SAMPLE LETTER TO HOSPITAL

[DATE]

[YOUR NAME]
[YOUR ADDRESS]

[HOSPITAL NAME]
[HOSPITAL ADDRESS]

Dear [HOSPITAL NAME]:

I received medical care at your hospital on [DATE]. I am now receiving bills from the hospital, [and/or] receiving notices from one or more collections agencies, [and/or] being sued for collection of this bill by [INSERT NAME OF AGENCY SUING]. My family income is no more than 350% of the federal poverty level and I am uninsured [or] my out-of-pocket health care costs exceed 10% of my income. According to AB 774 (California Health & Safety Code § 127400 *et seq*), I should be eligible for charity care or a discount payment program offered by the hospital.

[Select all the circumstances which apply]

- I was not given written notice regarding the hospital's charity care or discount payment policy while in the hospital, or when I was billed, [and/or] in the language I speak.
- The hospital refused to give me an application for charity care or a discount payment program.
- I was not permitted to set up a reasonable payment plan.
- I applied for financial assistance, but the hospital refused to accept my application.
- I applied for financial assistance, but the hospital did not process my application and make a final determination.
- My application for financial assistance was improperly denied. [Explain circumstances]

Until this matter is resolved, any collection activity against me is unlawful. If I am not offered payment assistance as required by law, I will file a complaint with the Department of Health Services or seek other remedy as permitted by the laws of this state. I also ask that you assist me in repairing any damage that may have been done to my credit. Please notify me immediately as to how you intend to resolve this.

Sincerely,

[YOUR NAME]

cc: [OTHER ENTITIES ATTEMPTING TO COLLECT ON THE BILL]

SAMPLE LETTER TO COLLECTION AGENCY

[DATE]

[YOUR NAME]
[YOUR ADDRESS]

[COLLECTION AGENCY NAME]
[COLLECTION AGENCY ADDRESS]

Re: Request for Suspension of Collection Pending Determination of Eligibility for Hospital Financial Assistance

Dear [COLLECTION AGENCY NAME]

My hospital bill from [HOSPITAL NAME] has been sent to you for collection. I believe that I should have been offered and granted financial assistance for the medical services that I received at [HOSPITAL NAME] on [INSERT DATE(S) OF SERVICES].

California has a new Hospital Fair Pricing Policies law that requires hospitals to have written financial policies and notify their patients of these policies. CA Health & Safety Code § 127400 *et seq.* According to the law "Uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level . . . shall be eligible to apply for participation under each hospital's charity care policy or discount payment policy." CA Health & Safety Code § 127405(a).
[Select the circumstances that apply]

- I am uninsured and the hospital did not inform me that I could apply for financial assistance or seek coverage from government program as required by CA Health & Safety Code § 127410(a) and § 127420(b). I am now trying to do so.
- I have applied for financial assistance and am waiting for a decision from the hospital. CA Health & Safety Code § 127425(e) requires that you wait to collect on this bill.
- The hospital wrongfully denied me financial assistance according to the requirements of CA Health & Safety Code § 127400 *et seq* and I am appealing this decision [or] filing a complaint with the Department of Health Services.
- According to CA Health & Safety Code § 127425(d), you may not report me to a credit reporting agency or commence a civil action against me for 150 days after I was initially billed.

If you continue to try to collect on this bill before a determination of financial assistance is made on my account, you may be in violation of the Rosenthal Fair Debt Collection Practices Act and the federal Fair Debt Collection Practices Act. CA Civil Code § 1788 *et seq.* and 15 U.S.C. § 1692 *et seq.*

I am asking that you cease collection on this bill until [HOSPITAL NAME] makes a decision regarding my financial assistance application.

Sincerely,

[YOUR NAME]
CC: [HOSPITAL NAME] (Send a copy to the hospital)

SAMPLE LETTER TO LICENSING AND CERTIFICATION

[DATE]

[YOUR NAME]
[YOUR ADDRESS]

[LICENSING & CERTIFICATION DISTRICT OFFICE ADMINISTRATOR][1]
[LICENSING & CERTIFICATION DISTRICT OFFICE]
[DISTRICT OFFICE ADDRESS]

RE: [NAME OF HOSPITAL]'s failure to comply with the financial assistance guidelines of AB 774

Dear District Administrator [NAME OF ADMINISTRATOR]:

I received care at [NAME OF HOSPITAL] on [DATES OF SERVICE]. The hospital is demanding payment on this bill, [and/or] my bill has been sent to collections, [and/or] I am being sued for collection of this bill, [and/or] I was forced to pay more than I owe. My income does not exceed 350% of the federal poverty level and I am uninsured [or] my annual out-of-pocket medical costs exceed 10% of my income. According to the California Health & Safety Code § 127405, I should be eligible for charity care or a discount on my charges with an extended payment plan.

[Select all the circumstances which apply]

- I was not given written notice regarding the hospital's charity care or discount payment policy while in the hospital, or when I was billed, [and/or] in the language I speak.
- The hospital refused to give me an application for charity care or a discount payment program.
- I was not permitted to set up a reasonable payment plan.
- I applied for financial assistance, but the hospital refused to accept my application.
- I applied for financial assistance, but the hospital did not process my application and make a final determination.
- My application for financial assistance was improperly denied. [Explain circumstances]

Please review [NAME OF HOSPITAL]'s failure to comply with the requirements of AB 774. I ask that you do everything in your power to force the hospital to comply as hospitals are required to follow this statute in order to stay licensed.

I authorize Licensing and Certification to disclose my name to the hospital solely for the purposes of this investigation. Please require that the hospital reduce or forgive my bill according to their policy [and/or] reimburse me with interest the amounts I already paid in excess.

Please let me know when you will respond to this complaint and how it is ultimately resolved. Thank you for your time.

Sincerely,

[YOUR NAME]

[1] Contact information for Licensing and Certification district offices may be found at: http://www.dhs.ca.gov/lnc/org/default.htm