionate and professional manner consistent with all New York State and federal laws and regulations**.**

"**Healthcare Assistance Program (HAP) Allowances**" ~ are the potential set of allowances that are available to uninsured patient for uninsured accounts, based on each such patient guarantor's financial resources and ability to pay for healthcare services. The allowances will be available to all uninsured patients with household incomes estimated to be less than 501% of the applicable Federal Poverty Guideline amount and who have a PARO score of less than 695. Charges for healthcare services provided to patients who qualify for the HAP Allowances may be adjusted through two separate allowances, the Fixed HAP Allowance and the Additional HAP Allowance. The Fixed HAP Allowance is based on an Uninsured Contract based on Medicaid Reimbursement. Each such account is also potentially subject to an Additional HAP Allowance based on a sliding scale of each patient guarantor's ability to pay as measured through an objective means test that is applied to all uninsured patients. This additional allowance is provided to uninsured patients with household incomes estimated to be less than 201% of the applicable Federal Poverty Guideline amount and who have a PARO score of less than 695.

"Medically Indigent" - refers to patients whom have been determined to be unable to pay all or some of amounts due for healthcare services because the amounts due exceed their ability to pay, even though they have income or assets that otherwise exceed the general eligibility limits for Uninsured Allowance, HAP Allowance or After Insurance Balance. Medically Indigent patients will be accommodated through the appeals process noted in **Attachment B**.

"Medicaid Spend Down" – When applying for Medicaid benefits, certain guarantors are required to pay a portion of their medical expenses before the will be able to receive Medicaid benefits. This situation is referred to as a "Medicaid Spend Down", as the guarantor must "spend down" a specified amount of assets prior to receiving benefits. Guarantors in this situation shall not be eligible for Healthcare Assistance until the Medicaid Spend Down amount specified by the applicable state Medicaid oversight has been exhausted.

"Non-Medically Necessary Elective Service Rates" ~ are rates established for services that are not medically necessary and elective in nature. These services include cosmetic surgery or other non-medically necessary services including, but not limited to, requested private room services. Childbirth education classes are provided free of charge for all Medicaid covered patients appropriate for the service.

PARO Score™ ~ PARO™ is a Financial Analysis tool developed and managed by PARO Financial Counseling Solutions that uses up to 200 points of publicly available information to estimate an individual's need for healthcare assistance. The tool uses the information provided by each individual at registration to develop a PARO Score, which is developed in a manner similar to a FICO score (Fair Isaac Corporation Credit), but is used to evaluate an individual's need for healthcare assistance. Catholic Health uses this score as part of the means test for healthcare assistance.

"Patient" ~ shall mean those persons who receive care at one of the Catholic Health facilities.

"Presumptive Eligibility" ~ the process by which the hospital may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance

"Uninsured Account" ~ is the patient account of any uninsured patient as defined below.

"Uninsured Allowance" ~ is the allowance that is available to uninsured patient "Uninsured" accounts, based on each such patient guarantor's financial resources and ability to pay for healthcare services. The Uninsured allowance will be available to uninsured patients with household incomes over 500% of the Federal Poverty Guideline. This allowance will be developed based on the use of Uninsured rates.

"Uninsured Patients" ~ are defined as all patients who are uninsured and do not otherwise qualify for any governmental health insurance, governmental health benefit or private health insurance policy, plan or program that provides coverage for any of the healthcare services rendered.

"Underinsured Patients" ~ the term Underinsured Patients, for the purpose of this policy, shall mean individuals who have health insurance but who have exhausted their benefits and are, in effect, without further insurance coverage for the healthcare services rendered. In such cases, and at such time as the patient has fully exhausted his/her applicable health insurance benefits, an underinsured patient shall be deemed uninsured, for the purposes of this policy. Underinsured patients may be eligible for Healthcare Assistance Allowances or an Uninsured Allowance, based upon their available resources and ability to pay for the healthcare services they receive from a Catholic Health facility, as defined in the policy.

"Uninsured Rates" ~ patients considered to have the ability to pay, after application of the objective means test assessment, will be expected to pay for healthcare services based on Catholic Health's established Uninsured Rates. These Uninsured Rates are service specific and established in line with Catholic Health's preferred third party payer rates and methods. The result is an expected payment similar to those expected from patients covered by third party insurers.

