

Cibola General Hospital 1016 E. Roosevelt Ave. Grants, NM 87020 Phone: 505-287-4446 Fax: 505-287-5309		Policy # 902026
Title: Patient Financial Assistance Policy		
Policy First Effective Date: 12/5/2025	Last Revision Date: 12/5/2025	Last Review Date: 12/5/2025

I. Policy:

Each hospital or clinic owned by Cibola General Hospital Corporation (CGHC), which includes Cibola General Hospital (CGH), Cibola Family Health Center (CFHC), Cibola Specialty Clinic (CSA), and Cibola Behavioral Health and Wellness (CBHW), (each, a “Hospital”), offers a financial assistance program for those patients who meet the eligibility tests described in this policy. CGHC provides Charity Care and self-pay discounts, adhering to the requirements of state law and does not discriminate based on race, color, national origin, sex (including pregnancy, sexual orientation, and gender identity), age, disability, or other categories protected by law.

The intent of this Financial Assistance Policy (the “Policy”) is to satisfy applicable federal and state laws and regulations; all provisions should be interpreted accordingly.

A significant objective of CGHC facilities is to provide care for patients in times of need. CGHC facilities provide Charity Care and a Discount Payment Program as a benefit to the communities we serve. To this end, CGHC facilities are committed to assisting low-income and/or uninsured eligible patients with appropriate discount payment and Charity Care programs. All patients will be treated fairly, with compassion and respect. Accompanying this Policy are the following documents, as referred to throughout this Policy:

- Summary of Financial Assistance:
 - Charity Care Program
 - Financial Assistance Discount Payment Program
 - Sliding Fee Discount Program
 - Breast and Cervical Program
 - Mammo Fund

II. Definitions:

- Amounts Generally Billed: The Hospital calculates the patient's responsibility using the prospective method as defined within Experian Price Estimator.
- Emergency and Medically Necessary: Any hospital emergency, inpatient, outpatient, or emergency medical care.
- EMTALA: The hospital complies with the requirement of the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act. There is nothing contained in this policy, which will preclude such compliance. This is a federal law that requires anyone

coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay.

- Guarantor: (1) for persons 18 years of age and older. The guarantor's spouse, domestic partner, and dependent children under 18 years of age, whether living at home or not; and (2) for persons under 18 years of age, parent, caretaker relatives.
- Good Faith Estimate: Provide a good faith estimate (as specified in paragraph (c)(1) of this section) to uninsured (or self-pay) individuals within the following timeframes:
 - (A) When a primary item or service is scheduled at least 3 business days before the date the item or service is scheduled to be furnished: Not later than 1 business day after the date of scheduling;
 - (B) When a primary item or service is scheduled at least 10 business days before such item or service is scheduled to be furnished: Not later than 3 business days after the date of scheduling; or
 - (C) When a good faith estimate is requested by an uninsured (or self-pay) individual: Not later than 3 business days after the date of the request. eCFR149.610
- No Surprises Act: The No Surprises Act is a Federal regulation that prohibits out-of-network providers from balance billing patients for services received in certain circumstances. Additionally, it requires out-of-network providers to give out-of-network patients a notification regarding their rights regarding balance billing and requires that out-of-network providers give Good Faith Estimates to out-of-network patients for services they seek.
- Out-of-Pocket Costs: any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medicaid cost sharing.
- No Surprise Billing:
 - Notice and Consent: When a patient has a choice of providers and chooses to receive services from an out-of-network facility or provider, facilities and providers must provide notice of out-of-network billing and consent to be balance billed ("Notice and Consent"). Out-of-network patients must be presented with and sign a Notice and Consent to continue treatment at a CGHC facility.
 - Notice and Consent: No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
 - If the service is scheduled within 72 hours of the service being provided, the Patient Good Faith Estimate must be provided on the day of the service being rendered.
 - If the service is scheduled for outpatient ambulatory same-day services, the estimate must be provided to the patient prior to rendering services.
 - For questions or more information about Rights to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

III. Applicability of the Policy:

This Policy applies to all emergency and other medically necessary care provided by the Hospital or a substantially related entity working in the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an emergency, inpatient, or outpatient basis. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance. The Hospital is not responsible for the

administration of any financial assistance program offered by the Hospital's non-employed medical staff physicians or such physicians' billing practices.

Financial assistance policies must balance a patient's need for financial assistance with the Hospital's broader fiscal stewardship. Financial assistance through discount payment and Charity Care programs is not a substitute for personal responsibility. It is the patients' responsibility to actively participate in the financial assistance screening process and, where applicable, contribute to the cost of their care based upon their ability to pay. Outside debt collection agencies and the Hospital's internal collection practices will reflect the mission and vision of the Hospital.