RESPONSIBILITIES:

All Catholic Health associates have a responsibility to be familiar with this policy and procedure. The following associates have additional responsibilities:

Patient Access Associates are responsible to ensure the process defined and document in this policy is followed for registration/admission of uninsured patients including completion of the HAP application.

Patient Financial Services Associates are responsible to ensure the process defined and document in this policy is followed for After Insurance Balance requests, application of After Insurance Balance, Uninsured, Fixed HAP and Additional HAP allowances to designated patient accounts and handling of questions and appeal requests from patients and patient guarantors.

The Vice President of Resident and Financial Services is responsible for the ongoing maintenance of this policy and procedure, the weekly calculation of Uninsured, Fixed HAP and Additional HAP allowances and the updating of Federal Poverty Level based allowance sliding scales based on changes to the Federal Poverty Levels.

MEASUREMENT AND REPORTING:

Regular reporting of volumes of uninsured accounts and allowances provided under this policy will be available through standard Clinical and Business Intelligence reporting mechanisms.

REVIEW LEVEL:
This policy will be reviewed annually to ensure compliance with related state and federal regulations and any changes in Catholic Health's operational methodology or process.

PROCEDURE:

Acute Care:

1. General Procedure Expectations:
    a. All reimbursement and collection practices engaged in and observed by Catholic Health employees, contractors and agents will reflect the Catholic Health's commitment to the reverence for individual human dignity, the common good and our special concern for and solidarity with the poor and disadvantaged.
    b. Its employees, contractors and agents behave in a manner that reflects the policies and values of Catholic Health, including treating patients and families with dignity, respect and compassion.
    c. Patients on admission are given, and receive, prompt access to charge information for any item or services provided to them upon request.
    d. Patients and their families are advised of Catholic Health's policies, including the Healthcare Assistance Program and the availability of need-based financial assistance, in easily understood terms and any language commonly used by patients in the community.
    e. Patients who do not qualify for Healthcare Assistance Program assistance, but who are in need of financial assistance, are offered reasonable, customary and appropriate extended payment terms or other reasonable and customary payment options that take into account the patient's financial status. Payments will not exceed 10% of the gross monthly income.
    f. Outstanding balances on patient accounts are pursued fairly and consistently, in a manner that reflects the values and commitments of a Catholic sponsored facility.
    g. Financial counselors are available to assist all patients.
    h. Information is posted in the admitting and registration areas, including the Emergency Department, regarding financial assistance available to patients, including but not limited to the Healthcare Assistance Program.
    i. Information given and available to patients shall be in the primary languages of patients served by Catholic Health. A summary of such information and policies shall be available to patients upon request.
2. Healthcare Assistance Notice:
    a. Catholic Health shall provide uninsured patients at registration or admission with a written combined summary of the HAP and HAP application a copy of which is include as Attachment A of this policy. All patients presenting for care not excluded from HAP will be extended either Uninsured Allowances or HAP Allowances based on the following established process.
3. Healthcare Assistance Determination:
    a. The HAP shall be implemented in a manner that is in accordance with all applicable New York State and Federal laws, rules and regulations.
    b. The assessment of an uninsured patient's ability to pay is based on a presumptive, objective, good faith determination of financial need, means test that will be applied to all uninsured patients in the same manner and will consider, at a minimum, all income, all income sources, the local cost of living, and family size. Other financial considerations, including, but not limited to other medical care obligations and the extent of the patient's medical bills, may also be considered.

- Uninsured patients with income levels estimated to be less than or equal to 200% of the federal poverty level and a PARO Score™ less than 695 will be eligible for a 100% healthcare assistance allowance.
- Uninsured patients with income levels between 201% and 500% of the Federal poverty level and a PARO Score™ less than 695 will be eligible for a percentage healthcare assistance discount and a Fixed HAP discount based on the sliding scale included as **Attachment C** to this Policy.
- Uninsured patients with income levels over 500% of the Federal poverty level or a PARO Score™ greater than 694 will be eligible for an Uninsured Allowance based on service specific calculations using the account specific services and charges and the applicable Uninsured Rates.

c. Eligibility for financial assistance through the HAP should be made during the first billing cycle following the delivery of healthcare services. However, the determination may be made at any point in the patient account revenue cycle.

d. An appeals process has been established, and is set forth in **Attachment B**. The appeal process shall be available to all uninsured patients who are denied HAP assistance and who do not agree with such denial. This appeal process is also available to those awarded HAP discounts that are less than expected.

4. After Insurance Balance Allowances

a. Individuals applying for After Insurance Balance Allowances must provide a written statement detailing their financial situation and the number of members in their household. The statement must be signed and dated. In addition, the application must also provide as applicable one of the following:

- Signed copy of their most recent federal tax return
- Copies of the their last three pay stubs
- Copies of their last three unemployment payment stubs
- Copies of their last two Social Security Payment Statements
- A signed and notarized statement verifying no income sources

b. Based on the financial information provided and number of members in the household an allowance will be provided based on the After Insurance Balance Sliding scale for the applicable year included in **Attachment C**.

c. Applications for After Insurance Balance Allowances are subject to all applicable sections of this policy, including **Attachment B** – Appeal of Healthcare Assistance Determinations:

5. Collection Practices: Refer to the Billing and Collections Policy CHS-RMC-08

a. An uninsured patient account will not be forwarded to a collection agency if the patient has completed a Healthcare Assistance Program application or appeal and is awaiting response or determination.

b. The forced sale or foreclosure of an uninsured patient's primary residence, in order to satisfy a patient account, shall be prohibited for all services with the exception of Community Based Care services.

c. Uninsured patients who are participating in the HAP must be notified at least thirty (30) days before their account is forwarded to a collection agency.

d. All collection agencies servicing Catholic Health accounts must obtain written consent from the Catholic Health before any legal actions is initiated on any patient account.

e. All collection agencies must agree in writing to follow all Catholic Health Uninsured Expected Payment and Collection Policies and Procedures

f. Management is accountable to ensure that all collection policies are in accordance with the federal Fair Debt Collection Practices Act and all applicable New York State Law.

g. All collection agencies must provide information to patients on how to apply for Healthcare Assistance or appeal a Healthcare Assistance determination that is below their expectations.

h. All collection agencies are prohibited from making collections from any patient who was eligible for Medicaid at the time services were rendered.

6. Training:

   a. Annual mandatory training on Catholic Health Uninsured Expected Payment and Collection Policies and Procedures and its HealthCare Assistance Program will be provided to personnel in Patient Financial Services and Registrations/Admissions.

7. Record Keeping:

   a. Catholic Health will maintain a log identifying healthcare assistance discounts extended to each individual. All applications and determinations shall be maintained by Catholic Health for a period no less than six (6) years from the date of application.

<u>Community Based Care:</u>

1. After Insurance Balance Allowances

   a. Individuals applying for After Insurance Balance Allowances must provide a written statement detailing their financial situation and the number of members in their household. The statement must be signed and dated. In addition, the application must also provide as applicable one of the following:

      - Signed copy of their most recent federal tax return
      - Copies of the their last three pay stubs
      - Copies of their last three unemployment payment stubs
      - Copies of their last two Social Security Payment Statements
      - A signed and notarized statement verifying no income sources

   b. Based on the financial information provided and number of members in the household an allowance will be provided based on the After Insurance Balance Sliding scale for the applicable year included in **Attachment C**.

   c. Applications for After Insurance Balance Allowances are subject to all applicable sections of this policy, including **Attachment B** – Appeal of Healthcare Assistance Determinations:

   d. Failure to provide all required documentation will result in automatic denial. Applications are valid for length of related admission.

Home Healthcare:

1. Healthcare Assistance Notice:
    a. Catholic Health Home Care applications are given to patients in Catholic Health facilities prior to their discharge from the facilities. Catholic Health Home Care also sends letters to Home Care patients with their bills, notifying them of the HAP program.
2. Healthcare Assistance Determination:
    a. The Manager of Patient Accounts receives all Homecare Assistance Applications and makes an objective, good faith determination of financial need based on the following criteria, income, cost of living, family size and other financial considerations.
        - Patients with income levels estimated to be less than or equal to 175% of the federal poverty will be eligible for a 100% healthcare assistance allowance.
        - Patients with income levels between 176% and 500% of the Federal poverty level will be eligible for a percentage healthcare assistance discount and a Fixed HAP discount based on the sliding scale.
        - Patients with income levels over 500% of the Federal poverty level will not qualify for HAP discount.
    b. All patients that apply for HAP will receive either a denial or acceptance letter from the manager of Patient Accounts
3. Record Keeping:

Catholic Health Home Care will maintain a log identifying healthcare assistance discounts extended to each individual. All applications and determinations shall be maintained by Catholic Health for a period no less than six (6) years from the date of application.