IV. Procedure:

1. Eligibility for Financial Assistance

o Self-Pay Patients

- Presumptive eligibility does not convey an entitlement for future services.
- The circumstances below are considered forms of Charity Care and may be documented as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to Charity Care, self-pay discounts, non-covered services and denials.
- The patient qualifies for limited benefits under the state's Medicaid program, *i.e.*, limited pregnancy or emergency benefits, but does not have benefits for other services provided at the Hospital. This includes non-covered services related to:
 - Services provided to Medicaid beneficiaries with restricted Medicaid (*i.e.*, patients that may only have pregnancy or emergency benefits, but receive other care from the Hospital);
 - Medicaid pending applications that are not subsequently approved, provided that the application indicates that the patient meets the criteria for Charity Care;
 - Medicaid or other indigent care program denials; and
 - Charges related to days exceeding a length of stay limit.
- Reasonable efforts have been made to locate and contact the patient, such efforts have been unsuccessful, and the Hospital's Chief Financial Officer or designee has reason to believe that the patient would qualify for Charity Care or the Discount Payment Program, *e.g.*, patient is deceased, bankrupt, incarcerated (and not reimbursed by a State Medicaid program), non-responsive, homeless, or unwilling to provide documentation.
- A third party collection agency has made efforts to collect the outstanding balance and has recommended to the Hospital's PFS Director that Charity Care or the Discount Payment Program be offered.
- Subsequent to collection efforts and payor negotiations, any unreimbursed charges from non-cosmetic services, including non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials, are considered a form of patient financial assistance at CGHC. Charges related to these discounts written off during the fiscal year are reported as uncompensated care.

o Determination of Income

- For purposes of determining eligibility for the Charity Care reference policy 902007 of the Finance Charity Determination policy.
 - For purposes of determining eligibility for the Sliding Fee reference policy 902025 of the Finance Sliding Fee Discount Program policy for CFHC, see patient Financial Assessment Form Policy 691031.
- **Federal Poverty Levels**
The measure of the Federal Poverty Level shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of persons in the patient’s Family or household. HHS Poverty Guidelines are updated periodically in 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, and available here: <https://aspe.hhs.gov/poverty-guidelines/>.

2. Application Process

Any patient who requests financial assistance will be asked to complete a financial assistance application. The application includes the office address and phone number to call if the patient has any questions concerning the financial assistance program or application process. A patient is expected to submit the financial assistance application promptly following care, but no later than 15 days following the date of the first post-discharge statement.

3. Resolution of Disputes

Any disputes regarding a patient’s eligibility for financial assistance shall be directed and resolved by the Hospital’s Chief Financial Officer.

4. Publication of Policy

In order to ensure that patients are aware of the existence of this Policy, the Hospital shall take the following measures:

- Posted on CGHC’s website.

5. Efforts to Obtain Information Regarding Coverage & Applications for Medicaid

The Hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Hospital to a patient including private health insurance, coverage offered through the federal health insurance marketplace, Medicare, Medicaid, and/or other government-funded programs designed to provide health coverage.

6. Discounts and Eligibility

For purposes of determining discounts, reference policy 902025 of the Sliding Fee Discount Program Policy for CFHC.

For purposes of determining discounts, reference policy 902027 of the Patient Discount Policy for CSA, CBHW, and CGH.

For purposes of determining payment plan options, reference policy 902028 of the Patient Payment Plan Policy for CGH, CFHC, CSA, and CBHW.

Patients who are not eligible for insurance coverage or hospital financial assistance may still qualify for the self-pay discount. For New Mexico residents, this discount provides a 40 percent reduction on hospital and physician charges when the remaining 60 percent is paid in full at the time of service. Patients who are unable to pay 60 percent at the time of service may instead be eligible for a 20 percent discount, with a payment plan available for the remaining 80 percent of the charges.

Self-pay discount and financial assistance are available only to uninsured patients with no other funding source. If your care is covered by third-party liability insurance, automobile insurance, or medical payments coverage, self-pay discount or financial assistance will not apply.

SLIDING FEE SCHEDULE

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)* Patients with incomes above 100% of poverty, but at or below 200% poverty, will be charged a nominal fee according to the sliding fee schedule based on their family size and income.												
Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	\$15,650	\$17,215	\$18,780	\$20,345	\$21,910	\$23,475	\$25,040	\$26,605	\$28,170	\$29,735	\$31,300	>\$31,300
2	\$21,150	\$23,265	\$25,380	\$27,495	\$29,610	\$31,725	\$33,840	\$35,955	\$38,070	\$40,185	\$42,300	>\$42,300
3	\$26,650	\$29,315	\$31,980	\$34,645	\$37,310	\$39,975	\$42,640	\$45,305	\$47,970	\$50,635	\$53,300	>\$53,300
4	\$32,150	\$35,365	\$38,580	\$41,795	\$45,010	\$48,225	\$51,440	\$54,655	\$57,870	\$61,085	\$64,300	>\$64,300
5	\$37,650	\$41,415	\$45,180	\$48,945	\$52,710	\$56,475	\$60,240	\$64,005	\$67,770	\$71,535	\$75,300	>\$75,300
6	\$43,150	\$47,465	\$51,780	\$56,095	\$60,410	\$64,725	\$69,040	\$73,355	\$77,670	\$81,985	\$86,300	>\$86,300
7	\$48,650	\$53,515	\$58,380	\$63,245	\$68,110	\$72,975	\$77,840	\$82,705	\$87,570	\$92,435	\$97,300	>\$97,300
8	\$54,150	\$59,565	\$64,980	\$70,395	\$75,810	\$81,225	\$86,640	\$92,055	\$97,470	\$102,885	\$108,300	>\$108,300
For each additional person, add	\$5,500	\$6,050	\$6,600	\$7,150	\$7,700	\$8,250	\$8,800	\$9,350	\$9,900	\$10,450	\$11,000	>\$11,000

*Based on the 2025 [Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia](#). Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.