Attachment A - **Acute Care Facilities Healthcare Assistance Program Application**

Healthcare Assistance Program Application Summary
The Catholic Health Healthcare Assistance Program provides discounts to patients based on need. In addition, we can help you apply for free or low-cost insurance. Please contact our Patient Financial Services Team for free and confidential assistance at (716) 601-3600.

Who qualifies for Healthcare Assistance?
Healthcare assistance is offered to all patient of Catholic Health receiving treatment at one of the Catholic Health acute facilities who are residents of NY State, a contiguous state or the state of Ohio; based on an income sliding scale.
Everyone in New York State who needs emergency services can receive care and get a discount if they do not have health insurance.
Everyone who lives in New York State can get a discount on non-emergency, medically necessary services in Catholic Health acute care facilities, if they do not have health insurance. You will not be denied medically necessary care because you need financial assistance.
You may apply for assistance regardless of immigration status.

Can someone help explain the program to me? Can someone help me apply?
If you do not have insurance and need care at a Catholic Health acute care facility, please contact our Patient Financial Services Team for free and confidential assistance at (716) 601-3600.
If you do not speak English, someone will help you in your own language.

How do I know what discount amount I am given?
Your discount will be reflected in your first billing statement from Catholic Health.

What if I don't agree with the discount amount I am given?
You have the right to appeal your healthcare assistance decision. You may do this by calling our Patient Financial Services Team at (716) 601-3600.

Charging Process
Charges, which represent the fees for services provided to each patient, as applied to each individual patient accounts based on the services provided during each encounter. Typical charges include emergency room evaluation and management, imaging charges for x-rays of a sprained ankle, or daily room charges for inpatient encounters. The amount charged for each service is consistent regardless of the type of expected payment, e.g., insurance, Medicaid, patient responsibility.

Application/Consent
Please review the statements below. Your signature acknowledges that you fall into one or more of these categories and will allow us to begin the healthcare assistance process. This is not a guarantee of a discount. If you disagree with your discount given, you may contact our Patient Financial Services Team at (716) 601-3600 or you may contact the Department of Health at (800) 804-5447.

- I do not have any form of health insurance, Medicare, or Medicaid coverage.
- I do not have the ability to pay for the services to be provided by Catholic Health.
- I would like to be considered for the Healthcare Assistance Program.

Please Print Your Name: _____
Signature: _____ Date: _____
Rev: 2/2018

Catholic Health

Attachment B - Appeal of Healthcare Assistance Determinations

Applicants Right to Appeal - An appeal procedure has been established which will cover disagreement and/or objection on the part of the applicant to healthcare assistance denials and/or healthcare assistance approvals which may be for less than the total healthcare assistance or less than expected. That procedure known as "Appeal of Healthcare Assistance Denial Process" is as follows:

As part of each written notice of determination, applicants will be advised as follows:

If you disagree with, or object to the Catholic Health decision regarding your application for healthcare assistance, then you may request that the decision be reviewed. A review may be requested in person or via the telephone with the Catholic Health Financial Clearance Manager. For telephone requests, please contact the Catholic Health Customer Service Office at 716-601-3600. For in person request, the Catholic Health Financial Clearance Office is located at:

Catholic Health Administrative and Training Center
144 Genesee Street, 3rd Floor
Buffalo, NY 14203

If, after reviewing the decision with the Catholic Health Financial Clearance Manager or other delegated staff members, you are not satisfied, you may request a final appeal of the decision. You will then be entitled to a complete re-evaluation of your application and a written determination of your appeal within thirty (30) days of the date of appeal.

Final Appeal Process

As part of the appeal process the requestor will be asked to provide documentation of financial status, including, but not limited to their last four pay stubs, their last two years W2 forms and/or SSA-1099. These documents and others provided will be used during the appeals process. The Financial Clearance Manager will review all final appeals and note the reason for such appeal. In addition, the Financial Clearance Manager will present such other factors as may be pertinent to the appeal regardless of whether such factors may or may not result in a determination in the favor of the applicant.

The Financial Clearance Manager will re-evaluate the application of the appealing applicant in accordance with the requirements of the Catholic Health program for Healthcare Assistance.

The results of that re-evaluation will be communicated to the applicant in writing within thirty (30) days of the date of the appeal or as soon thereafter as is possible.

The Catholic Health Chief Financial Officer may request a review of the appeal with or by the Catholic Health facilities Chief Executive Officer in the event of circumstances not explicitly or implicitly covered by the criteria or procedures of the Catholic Health healthcare assistance Program.

A written determination of the final appeal signed by the deciding party or parties will be mailed to the applicant within thirty (30) days of the date of the appeal.

Appeal Decision Final

With the exception of extraordinary circumstances, such as additional or revised information that would impact the original decision received after the date of the final appeal decision) all decisions rendered on appeals will be final.

The written notification of determination of a final appeal will not contain any further notice of right of either further review or appeal.

Attachment C:
Updated from the Federal Register/ Vol. 8, No. 19/ Friday, February 1, 2019

	FAMILY SIZE										
% Federal Poverty Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**HealthCare Assistance Discount**
Less Than 200%	<24,980	<33,820	< 42,660	< 51,500	< 60,340	< 69,180	< 78,020	< 86,860	< 95,700	< 104,540	100 % of balance after Fixed HAP Discount
200%	24,980	34,820	42,660	51,500	60,340	69,180	78,020	86,860	95,700	104,540	100 % of balance after Fixed HAP Discount
210%	26,229	35,511	44,793	54,075	63,357	72,639	81,921	91,203	100,485	109,767	90 % of balance after Fixed HAP Discount
220%	27,478	37,202	46,926	56,650	66,374	76,098	85,822	95,546	105,270	114,994	80% of balance after Fixed HAP Discount
230%	28,727	38,893	49,059	59,225	69,391	79,557	89,723	99,889	110,055	120,221	70% of balance after Fixed HAP Discount
240%	29,976	40,584	51,192	61,800	72,408	83,016	93,624	104,232	114,840	125,448	60% of balance after Fixed HAP Discount
250%	31,225	42,275	53,325	64,375	75,425	86,475	97,525	108,575	119,625	130,675	50% of balance after Fixed HAP Discount
260%	32,474	43,966	55,458	66,950	78,442	89,934	101,426	112,918	124,410	135,902	40% of balance after Fixed HAP Discount
270%	33,723	45,657	57,591	69,525	81,459	93,393	105,327	117,261	129,195	141,129	30% of balance after Fixed HAP Discount
280%	36,221	47,348	59,724	72,100	84,476	96,852	109,228	121,604	133,980	146,356	20% of balance after Fixed HAP Discount
290%	36,221	49,039	61,857	74,675	87,493	100,311	113,129	125,947	138,765	151,583	15% of balance after Fixed HAP Discount
300%	37,470	50,730	63,990	77,250	90,510	103,770	117,030	130,290	143,550	156,810	10% of balance after Fixed HAP Discount
350%	43,715	59,185	74,655	90,125	105,595	121,065	136,535	152,005	167,475	182,945	5% of balance after Fixed HAP Discount
400%	49,960	67,640	85,320	103,000	120,680	138,360	156,040	173,720	191,400	209,080	Fixed HAP Discount*
450%	56,205	76,095	95,985	115,875	135,765	155,655	175,545	195,435	215,325	235,215	Fixed HAP Discount*
500%	62,450	84,550	106,650	128,750	150,850	172,950	195,050	217,150	239,250	261,350	Fixed HAP Discount*
Over 500%	> 62,450	>84,550	> 106,650	> 128,750	> 150,850	> 172,950	> 195,050	> 217,150	> 239,250	> 261,350	Self Pay Discount**

ORIGINATION DATE: 1/1/2014

REPLACES (If applicable): NA

	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials	Date/ Initials
REVIEWED:	2/4/2014 SRK	1/29/2015 SRK	12/01/15 LS				02/14/18 BB	
REVISED:	2/4/2014 SRK	1/29/15 SRK	12/01/15 SRK	2/02/16 BB	03/24/16 BB	02/03/17 BB	02/14/18 SL	02/22/19 BB
REVISED:	6/13/19 SL							

CSC/OPC APPROVAL: 12/14/15, 3/30/16, 2/6/18, 6/26/19

REFERENCES: NA